

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** 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 01/01/07 to 12/31/07 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: 01/01/07 Ending: 12/31/07

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>176</u>	Skilled (SNF)	<u>176</u>	<u>64,240</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		<u>0</u>	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>24,933</u>	<u>17,680</u>	<u>17,739</u>	<u>60,352</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>24,933</u>	<u>17,680</u>	<u>17,739</u>	<u>60,352</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.95%

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 09/01/1990

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 17,739Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	437,803	81,536	60,088	579,427		579,427		579,427			1
2	Food Purchase		358,692		358,692		358,692	5,861	364,553			2
3	Housekeeping	221,550	38,066		259,616		259,616		259,616			3
4	Laundry	49,974	10,957	161,544	222,475		222,475		222,475			4
5	Heat and Other Utilities			218,059	218,059		218,059	2,686	220,745			5
6	Maintenance	164,243	35,847	46,148	246,238		246,238	34,872	281,110			6
7	Other (specify):* <b>Pastoral Care</b>	38,843	1,019	5,318	45,180		45,180	2,686	47,866			7
8	<b>TOTAL General Services</b>	912,413	526,117	491,157	1,929,687		1,929,687	46,105	1,975,792			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			22,640	22,640		22,640		22,640			9
10	Nursing and Medical Records	4,712,839	447,937	142,676	5,303,452		5,303,452		5,303,452			10
10a	Therapy			1,248,049	1,248,049		1,248,049		1,248,049			10a
11	Activities	199,787	9,636	44,403	253,826		253,826	838	254,664			11
12	Social Services	124,561	90	954	125,605		125,605		125,605			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	5,037,187	457,663	1,458,722	6,953,572		6,953,572	838	6,954,410			16
	<b>C. General Administration</b>											
17	Administrative	360,058	23,527	1,317,000	1,700,585		1,700,585	(361,409)	1,339,176			17
18	Directors Fees											18
19	Professional Services			25,457	25,457		25,457	245,759	271,216			19
20	Dues, Fees, Subscriptions & Promotions			43,137	43,137		43,137	3,231	46,368			20
21	Clerical & General Office Expenses			114,797	114,797		114,797	14,604	129,401			21
22	Employee Benefits & Payroll Taxes			1,361,489	1,361,489		1,361,489	153,383	1,514,872			22
23	Inservice Training & Education			16,148	16,148		16,148	6,969	23,117			23
24	Travel and Seminar			12,651	12,651		12,651	9,954	22,605			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			174,360	174,360		174,360	1,837	176,197			26
27	Other (specify):* <b>Bad Debt</b>			58,465	58,465		58,465	(58,465)				27
28	<b>TOTAL General Administration</b>	360,058	23,527	3,123,504	3,507,089		3,507,089	15,863	3,522,952			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,309,658	1,007,307	5,073,383	12,390,348		12,390,348	62,806	12,453,154			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena Villa Franciscan #0042861 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			400,602	400,602	400,602	179,155	579,757			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						285,913	285,913			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds						23,886	23,886			34
35	Rent-Equipment & Vehicles			19,253	19,253	19,253	3,249	22,502			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			419,855	419,855	419,855	492,203	912,058			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,236,399	1,236,399	1,236,399	(419,947)	816,452			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			96,096	96,096	96,096		96,096			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			1,332,495	1,332,495	1,332,495	(419,947)	912,548			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,309,658	1,007,307	6,825,733	14,142,698	14,142,698	135,062	14,277,760			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:

01/01/07

Ending:

12/31/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,601	30		9
10	Interest and Other Investment Income	(7,442)	32		10
11	Discounts, Allowances, Rebates & Refunds	(419,947)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,465)	27		24
25	Fund Raising, Advertising and Promotional	(10,125)	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>	\$ (480,378)		\$	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)	612,754		34
35	Other- Attach Schedule	(2,686)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 610,068		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 129,690		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					45
46	Other-Attach Schedule					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: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Food	\$ 27	7 1
2	Development Misc	2,659	7 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	<b>Total</b>	2,686	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	5,861	0	0	0	0	0	0	0	0	0	5,861	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,686	0	0	0	0	0	0	0	0	0	2,686	5
6	Maintenance	0	706	34,166	0	0	0	0	0	0	0	0	34,872	6
7	Other (specify):*	2,686	0	0	0	0	0	0	0	0	0	0	2,686	7
8	<b>TOTAL General Services</b>	<b>2,686</b>	<b>9,253</b>	<b>34,166</b>	<b>0</b>	<b>46,105</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	838	0	0	0	0	0	0	0	0	0	838	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>838</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>838</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(574,792)	213,383	0	0	0	0	0	0	0	0	(361,409)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	96,806	148,953	0	0	0	0	0	0	0	0	245,759	19
20	Fees, Subscriptions & Promotions	(10,125)	13,356	0	0	0	0	0	0	0	0	0	3,231	20
21	Clerical & General Office Expenses	0	14,604	0	0	0	0	0	0	0	0	0	14,604	21
22	Employee Benefits & Payroll Taxes	0	77,744	75,639	0	0	0	0	0	0	0	0	153,383	22
23	Inservice Training & Education	0	6,969	0	0	0	0	0	0	0	0	0	6,969	23
24	Travel and Seminar	0	9,954	0	0	0	0	0	0	0	0	0	9,954	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	1,837	0	0	0	0	0	0	0	0	0	1,837	26
27	Other (specify):*	(58,465)	0	0	0	0	0	0	0	0	0	0	(58,465)	27
28	<b>TOTAL General Administration</b>	<b>(68,590)</b>	<b>(353,522)</b>	<b>437,975</b>	<b>0</b>	<b>15,863</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(65,904)</b>	<b>(343,431)</b>	<b>472,141</b>	<b>0</b>	<b>62,806</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	15,601	0	163,554	0	0	0	0	0	0	0	0	179,155	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,442)	0	293,355	0	0	0	0	0	0	0	0	285,913	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	23,886	0	0	0	0	0	0	0	0	23,886	34
35	Rent-Equipment & Vehicles	0	0	3,249	0	0	0	0	0	0	0	0	3,249	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>8,159</b>	<b>0</b>	<b>484,044</b>	<b>0</b>	<b>492,203</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	(419,947)	0	0	0	0	0	0	0	0	0	0	(419,947)	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>(419,947)</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>(419,947)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(477,692)</b>	<b>(343,431)</b>	<b>956,185</b>	<b>0</b>	<b>135,062</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 5,861	\$ 5,861
2	V	5 Utilities		Provena Senior Services	100.00%	2,686	2,686
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	706	706
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	838	838
5	V	17 Admin - Misc. Other	879,960	Provena Senior Services	100.00%	17,550	(862,410)
6	V	17 Administrative Services		Provena Senior Services	100.00%	287,618	287,618
7	V	19 Professional Salaries		Provena Senior Services	100.00%	96,806	96,806
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	13,356	13,356
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	14,604	14,604
10	V	22 Employee Benefits		Provena Senior Services	100.00%	77,744	77,744
11	V	23 Education/Conference		Provena Senior Services	100.00%	6,969	6,969
12	V	24 Travel		Provena Senior Services	100.00%	9,954	9,954
13	V	26 Insurance		Provena Senior Services	100.00%	1,837	1,837
14	Total		\$ 879,960			\$ 536,529	\$ * (343,431)

\* 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%	\$ 5,185	\$ 5,185	15
16	V	32 Interest		Provena Senior Services	100.00%	293,355	293,355	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	23,886	23,886	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	3,249	3,249	18
19	V	17 Admin Salaries	180,480	Provena Health Services	100.00%	144,929	(35,551)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	34,113	34,113	20
21	V	30 Depreciation		Provena Health Services	100.00%	158,369	158,369	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	148,953	148,953	22
23	V	17 Information Systems Salaries	256,560	Provena Health Services	100.00%	49,367	(207,193)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	11,321	11,321	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	327,798	327,798	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	68,977	68,977	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	16,235	16,235	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	59,352	59,352	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	13,970	13,970	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	34,166	34,166	30
31	V	39 Ancillary Services - Other	1,236,399	Provena Senior Services Pharmacy	100.00%	1,236,399		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,673,439			\$ 2,629,624	\$ * 956,185	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: 01/01/07 Ending: 12/31/07

## 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: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 6,620,619	19	\$ 44,100	\$	879,960	\$ 5,861	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		879,960	2,686	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		879,960	706	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		879,960	838	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		879,960	17,550	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	879,960	287,618	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		879,960	96,806	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		879,960	13,356	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		879,960	14,604	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		879,960	77,744	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		879,960	6,969	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		879,960	9,954	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		879,960	1,837	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		879,960	5,185	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		879,960	293,355	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		879,960	23,886	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		879,960	3,249	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 862,204	25

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,239,804	10	\$ 995,585	\$ 995,585	180,480	\$ 144,929	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		180,480	34,113	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		180,480	158,369	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		180,480	148,953	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	256,560	49,367	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		256,560	11,321	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		256,560	327,798	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	180,480	68,977	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		180,480	16,235	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	256,560	59,352	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		256,560	13,970	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		256,560	34,166	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					\$ 7,328,354	\$ 2,215,133		\$ 1,067,550	25

Facility Name & ID Number Provena Villa Franciscan

# 0042861

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		\$ 1,236,399	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				\$	\$		\$ 1,236,399	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	Home Office Allocation									\$ 293,355	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>					\$	\$			\$ 293,355	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 293,355	15									

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

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

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

Facility Name & ID Number Provena Villa Franciscan# 0042861 Report Period Beginning: 01/01/07Ending: 12/31/07

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 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 2007 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:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

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:

01/01/07

Ending:

12/31/07

**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	\$ 6,561,190	\$ 218,570	25	\$ 218,570		\$ 4,614,109	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			1991	2,510	126	20	126		1,967	9
10	Various			1992	55,495	2,666	19	2,666		43,307	10
11	Various			1993	22,368	897	17	897		17,715	11
12	Various			1994	21,786	1,089	20	1,089		15,101	12
13	Various			1995	80,058	2,529	16	2,529		42,828	13
14	Various			1996	45,626	769	10	769		38,646	14
15	Various			1997	18,743	1,312	9	1,312		17,334	15
16	Various			1998	21,439		5			21,439	16
17	Various			1999	4,936		7			4,936	17
18	Various			2000	73,038	4,046	7	4,046		68,743	18
19	Various			2001	13,173		5			13,173	19
20	Various			2002	5,856	769	7	769		4,439	20
21	Various			2003	37,126	4,584	9	4,584		20,345	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:

01/01/07

Ending:

12/31/07

**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	NORLAKE OUTDOOR WALK-IN	2004	\$ 65,170	\$ 4,345	15	\$ 4,345	\$	\$ 14,120	37
38	INSTALLATION OF 12 ISOLA	2004	13,395	893	15	893		3,126	38
39	CUBICLE TRACKS AND CURTA	2004	11,808	590	20	590		2,066	39
40	REPAVING PARKING LOT	2004	10,964	1,370	8	1,370		4,797	40
41	SIXTY CU/FT OF SST-60 SA	2004	9,950	663	15	663		2,322	41
42	CARPET REPLACEMENT	2004	6,251	1,250	5	1,250		4,376	42
43	LAMINATION OF VENETIAN N	2004	5,246	350	15	350		1,396	43
44	KEYPAD ALARM SYSTEM	2004	3,926	393	10	393		1,374	44
45	DIVERTING RELAY, MODULAR	2004	2,426	303	8	303		1,061	45
46	ELECTRIC PNEUMA	2004	1,900	380	5	380		1,330	46
47	FURNISH AND INSTALL (4)	2004	1,691	169	10	169		592	47
48	FIRE DAMPER	2004	1,389	93	15	93		324	48
49	CERAMIC FLOOR TILE	2004	1,387	69	20	69		277	49
50	WINDOW TREATMENT FOR VEN	2004	1,296	259	5	259		1,037	50
51	REPAVING OF PARKING LOT	2004	1,023	128	8	128		448	51
52									52
53	ROOF REPLACEMENT	2005	26,675	2,668	10	2,668		6,669	53
54	DESIGN DEVELOPMENT/ SCHE	2005	9,480	948	10	948		2,370	54
55	COPY OF IDPH DIV. OF LON	2005	6,000	400	15	400		1,000	55
56	(2) FIRE DAMPERS	2005	2,398	240	10	240		719	56
57	TRANSFER OF PLANS TO CAD	2005	1,262	126	10	126		311	57
58									58
59	PT/OT ADDITION	2006	565,705	28,285	20	28,285		40,439	59
60	INSTALL NEW SIDEWALKS AN	2006	20,100	1,340	15	1,340		2,010	60
61	CUSTOM BLACK STEEL GATE	2006	3,180	318	10	318		477	61
62	INSTALL (3) SPRINKLER HE	2006	2,400	240	10	240		480	62
63	LANDSCAPE SIDEWALK PROJE	2006	2,250	225	10	225		338	63
64	ELECTRONIC PANIC EXIT DE	2006	1,932	193	10	193		290	64
65	REPLACE PIN PAD AT BACK	2006	1,285	129	10	129		193	65
66	PROJECT DEVELOPMENT AND	2006	748	107	7	107		160	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,744,581	\$ 283,831		\$ 283,831	\$	\$ 5,018,183	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:

01/01/07

Ending:

12/31/07

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		\$ 7,744,581	\$ 283,831		\$ 283,831	\$	\$ 5,018,183	1
2	SHOWER ROOM REMODEL	2007	75,860	2,529	15	5,057	2,529	2,529	2
3	NEW COMPRESSOR	2007	19,980	666	15	1,332	666	666	3
4	UPGRADE TO PHONE SYSTEM	2007	2,652	133	10	265	133	133	4
5	CARPET FOR ADMISSIONS OF	2007	2,439	488	5	976	488	488	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	TOTAL (lines 1 thru 33)		\$ 7,845,512	\$ 287,646		\$ 291,461	\$ 3,815	\$ 5,021,998	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: 01/01/07 Ending: 12/31/07

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	\$ 1,033,194	\$ 101,170	\$ 101,170	\$	10	\$ 378,451	71
72	Current Year Purchases	179,761	11,786	23,572	11,786		11,786	72
73	Fully Depreciated Assets	566,587					561,167	73
74	Home Office Allocation		163,554	163,554				74
75	TOTALS	\$ 1,779,542	\$ 276,510	\$ 288,296	\$ 11,786		\$ 951,404	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)	\$ 9,911,048	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 564,156	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 579,757	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,601	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,973,402	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				23,886			5
6					_____			6
7	TOTAL				\$ 23,886			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 102,012 Description: Nursing \$76687, Activities \$210, Dietary \$2365, Plant Eng \$248, Admin \$19253, Home Office \$3249

(Attach a schedule detailing the breakdown of movable equipment)

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

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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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:

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## 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	\$	10,666	\$ 575,986	\$	10,666	\$ 575,986	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		2,256	121,843		2,256	121,843	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		10,189	550,220		10,189	550,220	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				1,236,399		1,236,399	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>			\$	23,112	\$ 1,248,049	\$ 1,236,399	23,112	\$ 2,484,448	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 # 0042861 Report Period Beginning: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (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	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	11,176,143		3
4	Supply Inventory (priced at )	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		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>	\$ 20,759,191	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		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>	120,120		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 65,780,207	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 86,539,398	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,826,767	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,861,673		28
29	Short-Term Notes Payable	42,163		29
30	Accrued Salaries Payable	2,756,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	823,060		32
33	Accrued Interest Payable	41,064		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>	817,281		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 11,248,905	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,036,737	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,285,642	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,253,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 86,539,398	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,965,790	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,106,523	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	263,905	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	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)	\$ 147,233	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)	\$ 73,253,756	24 *

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

Facility Name & ID Number Provena Villa Franciscan# 0042861Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 10,364,732	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,364,732	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,299,240	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,299,240	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	41,518	13
14	Non-Patient Meals	140	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,135,427	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	44,317	20
21	Other Medical Services		21
22	Laundry	28,655	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,250,057	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	26,008	24
25	Interest and Other Investment Income***	7,426	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 33,434	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	419,947	28
28a	<u>Misc. Income</u>	46,981	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 466,928	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,414,391	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,929,687	31
32	Health Care	6,953,572	32
33	General Administration	3,507,089	33
<b>B. Capital Expense</b>			
34	Ownership	419,855	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,236,399	35
36	Provider Participation Fee	96,096	36
<b>D. Other Expenses (specify):</b>			
37	<u>Loss of SOFA</u>	7,788	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,150,486	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	263,905	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 263,905	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:

01/01/07

Ending:

12/31/07

**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	1,884	2,080	\$ 86,855	\$ 41.76	1
2	Assistant Director of Nursing	1,968	2,080	74,384	35.76	2
3	Registered Nurses	42,092	44,459	1,333,871	30.00	3
4	Licensed Practical Nurses	42,812	46,252	1,277,091	27.61	4
5	CNAs & Orderlies	126,517	134,247	1,889,523	14.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,675	4,194	51,115	12.19	8
9	Activity Director	1,832	2,080	44,989	21.63	9
10	Activity Assistants	12,845	13,829	154,798	11.19	10
11	Social Service Workers	7,243	8,153	124,561	15.28	11
12	Dietician	1,968	2,240	50,142	22.38	12
13	Food Service Supervisor	3,998	4,210	56,409	13.40	13
14	Head Cook	6,847	7,174	88,771	12.37	14
15	Cook Helpers/Assistants	24,409	25,736	242,481	9.42	15
16	Dishwashers					16
17	Maintenance Workers	9,788	10,704	164,243	15.34	17
18	Housekeepers	20,284	21,686	221,550	10.22	18
19	Laundry	4,608	5,247	49,974	9.52	19
20	Administrator	1,824	2,080	99,101	47.64	20
21	Assistant Administrator	1,944	2,080	61,808	29.72	21
22	Other Administrative	3,884	4,115	72,309	17.57	22
23	Office Manager	3,596	3,972	70,885	17.85	23
24	Clerical	4,449	4,651	55,955	12.03	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>	1,928	2,076	38,843	18.71	33
34	TOTAL (lines 1 - 33)	330,395	353,345	\$ 6,309,658 *	\$ 17.86	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	692	\$ 45,452	1,3	35
36	Medical Director	\$1000/mo	11,000	9,3	36
37	Medical Records Consultant	32	1,378	10,3	37
38	Nurse Consultant	34	2,846	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	24	1,155	11,3	44
45	Social Service Consultant	12	705	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	794	\$ 62,536		49

**C. CONTRACT NURSES**

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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$7,740
- (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. \$ 68,823 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. \$ 96,096  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 140
- (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.