

Facility Name & ID Number Provena Villa Franciscan# 0042861 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>64,416</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>176</u>	<u>64,416</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>20,198</u>	<u>17,595</u>	<u>23,139</u>	<u>60,932</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>20,198</u>	<u>17,595</u>	<u>23,139</u>	<u>60,932</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.59%

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 & 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 176 and days of care provided 23,139Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

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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
	A. General Services										
1	Dietary	507,084	75,337	16,555	598,976		598,976		598,976		1
2	Food Purchase		388,215		388,215		388,215	3,011	391,226		2
3	Housekeeping	226,181	46,732	863	273,776		273,776		273,776		3
4	Laundry	60,555	11,912	163,916	236,383		236,383		236,383		4
5	Heat and Other Utilities			260,071	260,071		260,071	4,873	264,944		5
6	Maintenance	182,176	44,515	57,172	283,863		283,863	52,783	336,646		6
7	Other (specify):* Pastoral Care	39,753	1,204	4,518	45,475		45,475	1,072	46,547		7
8	TOTAL General Services	1,015,749	567,915	503,095	2,086,759		2,086,759	61,739	2,148,498		8
	B. Health Care and Programs										
9	Medical Director			19,300	19,300		19,300		19,300		9
10	Nursing and Medical Records	5,371,908	585,922	94,392	6,052,222		6,052,222		6,052,222		10
10a	Therapy			1,812,471	1,812,471		1,812,471		1,812,471		10a
11	Activities	236,600	12,332	42,808	291,740		291,740	980	292,720		11
12	Social Services	135,259	418	1,097	136,774		136,774		136,774		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,743,767	598,672	1,970,068	8,312,507		8,312,507	980	8,313,487		16
	C. General Administration										
17	Administrative	371,316	28,671	1,379,622	1,779,609		1,779,609	(590,921)	1,188,688		17
18	Directors Fees										18
19	Professional Services			22,179	22,179		22,179	79,236	101,415		19
20	Dues, Fees, Subscriptions & Promotions			64,527	64,527		64,527	(4,120)	60,407		20
21	Clerical & General Office Expenses			81,003	81,003		81,003	14,247	95,250		21
22	Employee Benefits & Payroll Taxes			1,445,043	1,445,043		1,445,043	361,633	1,806,676		22
23	Inservice Training & Education			16,768	16,768		16,768	5,222	21,990		23
24	Travel and Seminar			12,670	12,670		12,670	10,679	23,349		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			143,136	143,136		143,136	742	143,878		26
27	Other (specify):* Bad Debt			(48,891)	(48,891)		(48,891)	48,891			27
28	TOTAL General Administration	371,316	28,671	3,116,057	3,516,044		3,516,044	(74,391)	3,441,653		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,130,832	1,195,258	5,589,220	13,915,310		13,915,310	(11,672)	13,903,638		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			398,782	398,782	398,782	146,220	545,002				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						1,145,599	1,145,599				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						32,927	32,927				34
35	Rent-Equipment & Vehicles			19,124	19,124	19,124	4,974	24,098				35
36	Other (specify):*											36
37	TOTAL Ownership			417,906	417,906	417,906	1,329,720	1,747,626				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,571,537	1,571,537	1,571,537	(603,430)	968,107				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,624	96,624	96,624		96,624				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,668,161	1,668,161	1,668,161	(603,430)	1,064,731				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,130,832	1,195,258	7,675,287	16,001,377	16,001,377	714,618	16,715,995				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: 01/01/08

Ending: 12/31/08

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	(1,804)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,095	30		9
10	Interest and Other Investment Income	(3,022)	32		10
11	Discounts, Allowances, Rebates & Refunds	(603,430)	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	48,891	27		24
25	Fund Raising, Advertising and Promotional	(16,345)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (568,615)		\$	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)	1,282,161		34
35	Other- Attach Schedule	1,072		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,283,233		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 714,618		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Provena Villa Franciscan

ID# 0042861

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ 1,072	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,072		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,804)	4,815	0	0	0	0	0	0	0	0	0	3,011	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,873	0	0	0	0	0	0	0	0	0	4,873	5
6	Maintenance	0	2,218	50,565	0	0	0	0	0	0	0	0	52,783	6
7	Other (specify):*	1,072	0	0	0	0	0	0	0	0	0	0	1,072	7
8	TOTAL General Services	(732)	11,906	50,565	0	61,739	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	980	0	0	0	0	0	0	0	0	0	980	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	980	0	0	0	0	0	0	0	0	0	980	16
	C. General Administration													
17	Administrative	0	(550,483)	(40,438)	0	0	0	0	0	0	0	0	(590,921)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	51,295	27,941	0	0	0	0	0	0	0	0	79,236	19
20	Fees, Subscriptions & Promotions	(16,345)	12,225	0	0	0	0	0	0	0	0	0	(4,120)	20
21	Clerical & General Office Expenses	0	14,247	0	0	0	0	0	0	0	0	0	14,247	21
22	Employee Benefits & Payroll Taxes	0	91,319	270,314	0	0	0	0	0	0	0	0	361,633	22
23	Inservice Training & Education	0	5,222	0	0	0	0	0	0	0	0	0	5,222	23
24	Travel and Seminar	0	10,679	0	0	0	0	0	0	0	0	0	10,679	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	742	0	0	0	0	0	0	0	0	0	742	26
27	Other (specify):*	48,891	0	0	0	0	0	0	0	0	0	0	48,891	27
28	TOTAL General Administration	32,546	(364,754)	257,817	0	(74,391)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	31,814	(351,868)	308,382	0	(11,672)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	7,095	0	139,125	0	0	0	0	0	0	0	0	146,220	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,022)	0	1,148,621	0	0	0	0	0	0	0	0	1,145,599	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	32,927	0	0	0	0	0	0	0	0	32,927	34
35	Rent-Equipment & Vehicles	0	0	4,974	0	0	0	0	0	0	0	0	4,974	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,073	0	1,325,647	0	1,329,720	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(603,430)	0	0	0	0	0	0	0	0	0	0	(603,430)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(603,430)	0	0	0	0	0	0	0	0	0	0	(603,430)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(567,543)	(351,868)	1,634,029	0	714,618	45							

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08

Ending:

12/31/08

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%	\$ 4,815	\$ 4,815 1
2	V	5 Utilities		Provena Senior Services	100.00%	4,873	4,873 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	2,218	2,218 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	980	980 4
5	V	17 Admin - Misc. Other	866,520	Provena Senior Services	100.00%	(2,633)	(869,153) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	318,670	318,670 6
7	V	19 Professional Services		Provena Senior Services	100.00%	51,295	51,295 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	12,225	12,225 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	14,247	14,247 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	91,319	91,319 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	5,222	5,222 11
12	V	24 Travel		Provena Senior Services	100.00%	10,679	10,679 12
13	V	26 Insurance		Provena Senior Services	100.00%	742	742 13
14	Total		\$ 866,520			\$ 514,652	\$ * (351,868) 14

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

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 01/01/08 Ending: 12/31/08

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%	\$ 4,812	\$ 4,812	15
16	V	32 Interest		Provena Senior Services	100.00%	417,172	417,172	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	32,927	32,927	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	4,974	4,974	18
19	V	17 Admin Salaries	201,462	Provena Health Services	100.00%	125,544	(75,918)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	95,541	95,541	20
21	V	30 Depreciation		Provena Health Services	100.00%	134,313	134,313	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	27,941	27,941	22
23	V	17 Information Systems Salaries	311,640	Provena Health Services	100.00%	217,938	(93,702)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	57,811	57,811	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	29,482	29,482	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	40,445	40,445	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	63,821	63,821	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	59,255	59,255	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	53,141	53,141	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	50,565	50,565	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	731,449	731,449	31
32	V	39 Ancillary Services - Other	1,571,537	Provena Senior Services Pharmacy	100.00%	1,571,537		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,084,639			\$ 3,718,668	\$ * 1,634,029	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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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 6,616,778	19	\$ 36,766	\$	866,520	\$ 4,815	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		866,520	4,873	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		866,520	2,218	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		866,520	980	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		866,520	(2,633)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	866,520	318,670	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		866,520	51,295	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		866,520	12,225	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		866,520	14,247	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		866,520	91,319	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		866,520	5,222	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		866,520	10,679	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		866,520	742	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		866,520	4,812	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		866,520	417,172	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		866,520	32,927	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		866,520	4,974	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 974,537	25

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,391,394	9	\$ 867,070	\$ 867,070	201,462	\$ 125,544	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		201,462	95,541	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		201,462	134,313	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		201,462	27,941	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		201,462	217,938	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	311,640	57,811	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		311,640	29,482	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		311,640	40,445	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	201,462	63,821	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	311,640	59,255	10
11	6	Information Systems - Equip Maint	Direct Cost	2,155,920	9	367,627		311,640	53,141	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		201,462	50,565	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		201,462	731,449	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					\$ 11,655,695	\$ 2,117,706		\$ 1,687,246	25

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$ 1,571,537	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				\$	\$		\$ 1,571,537	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			
A. Directly Facility Related																				
Long-Term																				
1	Home Office Allocation									\$ 417,172	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 417,172	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 417,172	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 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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).

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	TOTALS			\$ 285,994	3

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	176		1990	1990	\$ 6,561,190	\$ 210,130	25	\$ 210,130		\$ 4,824,239	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1991		2,510	126	20	126		2,092	9
10	Various		1992		55,495	2,666	19	2,666		45,973	10
11	Various		1993		22,368	897	17	897		18,612	11
12	Various		1994		21,786	1,089	20	1,089		16,190	12
13	Various		1995		80,058	2,529	16	2,529		45,357	13
14	Various		1996		45,626	769	10	769		39,414	14
15	Various		1997		17,775	169	10	169		16,535	15
16	Various		1998		21,439		5			21,439	16
17	Various		1999		4,936		7			4,936	17
18	Various		2000		61,568	1,336	6	1,336		60,711	18
19	Various		2001		11,608		5			11,608	19
20	Various		2002		4,025	315	8	315		2,923	20
21	Various		2003		29,496	3,414	10	3,414		17,452	21
22	Various		2004		137,282	9,876	12	9,876		49,901	22
23											23
24			2005		26,675	2,668	10	2,668		9,336	24
25		ROOF REPLACEMENT	2005		9,480	948	10	948		3,318	25
26		DESIGN DEVELOPMENT/ SCHE	2005		6,000	400	15	400		1,400	26
27		COPY OF IDPH DIV. OF LON	2005		2,398	240	10	240		959	27
28		(2) FIRE DAMPERS	2005		1,262	126	10	126		437	28
29		TRANSFER OF PLANS TO CAD									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 & ID Number Provena Villa Franciscan

0042861

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	PT/OT ADDITION	2006	\$ 565,705	\$ 28,285	20	\$ 28,285	\$	\$ 68,724	37
38	INSTALL NEW SIDEWALKS AN	2006	20,100	1,340	15	1,340		3,350	38
39	CUSTOM BLACK STEEL GATE	2006	3,180	318	10	318		795	39
40	INSTALL (3) SPRINKLER HE	2006	2,400	240	10	240		720	40
41	LANDSCAPE SIDEWALK PROJE	2006	2,250	225	10	225		563	41
42	ELECTRONIC PANIC EXIT DE	2006	1,932	193	10	193		483	42
43	REPLACE PIN PAD AT BACK	2006	1,285	129	10	129		321	43
44	PROJECT DEVELOPMENT AND	2006	748	107	7	107		267	44
45									45
46	SHOWER ROOM REMODEL	2007	75,860	5,057	15	5,057		7,586	46
47	NEW COMPRESSOR	2007	19,980	1,332	15	1,332		1,998	47
48	UPGRADE TO PHONE SYSTEM	2007	2,652	265	10	265		398	48
49	CARPET FOR ADMISSIONS OF	2007	2,439	488	5	488		976	49
50									50
51	WATER HEATER	2008	2,843	142	10	284	142	142	51
52	HOMERUN CABLE INSTALLATION FROM UNIT	2008	6,045	202	15	403	202	202	52
53	NURSES STATION	2008	2,726	91	15	182	91	91	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,833,122	\$ 276,111		\$ 276,546	\$ 435	\$ 5,279,449	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: 01/01/08 Ending: 12/31/08

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	\$ 1,110,332	\$ 116,012	\$ 116,012	\$		\$ 407,975	71
72	Current Year Purchases	109,716	6,660	13,319	6,660		6,660	72
73	Fully Depreciated Assets	569,046					563,236	73
74			139,125	139,125				74
75	TOTALS	\$ 1,789,093	\$ 261,796	\$ 268,456	\$ 6,660		\$ 977,871	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)	\$ 9,908,209	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 537,907	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 545,002	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,094	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,257,319	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				32,927			5
6					_____			6
7	TOTAL				\$ 32,927			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 62,479 Description: Nursing \$36,709; Activities \$483; Dietary \$2,384; Plant \$-223; Admin \$ 18,152; Home Office \$4,974

(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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$	14,494	\$ 897,763	\$	14,494	\$ 897,763	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,470	92,031		1,470	92,031	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		13,351	822,677		13,351	822,677	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				1,571,537		1,571,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	29,315	\$ 1,812,471	\$ 1,571,537	29,315	\$ 3,384,008	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: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,556,064	\$	1
2	Cash-Patient Deposits	112,800		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,518,279		3
4	Supply Inventory (priced at)	609,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,320		6
7	Other Prepaid Expenses	150,561		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,969,783	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,624,013		12
13	Land	6,742,855		13
14	Buildings, at Historical Cost	84,767,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,707,364		16
17	Accumulated Depreciation (book methods)	(52,758,206)		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>	113,256		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,197,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 87,166,931	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,366,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,621,117		28
29	Short-Term Notes Payable	50,318		29
30	Accrued Salaries Payable	3,252,222		30
31	Accrued Taxes Payable (excluding real estate taxes)	103,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	935,960		32
33	Accrued Interest Payable	29,590		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	1,231,737		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,590,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,218,868		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	289,981		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,947,593	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,537,826	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,629,105	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 87,166,931	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,253,756	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(358,099)	3
4	Adj. To reconcile consolidated equity & consolidated income	(797,437)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,098,220	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,091,472	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	683,319	11
12	Expenditures for Specific Purposes	(243,906)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,530,885	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,629,105	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Villa Franciscan# 0042861Report Period Beginning: 01/01/08Ending: 12/31/08**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,449,903	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,449,903	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,267,361	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,267,361	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	42,017	13
14	Non-Patient Meals	1,804	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,508,173	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	52,643	20
21	Other Medical Services		21
22	Laundry	27,665	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,632,302	23
D. Non-Operating Revenue			
24	Contributions	28,701	24
25	Interest and Other Investment Income***	3,022	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,723	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	603,430	28
28a	Misc Income & Gain/Loss SOFA	108,130	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 711,560	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,092,849	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,086,759	31
32	Health Care	8,312,507	32
33	General Administration	3,516,044	33
B. Capital Expense			
34	Ownership	417,906	34
C. Ancillary Expense			
35	Special Cost Centers	1,571,537	35
36	Provider Participation Fee	96,624	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,001,377	40
41	Income before Income Taxes (line 30 minus line 40)**	1,091,472	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,091,472	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,860	2,080	\$ 96,636	\$ 46.46	1
2	Assistant Director of Nursing	1,912	2,080	83,790	40.28	2
3	Registered Nurses	53,328	56,135	1,778,972	31.69	3
4	Licensed Practical Nurses	46,770	49,576	1,309,589	26.42	4
5	CNAs & Orderlies	137,730	143,677	2,043,948	14.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,255	4,633	58,973	12.73	8
9	Activity Director	2,002	2,175	47,971	22.06	9
10	Activity Assistants	15,127	16,621	188,629	11.35	10
11	Social Service Workers	7,621	8,296	135,259	16.30	11
12	Dietician	2,112	2,328	55,755	23.95	12
13	Food Service Supervisor	5,383	5,911	98,155	16.61	13
14	Head Cook	7,034	7,737	89,628	11.58	14
15	Cook Helpers/Assistants	26,661	28,400	263,546	9.28	15
16	Dishwashers					16
17	Maintenance Workers	11,075	11,980	182,176	15.21	17
18	Housekeepers	19,962	21,031	226,181	10.75	18
19	Laundry	5,541	5,840	60,555	10.37	19
20	Administrator	1,528	2,080	105,791	50.86	20
21	Assistant Administrator	1,596	1,728	56,756	32.84	21
22	Other Administrative	9,470	10,228	143,656	14.05	22
23	Office Manager	1,736	1,840	36,220	19.68	23
24	Clerical	2,562	2,647	28,892	10.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral</u>	1,860	2,092	39,754	19.00	33
34	TOTAL (lines 1 - 33)	367,125	389,115	\$ 7,130,832 *	\$ 18.33	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	111	\$ 6,639	1,3	35
36	Medical Director	\$1000/mo	12,000	9,3	36
37	Medical Records Consultant	30	2,104	10,3	37
38	Nurse Consultant	163	20,334	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	12	879	11,3	44
45	Social Service Consultant	12	720	12,3	45
46	Other(specify)				46
47	<u>Rehabilitation Director</u>	\$1000/mo	6,000	9,3	47
48	<u>Dentist</u>		1,300	9,3	48
49	TOTAL (lines 35 - 48)	328	\$ 49,976		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

Facility Name & ID Number Provena Villa Franciscan

0042861

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 105,791	Workers' Compensation Insurance	\$ 183,480	IDPH License Fee	\$	
Administrative Staff	Office Mgr	0	36,220	Unemployment Compensation Insurance	16,743	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	23,346	FICA Taxes	523,013	Health Care Worker Background Check		
Administrative Staff	Receptionist	0	28,881	Employee Health Insurance	523,644	(Indicate # of checks performed <u>103</u>)		
Administrative Staff	Human Resource	0	36,674	Employee Meals		Patient Background Checks	<u>387</u>	
Administrative Staff	Asst Administrator	0	56,756	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	33,015	
Administrative Staff	Admissions	0	83,648	Life Insurance	22,305	Dues & Subscriptions	13,649	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	134,471	Advertising & Public Relations	17,863	
(List each licensed administrator separately.)			\$ 371,316	Executive Benefits	7,648			
B. Administrative - Other				Employe Recognition	2,804	Home Office Allocation	12,225	
Description			Amount	Employment Screenings	30,935	Less: Public Relations Expense	()	
Corporate Service Fee			\$ 201,462	Home Office Allocation	361,633	Non-allowable advertising	(16,345)	
Corporate IS Fee			311,640			Yellow page advertising	()	
Mgmt Fee			623,760	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,806,676	
Mgmt Fee Interest			242,760	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,379,622	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services								
Vendor/Payee	Type		Amount					
Legal Expense	Various		\$ 6,786					
Survey & Analytical Tools	Various		4,607					
Shredding/Storage	Various		3,183					
Promotional items	Various		945					
Medical Records/Services	Various		1,859					
Collect Fee	Various		128					
Fire Protection	Various		998					
Outsourced Services	Various		2,334					
Surety Bond	Various		240					
Care Counseling	Various		599					
Aqua Deco	Various		500					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 22,179					
				G. Schedule of Travel and Seminar**				
				Description		Amount		
				Out-of-State Travel		\$		
				In-State Travel		12,670		
				Seminar Expense				
				Home Office Allocation		10,679		
				Entertainment Expense		()		
				(agree to Sch. V, line 24, col. 8)				
				TOTAL		\$ 23,349		

* 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. Life Service Network \$8,729
- (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. \$ 71,262 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. \$ 96,624
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,804
- (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.