

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0042861

**Facility Name:** Provena Villa Franciscan

**Address:** 210 North Springfield Avenue Joliet 60435  
 Number City Zip Code

**County:** Will

**Telephone Number:** (815) 725-3400 **Fax #** (815) 725-2160

**HFS ID Number:** 371127787008

**Date of Initial License for Current Owners:** 12/01/97

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501 C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Provena Villa Franciscan# 0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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 10/1/06

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>136</u>	Skilled (SNF)	<u>176</u>	<u>64,240</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>176</u>	<u>64,240</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,128</u>	<u>19,203</u>	<u>13,759</u>	<u>55,090</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,128</u>	<u>19,203</u>	<u>13,759</u>	<u>55,090</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.76%

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

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

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

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

N/A - NoneF. Does the facility maintain a daily midnight census? Yes

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

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 9/1/1990

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/1/1997 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 114 and days of care provided 13,325Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	408,367	79,870	38,870	527,107		527,107		527,107			1
2	Food Purchase		332,126		332,126		332,126	4,377	336,503			2
3	Housekeeping	196,492	43,947		240,439		240,439		240,439			3
4	Laundry	67,006	12,564	107,957	187,527		187,527		187,527			4
5	Heat and Other Utilities			175,866	175,866		175,866	1,509	177,375			5
6	Maintenance	153,676	29,696	47,439	230,811		230,811	60,382	291,193			6
7	Other (specify):* <b>Pastoral Care</b>	37,757	2,210	12,713	52,680		52,680	(11,952)	40,728			7
8	<b>TOTAL General Services</b>	<b>863,298</b>	<b>500,413</b>	<b>382,845</b>	<b>1,746,556</b>		<b>1,746,556</b>	<b>54,316</b>	<b>1,800,872</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	4,289,881	439,010	706,535	5,435,426		5,435,426		5,435,426			10
10a	Therapy			759,621	759,621		759,621		759,621			10a
11	Activities	199,864	15,622	44,518	260,004		260,004	1,740	261,744			11
12	Social Services	96,438	196	814	97,448		97,448		97,448			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>4,586,183</b>	<b>454,828</b>	<b>1,523,488</b>	<b>6,564,499</b>		<b>6,564,499</b>	<b>1,740</b>	<b>6,566,239</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	327,381	17,519	1,031,100	1,376,000		1,376,000	(523,896)	852,104			17
18	Directors Fees											18
19	Professional Services			65,475	65,475		65,475	380,280	445,755			19
20	Dues, Fees, Subscriptions & Promotions			48,790	48,790		48,790	(5,539)	43,251			20
21	Clerical & General Office Expenses			69,821	69,821		69,821	(360,204)	(290,383)			21
22	Employee Benefits & Payroll Taxes			1,262,744	1,262,744		1,262,744	163,401	1,426,145			22
23	Inservice Training & Education			18,450	18,450		18,450	5,255	23,705			23
24	Travel and Seminar			9,400	9,400		9,400	7,906	17,306			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			167,280	167,280		167,280	194	167,474			26
27	Other (specify):* <b>Bad Debt</b>			90,887	90,887		90,887	(90,887)				27
28	<b>TOTAL General Administration</b>	<b>327,381</b>	<b>17,519</b>	<b>2,763,947</b>	<b>3,108,847</b>		<b>3,108,847</b>	<b>(423,490)</b>	<b>2,685,357</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,776,862</b>	<b>972,760</b>	<b>4,670,280</b>	<b>11,419,902</b>		<b>11,419,902</b>	<b>(367,434)</b>	<b>11,052,468</b>			<b>29</b>

\*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 Villa Franciscan #0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			363,670	363,670	363,670	144,973	508,643				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						245,093	245,093				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						19,022	19,022				34
35	Rent-Equipment & Vehicles			12,137	12,137	12,137	1,711	13,848				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			375,807	375,807	375,807	410,799	786,606				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,136,503	1,136,503	1,136,503		1,136,503				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360	96,360		96,360				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			1,232,863	1,232,863	1,232,863		1,232,863				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,776,862	972,760	6,278,950	13,028,572	13,028,572	43,365	13,071,937				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 Villa Franciscan

# 0042861

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	26,204	30		9
10	Interest and Other Investment Income	(5,003)	32		10
11	Discounts, Allowances, Rebates & Refunds	(372,854)	21		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	(90,887)	27		24
25	Fund Raising, Advertising and Promotional	(15,639)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (458,179)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	513,496		34
35	Other- Attach Schedule	(11,952)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 501,544		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 43,365		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Provena Villa Franciscan

ID# 0042861

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Office Supplies	\$ (605)	7	1
2	Development R&M	(4)	7	2
3	Development Advertising	(150)	7	3
4	Development Dues	(525)	7	4
5	Development Misc.	(10,668)	7	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,952)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	4,377	0	0	0	0	0	0	0	0	0	4,377	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	1,509	0	0	0	0	0	0	0	0	0	1,509	5
6	Maintenance	0	298	60,084	0	0	0	0	0	0	0	0	60,382	6
7	Other (specify):*	(11,952)	0	0	0	0	0	0	0	0	0	0	(11,952)	7
8	<b>TOTAL General Services</b>	<b>(11,952)</b>	<b>6,184</b>	<b>60,084</b>	<b>0</b>	<b>54,316</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,740	0	0	0	0	0	0	0	0	0	1,740	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>1,740</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,740</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(425,253)	(98,643)	0	0	0	0	0	0	0	0	(523,896)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	40,931	339,349	0	0	0	0	0	0	0	0	380,280	19
20	Fees, Subscriptions & Promotions	(15,639)	10,100	0	0	0	0	0	0	0	0	0	(5,539)	20
21	Clerical & General Office Expenses	(372,854)	12,650	0	0	0	0	0	0	0	0	0	(360,204)	21
22	Employee Benefits & Payroll Taxes	0	65,679	97,722	0	0	0	0	0	0	0	0	163,401	22
23	Inservice Training & Education	0	5,255	0	0	0	0	0	0	0	0	0	5,255	23
24	Travel and Seminar	0	7,906	0	0	0	0	0	0	0	0	0	7,906	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	194	0	0	0	0	0	0	0	0	0	194	26
27	Other (specify):*	(90,887)	0	0	0	0	0	0	0	0	0	0	(90,887)	27
28	<b>TOTAL General Administration</b>	<b>(479,380)</b>	<b>(282,538)</b>	<b>338,428</b>	<b>0</b>	<b>(423,490)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(491,332)</b>	<b>(274,614)</b>	<b>398,512</b>	<b>0</b>	<b>(367,434)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	26,204	0	118,769	0	0	0	0	0	0	0	0	144,973	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,003)	0	250,096	0	0	0	0	0	0	0	0	245,093	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	19,022	0	0	0	0	0	0	0	0	19,022	34
35	Rent-Equipment & Vehicles	0	0	1,711	0	0	0	0	0	0	0	0	1,711	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>21,201</b>	<b>0</b>	<b>389,598</b>	<b>0</b>	<b>410,799</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(470,131)</b>	<b>(274,614)</b>	<b>788,110</b>	<b>0</b>	<b>43,365</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 4,377	\$ 4,377 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,509	1,509 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	298	298 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,740	1,740 4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	14,238	14,238 5
6	V	17 Administrative Salaries	682,140	Provena Senior Services	100.00%	242,649	(439,491) 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	40,931	40,931 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	10,100	10,100 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	12,650	12,650 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	65,679	65,679 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	5,255	5,255 11
12	V	24 Travel		Provena Senior Services	100.00%	7,906	7,906 12
13	V	26 Insurance		Provena Senior Services	100.00%	194	194 13
14	Total		\$ 682,140			\$ 407,526	\$ * (274,614) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 3,902	\$ 3,902	15
16	V	32 Interest		Provena Senior Services	100.00%	250,096	250,096	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	19,022	19,022	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,711	1,711	18
19	V	17 Admin Salaries	166,920	Provena Health Services	100.00%	105,776	(61,144)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	41,294	41,294	20
21	V	30 Depreciation		Provena Health Services	100.00%	114,867	114,867	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	339,349	339,349	22
23	V	17 Information Systems Salaries	182,040	Provena Health Services	100.00%	25,644	(156,396)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	10,011	10,011	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	16,533	16,533	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	71,102	71,102	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	27,758	27,758	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	47,795	47,795	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	18,659	18,659	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	43,551	43,551	30
31	V	39 Ancillary Services - Other	1,136,503	Provena Senior Services Pharmacy	100.00%	1,136,503		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,485,463			\$ 2,273,573	\$ * 788,110	39

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

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 5,596,693	20	\$ 35,910	\$	682,140	\$ 4,377	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		682,140	1,509	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		682,140	298	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		682,140	1,740	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		682,140	14,238	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	682,140	242,649	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		682,140	40,931	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		682,140	10,100	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		682,140	12,650	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		682,140	65,679	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		682,140	5,255	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		682,140	7,906	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		682,140	194	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		682,140	3,902	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		682,140	250,096	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		682,140	19,022	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		682,140	1,711	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 682,257	25

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,192,116	10	\$ 755,436	\$ 755,436	166,920	\$ 105,776	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		166,920	41,294	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		166,920	114,867	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		166,920	339,349	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	182,040	25,644	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		182,040	10,011	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		182,040	16,533	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	166,920	71,102	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		166,920	27,758	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	182,040	47,795	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		182,040	18,659	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		182,040	43,551	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					\$ 6,160,228	\$ 1,788,423		\$ 862,339	25

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Provena Senior Services Pharmacy  
 Street Address 1475 Harvard Drive  
 City / State / Zip Code Kankakee, IL 60901  
 Phone Number ( 815)928-6141  
 Fax Number ( 815)946-3238

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 1,136,503	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				\$	\$		\$ 1,136,503	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10	<b>Provena Senior Services</b>									<b>245,093</b>	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	<b>245,093</b>	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	<b>245,093</b>	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Provena Villa Franciscan COUNTY Will

FACILITY IDPH LICENSE NUMBER 0042861

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 2005 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 2005.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 Villa Franciscan

# 0042861 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

---

---

---

---

---

---

---

---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1990</u>	<u>\$ 285,994</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 285,994</b>	3

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1990	1990	\$ 6,601,325	\$ 219,487	23	\$ 219,487		\$ 4,434,399	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1991	2,510	126	20	126		1,841	9
10	Various			1992	57,831	2,666	20	2,666		42,977	10
11	Various			1993	28,123	1,185	20	1,185		20,631	11
12	Various			1994	32,574	1,443	20	1,443		22,522	12
13	Various			1995	80,456	2,529	20	2,529		40,697	13
14	Various			1996	45,626	3,056	10	3,056		37,877	14
15	Various			1997	18,743	1,105	13	1,105		16,022	15
16	Various			1999	4,936	304	7	304		4,936	16
17	Various			2000	73,038	6,373	7	6,373		64,697	17
18	Various			2001	13,173	1,027	5	1,027		13,173	18
19	Various			2002	8,202	1,325	5	1,325		5,781	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

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DESC: CCTV	2003	\$ 3,910	\$ 782	5	\$ 782	\$	\$ 2,737	37
38	DESC: MCQUAY COMPRESSOR FOR KITCHEN UNIT	2003	3,629	302	12	302		1,058	38
39	DESC: MURAL DAMIANO UNIT	2003	1,850	370	5	370		1,295	39
40	DESC: RELIEF VALVE FOR REFRIGERATION SYSTE	2003	2,735	391	7	391		1,367	40
41	DESC: STAINED GLASS WINDOW FOR CHAPEL	2003	1,575	158	10	158		551	41
42	DESC: SECURITY SYSTEM	2003	3,390	339	10	339		1,187	42
43	DESC: MURAL	2003	3,000	600	5	600		2,100	43
44	DESC: SELONOID FOR HOT WATER TANK	2003	985	99	10	99		345	44
45	DESC: WANDER GUARD SYSTEM	2003	1,853	124	15	124		432	45
46	DESC: REPAIR REACH-IN FREEZER	2003	2,764	276	10	276		968	46
47	DESC: ALARM SYSTEM	2003	3,860	386	10	386		1,351	47
48	DESC: CERAMIC FLOOR TILE	2003	1,387	69	20	69		208	48
49	DESC: WINDOW TREATMENT FOR VENETIAN LOUNGE	2003	1,296	259	5	259		778	49
50	DESC: LAMINATION OF VENETIAN NURSES STATIO	2003	5,246	350	15	350		1,046	50
51									51
52	DESC: KEYPAD ALARM SYSTEM	2004	3,926	393	10	393		982	52
53	DESC: CARPET REPLACEMENT	2004	6,251	1,250	5	1,250		3,126	53
54	DESC: FIRE DAMPER	2004	1,389	93	15	93		232	54
55	DESC: REPAVING OF PARKING LOT	2004	1,023	128	8	128		320	55
56	DESC: REPAVING PARKING LOT	2004	10,964	1,370	8	1,370		3,426	56
57	DESC: FURNISH AND INSTALL (4) GE 90 AMP CO	2004	1,691	169	10	169		423	57
58	DESC: ELECTRIC PNEUMA	2004	1,900	380	5	380		950	58
59	DESC: NORLAKE OUTDOOR WALK-IN COOLER/FREEZ	2004	65,170	4,345	15	4,345		9,775	59
60	DESC: DIVERTING RELAY, MODULAR GASKET, SOC	2004	2,426	303	8	303		758	60
61	DESC: SIXTY CU/FT OF SST-60 SALT SAVING TE	2004	9,950	663	15	663		1,658	61
62	DESC: INSTALLATION OF 12 ISOLATIONS VALVES	2004	13,395	893	15	893		2,233	62
63	DESC: CUBICLE TRACKS AND CURTAINS	2004	11,808	590	20	590		1,476	63
64	DESC: (2) FIRE DAMPERS	2004	2,398	240	10	240		480	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,136,308	\$ 255,948		\$ 255,948	\$	\$ 4,746,815	70

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

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,136,308	\$ 255,948		\$ 255,948	\$	\$ 4,746,815	1
2	Totals from Page 12A, Carried Forward	2005	26,675	2,668	10	2,668		4,001	2
3	DESC: ROOF REPLACEMENT	2005	9,480	948	10	948		1,422	3
4	DESC: DESIGN DEVELOPMENT/ SCHEMATIC DESIGN	2005	1,262	126	10	126		185	4
5	DESC: TRANSFER OF PLANS TO CAD - PT/OT EXP	2005	6,000	400	15	400		600	5
6	DESC: COPY OF IDPH DIV. OF LONG TERM CARE	2005	2,400	240	10	240		240	6
7	DESC: INSTALL (3) SPRINKLER HEADS								7
8		2006	1,932	97	10	193	97	97	8
9	DESC: ELECTRONIC PANIC EXIT DEVICE	2006	20,100	670	15	1,340	670	670	9
10	DESC: INSTALL NEW SIDEWALKS AND REPAIR CO	2006	1,285	64	10	129	64	64	10
11	DESC: REPLACE PIN PAD AT BACK DOOR	2006	748	53	7	107	53	53	11
12	DESC: PROJECT DEVELOPMENT AND SCHEMATICAL	2006	3,180	159	10	318	159	159	12
13	DESC: CUSTOM BLACK STEEL GATE	2006	2,250	113	10	225	113	113	13
14	DESC: LANDSCAPE SIDEWALK PROJECT	2006	486,151	12,154	20	24,308	12,154	12,154	14
15	DESC: PT/OT ADDITION								15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,697,771	\$ 273,639		\$ 286,948	\$ 13,310	\$ 4,766,573	34

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

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 736,758	\$ 77,137	\$ 77,137	\$	15	\$ 320,579	71
72	Current Year Purchases	266,061	12,894	25,789	12,894	9	25,789	72
73	Fully Depreciated Assets	878,173					878,173	73
74	Home office allocation		118,769	118,769				74
75	TOTALS	\$ 1,880,992	\$ 208,800	\$ 221,695	\$ 12,894		\$ 1,224,541	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 9,864,757	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 482,439	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 508,643	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,204	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,991,113	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				19,022			5
6					_____			6
7	TOTAL				\$ 19,022			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 99,271 Description: Nursing \$83,480, Activities \$345, Dietary \$1,598, Admin \$12,137, Home Office \$1,711

(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	N/A		\$ _____	\$ _____	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 Villa Franciscan # 0042861 Report Period Beginning: 01/01/06 Ending: 12/31/06

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

Facility Name & ID Number Provena Villa Franciscan# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	6,440	\$ 336,194	\$	6,440	\$ 336,194	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,859	97,061		1,859	97,061	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		6,252	326,366		6,252	326,366	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,136,503		1,136,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	14,551	\$ 759,621	\$ 1,136,503	14,551	\$ 1,896,124	14

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

Facility Name & ID Number Provena Villa Franciscan# 0042861Report Period Beginning: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 9,196,621	\$	1
2	Cash-Patient Deposits	104,225		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	10,284,617		3
4	Supply Inventory (priced at )	527,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,880		6
7	Other Prepaid Expenses	180,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 20,311,169	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,785,655		12
13	Land	6,865,930		13
14	Buildings, at Historical Cost	81,049,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,957,954		16
17	Accumulated Depreciation (book methods)	(48,335,409)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	126,984		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 64,450,517	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 84,761,686	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,462,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,875,684		28
29	Short-Term Notes Payable	38,451		29
30	Accrued Salaries Payable	2,295,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	676,390		32
33	Accrued Interest Payable	32,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 9,045,089	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,214,014	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 11,259,103	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,502,585	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 84,761,688	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,753,215	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(3,000,000)	3
4	Adj. To reconcile consolidated equity & consolidated income	2,656,011	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,409,226	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(1,162,838)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	85,263	9
10	Stock Options Exercised		10
11	Contributions and Grants	381,287	11
12	Expenditures for Specific Purposes	(210,353)	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)	\$ (906,641)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,502,585	24 *

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

Facility Name & ID Number Provena Villa Franciscan# 0042861Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,651,097	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,651,097	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,582,994	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,582,994	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	36,258	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	44,106	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	60,132	20
21	Other Medical Services		21
22	Laundry	31,130	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 171,626	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	34,657	24
25	Interest and Other Investment Income***	5,003	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 39,660	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	372,854	28
28a	<u>Misc. Income</u>	47,503	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 420,357	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,865,734	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,746,557	31
32	Health Care	6,564,499	32
33	General Administration	3,108,845	33
<b>B. Capital Expense</b>			
34	Ownership	375,808	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,136,503	35
36	Provider Participation Fee	96,360	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,028,572	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,162,838)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,162,838)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,840	1,948	\$ 70,815	\$ 36.35	1
2	Assistant Director of Nursing	1,848	1,912	62,480	32.68	2
3	Registered Nurses	27,885	28,942	905,717	31.29	3
4	Licensed Practical Nurses	52,926	56,088	1,402,539	25.01	4
5	CNAs & Orderlies	122,161	129,221	1,766,102	13.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,880	6,351	82,228	12.95	8
9	Activity Director	1,864	2,080	44,515	21.40	9
10	Activity Assistants	13,127	14,442	155,349	10.76	10
11	Social Service Workers	5,325	5,869	96,438	16.43	11
12	Dietician	3,783	4,168	70,023	16.80	12
13	Food Service Supervisor	2,451	2,594	38,838	14.97	13
14	Head Cook	6,385	7,114	86,948	12.22	14
15	Cook Helpers/Assistants	22,442	23,914	212,558	8.89	15
16	Dishwashers					16
17	Maintenance Workers	9,351	10,534	153,676	14.59	17
18	Housekeepers	19,478	21,180	196,492	9.28	18
19	Laundry	6,635	7,244	67,006	9.25	19
20	Administrator	1,808	2,080	94,409	45.39	20
21	Assistant Administrator	1,780	1,941	58,427	30.10	21
22	Other Administrative	7,418	8,007	111,716	13.95	22
23	Office Manager	1,856	1,976	34,898	17.66	23
24	Clerical	2,592	2,674	27,931	10.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral Care</u>	1,956	2,080	37,757	18.15	33
34	TOTAL (lines 1 - 33)	320,791	342,359	\$ 5,776,862 *	\$ 16.87	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	457	\$ 27,622	1,3	35
36	Medical Director	\$1,000/mo	12,000	9,3	36
37	Medical Records Consultant	32	1,400	10,3	37
38	Nurse Consultant	187	8,389	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	931	11,3	44
45	Social Service Consultant	11	649	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	706	\$ 50,991		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,929	\$ 214,388	10,3	50
51	Licensed Practical Nurses	4,142	166,647	10,3	51
52	Certified Nurse Assistants/Aides	4,865	99,353	10,3	52
53	TOTAL (lines 50 - 52)	12,936	\$ 480,388		53

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ann Dodge	Administrator	0	\$ 94,409	Workers' Compensation Insurance	\$ 103,440	IDPH License Fee	\$	
Administrative Staff	Office Mgr	0	34,898	Unemployment Compensation Insurance	21,224	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	28,801	FICA Taxes	425,781	Health Care Worker Background Check		
Administrative Staff	Receptionist	0	27,931	Employee Health Insurance	562,882	(Indicate # of checks performed <u>174</u> )		
Administrative Staff	Human Resource	0	35,361	Employee Meals		Patient Background Checks	<u>211</u>	
Administrative Staff	Asst Administrator	0	58,427	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	13,946	
Administrative Staff	Admissions	0	47,554	Life Insurance	21,998	Dues & Subscriptions	15,580	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	78,450	Advertising & Public Relations	19,264	
(List each licensed administrator separately.)			\$ 327,381	Executive Benefits	7,753			
B. Administrative - Other				Employe Recognition	5,641	Home Office Allocation	10,100	
Description			Amount	Employment Screenings	35,575	Less: Public Relations Expense	( )	
Corporate Service Fee			\$ 166,920	Home Office Allocation	163,401	Non-allowable advertising	(15,639)	
Corporate IS Fee			182,040			Yellow page advertising	( )	
Mgmt Fee			493,500	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,426,145	
Mgmt Fee Interest			188,640	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,031,100	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 35,058	Out-of-State Travel			\$	
Survey & Analytical Tools	Various		8,027					
Shredding	Various		926	In-State Travel			9,400	
Companion Radio	Various		265					
Medical Records/Services	Various		10,993	Seminar Expense				
Collect Fee	Various		808					
Transportation	Various		5,400	Home Office Allocation			7,906	
Outsourced Services	Various		3,998					
TOTAL (agree to Schedule V, line 19, column 3)				Entertainment Expense			( )	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 65,475	TOTAL (agree to Sch. V, line 24, col. 8)			\$ 17,306	

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. 7219 Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 176
- (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. \$ 49,240 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. \$ 96,360  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.