

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0045419</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Franciscan Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/11</u> to <u>06/30/12</u> 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.	
Address: <u>1270 Franciscan Drive</u> <u>Lemont</u> <u>60439</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(630) 257-5801</u> Fax # <u>(630) 257-2245</u>			
HFS ID Number: <u>351124441002</u>			
Date of Initial License for Current Owners: <u>04/19/65</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT		☐ PROPRIETARY	
☒ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code <u>501C(3)</u>		☐ Corporation	
		☐ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other	
In the event there are further questions about this report, please contact:		Officer or Administrator of Provider	
Name: <u>Steve Lavenda</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(847) 236-1111</u>		(Type or Print Name) _____	
Email Address: <u>slavenda@frrcpas.com</u>		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>	
		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u>	
		<u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franciscan Village

0045419 Report Period Beginning: 07/01/11 Ending: 06/30/12

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 N/A

	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>127</u>	Skilled (SNF)	<u>127</u>	<u>46,482</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>127</u>	TOTALS	<u>127</u>	<u>46,482</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15</u>	<u>213</u>	<u>10,321</u>	<u>10,549</u>	8
9	SNF/PED					9
10	ICF	<u>9,690</u>	<u>18,970</u>		<u>28,660</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,705</u>	<u>19,183</u>	<u>10,321</u>	<u>39,209</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.35%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? None (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) Meals and Beauty Shop Services - Franciscan Village

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☒ NO ☐

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 01/20/1990

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 38 and days of care provided 9,517

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/12 Fiscal Year: 06/30/12

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

Facility Name & ID Number Franciscan Village # 0045419 Report Period Beginning: 07/01/11 Ending: 06/30/12
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	333,159	90,081	223,343	646,583		646,583	(925)	645,658			1
2	Food Purchase		360,122		360,122		360,122	(60,048)	300,074			2
3	Housekeeping	253,809	58,534		312,343		312,343	(1,627)	310,716			3
4	Laundry			141,803	141,803		141,803		141,803			4
5	Heat and Other Utilities			413,905	413,905		413,905	(16,712)	397,193			5
6	Maintenance	407,754	35,566	144,796	588,116		588,116	(2,702)	585,414			6
7	Other (specify):*											7
8	TOTAL General Services	994,722	544,303	923,847	2,462,872		2,462,872	(82,014)	2,380,858			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,934,395	117,039	21,808	3,073,242		3,073,242	(6,067)	3,067,175			10
10a	Therapy	216,162	1,538	82,774	300,474		300,474	(80,357)	220,117			10a
11	Activities	242,801	39,817	2,554	285,172		285,172		285,172			11
12	Social Services	163,378	2,992	12,850	179,220		179,220	(8,795)	170,425			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,556,736	161,386	149,986	3,868,108		3,868,108	(95,219)	3,772,889			16
	C. General Administration											
17	Administrative	146,346		793,413	939,759		939,759		939,759			17
18	Directors Fees											18
19	Professional Services			59,484	59,484		59,484		59,484			19
20	Dues, Fees, Subscriptions & Promotions			29,420	29,420		29,420	(11,409)	18,011			20
21	Clerical & General Office Expenses	320,747	35,166	113,433	469,346		469,346	(138,405)	330,941			21
22	Employee Benefits & Payroll Taxes			1,794,225	1,794,225		1,794,225	(4,963)	1,789,262			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,689	4,689		4,689		4,689			24
25	Other Admin. Staff Transportation			3,281	3,281		3,281	(22)	3,259			25
26	Insurance-Prop.Liab.Malpractice			103,994	103,994		103,994		103,994			26
27	Other (specify):*											27
28	TOTAL General Administration	467,093	35,166	2,901,939	3,404,198		3,404,198	(154,799)	3,249,399			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,018,551	740,855	3,975,772	9,735,178		9,735,178	(332,032)	9,403,146			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			1,590,290	1,590,290		1,590,290	(1,204,947)	385,343			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			704,204	704,204		704,204	(36,411)	667,793			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			202,441	202,441		202,441	(54,765)	147,676			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			66,175	66,175		66,175	(21,679)	44,496			36
37	TOTAL Ownership			2,563,110	2,563,110		2,563,110	(1,317,802)	1,245,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		597,668	968,915	1,566,583		1,566,583	(43)	1,566,540			39
40	Barber and Beauty Shops	14,301	2,489	82,817	99,607		99,607	(99,607)				40
41	Coffee and Gift Shops	44,450	32,405	13	76,868		76,868	(76,868)				41
42	Provider Participation Fee			252,431	252,431		252,431		252,431			42
43	Other (specify):*	1,350,688	461,125	1,300,295	3,112,108		3,112,108	(3,113,778)	(1,670)			43
44	TOTAL Special Cost Centers	1,409,439	1,093,687	2,604,471	5,107,597		5,107,597	(3,290,296)	1,817,301			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,427,990	1,834,542	9,143,353	17,405,885		17,405,885	(4,940,130)	12,465,755			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,374)	02		4
5	Telephone, TV & Radio in Resident Rooms	(16,712)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,027	30		9
10	Interest and Other Investment Income	(36,411)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,694)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,759)	20		28
29	Other-Attach Schedule	(4,838,557)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,940,130)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (4,940,130)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Franciscan Village

	ID#	0045419
Report Period Beginning:		07/01/11
Ending:		06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (2,064)	21	1
2	Beverages Alcohol	(4,287)	02	2
3	Bond fees	(9,404)	21	3
4	Patient Loss Replacement	(3,012)	21	4
5	Entertainment & Gifts	(312)	21	5
6	Loss on Disposal of Asset	(21,679)	36	6
7	Supplies- Personal	(6,067)	10	7
8	Letter of Credit Fees	(61,038)	21	8
9	Investment Manager Fees	(1,348)	21	9
10	Senior Fit Therapy	(80,357)	10a	10
11	Beauty Shop Salaries	(14,301)	40	11
12	Beauty Shop Expense	(85,306)	40	12
13	Deli Expense	(44,451)	41	13
14	Deli Expense	(32,417)	41	14
15	Assisted Living Salaries	(221,071)	43	15
16	Assisted Living Expense	(114)	43	16
17	Independent Living Salaries	(144,658)	43	17
18	Independent Living Expense	(15)	43	18
19	Marketing Salaries	(197,096)	43	19
20	Marketing Expense	(178,369)	43	20
21	Mission Integration	(46)	43	21
22	Fundraising Salaries	(35,298)	43	22
23	Fundraising Expense	(3,788)	43	23
24	Facility Rent	(54,765)	34	24
25	Vending Machine	(925)	01	25
26	Rebates & Refunds	(52,387)	02	26
27	Misc Expense	(450)	21	27
28	Misc Income	(1,420)	21	28
29	Misc Income - Claims and Collections	(1,010)	21	29
30	Misc Income - Jury Duty	(17)	21	30
31	Misc Income - Late Fees Revenue	(50)	21	31
32	Non-Operating Revenue	(534)	21	32
33	Life Enrichment Revenue	(8,795)	12	33
34	Maintenance and Transportation Revenue	(1,850)	06	34
35	Housekeeping Revenue	(1,627)	03	35
36	Capitalized R&M	(10,775)	06	36
37	Non-Care Depreciation	(1,222,974)	30	37
38	ILU/ALU Allocations	(2,448,657)	43	38
39	Telephone Revenue	(6,052)	21	39
40	Non-Allowable Travel	(22)	25	40
41	Employee Referral Bonus	(3,125)	22	41
42	Additional R&M	115,334	43	42
43	Additional R&M	9,923	06	43
44	Exec Benefits - Life	(1,838)	22	44
45	Pharmacy Revenue - AL	(43)	39	45
46				46
47				47
48				48
49	Total	(4,838,557)		49

Franciscan Village

Report Period Beginning:

Ending:

ID#

0045419

07/01/11

06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

Summary A

06/30/12

[illegible]

Summary B

06/30/12

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Franciscan Communities	100%	See PG6 Supplemental		See PG6 Supplemental		

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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	17	FSCSC Shared Expenses	\$ 793,413	Franciscan Sisters of Chicago Service Corp.	100.00%	\$ 793,413	\$	15
16	V	43	FSCSC Shared Expenses	363,394	Franciscan Sisters of Chicago Service Corp.	100.00%	363,394		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,156,807			\$ 1,156,807	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			FRANCISCAN COMMUNITIES, INC. □ D/B/A ADDOLORATA VILLA	WHEELING	FRANCISCAN SISTERS OF CHICAGO	LEMONT	RELIGIOUS CONGREGATION	1
2			FRANCISCAN COMMUNITIES, INC. □ D/B/A ST. JOSEPH HOME	CHICAGO	FRANCISCAN SISTERS OF CHICAGO	HOMEWOOD	CORP. MANAGEMENT	2
3			MOTHER THERESA HOME	LEMONT	FRANCISCAN HOME CARE	CROWN POINT, IN	HOME HEALTH	3
4			ST. ANTHONY HOME	CROWN POINT, IN	ST. JUDE HOUSE	CROWN POINT, IN	WOMEN'S SHELTER	4
5			UNIVERSITY PLACE	WEST LAFAYETTE, IN	MARIAN VILLAGE	HOMER GLEN	RETIREMENT COMMUNITY	5
6			VILLAGE AT VICTORY LAKES	LINDENHURST, IL	ST. ANTHONY HOME	CROWN POINT, IN	HOSPICE	6
7			MOUNT ALVERNA	PARMA, OH				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

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JUDY AMIANO	BOARD MEMBER	CEO	0%	SEE ATTACHED	5.26	13.15%	Alloc Sal	\$ 53,770	17-3, 43-3	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	\$ 53,770		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

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____)
Fax Number (_____)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franciscan Village # 0045419 Report Period Beginning: 07/01/11 Ending: 06/30/12

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 Franciscan Sisters of Chicago Service Corp.
Street Address 1260 Franciscan Drive
City / State / Zip Code Lemont, IL 60439
Phone Number (630) 257-3987
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	FSCSC Shared Expenses				\$			\$ 793,413	1
2	43	FSCSC Shared Expenses							363,394	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					\$	\$		\$ 1,156,807	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franciscan Village # 0045419 Report Period Beginning: 07/01/11 Ending: 06/30/12

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 _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	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						\$	\$			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					\$	\$		\$	25

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 06/30/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franciscan Village # 0045419 Report Period Beginning: 07/01/11 Ending: 06/30/12

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
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	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						\$	\$			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					\$	\$		\$	25

Ending: 06/30/12

Fax Number**SEE ACCOUNTANTS' COMPILATION REPORT**

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	Amalgamated Bank		X	Facility Acquisition	\$4,500.00		\$ 4,050,000	\$ 4,050,000		Variable	\$ 9,749	1	
2	Amalgamated Bank		X	Facility Acquisition	\$19,176.73	06/01/03	3,432,000	372,778	05/01/13	Variable	53,267	2	
3	Amalgamated Bank		X	Facility Acquisition	\$15,827.29	06/01/03	2,181,925	2,181,925	05/01/19	Variable	147,621	3	
4	Amalgamated Bank		X	Facility Acquisition	\$56,500.00	02/14/07	12,462,000	12,462,000	05/01/37	Variable	680,760	4	
5	See Supplemental Schedule											5	
	Working Capital												
6												6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$96,004.02		\$ 22,125,925	\$ 19,066,703			\$ 891,397	9	
	B. Non-Facility Related*												
10	Interest Income										(36,411)	10	
11	Non-Allowable Interest										(187,193)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (223,604)	14	
15	TOTALS (line 9+line14)						\$ 22,125,925	\$ 19,066,703			\$ 667,793	15	

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

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007		8		
	2008		9		
	2009		10		
	2010		11		
	2011		12		
Exempt from Property Tax					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Franciscan Village</u>	COUNTY	<u>Cook</u>
---------------	---------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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?

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Franciscan Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045419

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 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 62,872 B. General Construction Type: Exterior Brick/Masonry Frame Steel Number of Stories 3
- 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).

Franciscan Communities, dba Franciscan Village - A retirement Community Consistiing of:
52 Independent Living Coach Homes 48,000 Square Feet
150 Independent Living Apartments 143, 354 Square Feet
30 Assisted Living Apartments 38,662 Square Feet

- 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>Land Leased from Franciscan Sisters of Chicago</u>		<u>1989</u>	<u>\$ 293,706</u>	1
2					2
3	TOTALS			<u>\$ 293,706</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150		1990	1989	\$ 5,724,856	\$	35	\$ 190,829	\$ 190,829	\$ 4,240,566	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1990		255,458		20	8,735	8,735	201,524	9
10	Various		1992		5,771		20			5,771	10
11	Various		1993		787,402		20	37,776	37,776	705,080	11
12	Various		1994		15,343		20	524	524	11,111	12
13	Various		1995		160,749		20	5,130	5,130	114,077	13
14	Various		1996		30,285		20	(27)	(27)	30,686	14
15	Various		1997		21,163		20			21,163	15
16	Various		1998		13,574		20			13,574	16
17	Various		1999		9,158		20	(772)	(772)	13,789	17
18	Various		2000		23,871		20			23,871	18
19	Various		2001		39,091		20			39,091	19
20	Various		2002		84,945		20	3,660	3,660	59,563	20
21	Various		2003		27,610		20	2,247	2,247	21,902	21
22	Various		2004		112,667		20	7,887	7,887	71,981	22
23	Various		2005		56,863		20	2,840	2,840	27,623	23
24	Various		2006		39,041		20	1,950	1,950	11,879	24
25	Various		2007		37,147		20	1,857	1,857	9,430	25
26	Various		2008		46,659		20	2,333	2,333	9,912	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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69			367,316			(367,316)		69
70		\$ 7,491,653	\$ 367,316		\$ 264,970	\$ (102,346)	\$ 5,632,593	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Franciscan Village

0045419

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 7,491,653	\$ 367,316		\$ 264,970	\$ (102,346)	\$ 5,632,593	1
2	Tray Counter For Mth 2Nd Flr Dining Room	2009	544		20	27	27	108	2
3	Wrapping Of Pump And Pipes In Mth Ceiling	2009	1,100		20	55	55	220	3
4	Ag Architecture - Building Exterior	2009	38,457		20	1,923	1,923	5,769	4
5	Illinois Dept. Of Public Health - Building Exterior	2009	9,682		20	484	484	1,452	5
6	Ag Architecture - Building Exterior	2009	148,660		20	7,433	7,433	22,299	6
7	Southwest Town - Chiller Leaks & Repairs	2009	7,317		20	366	366	1,098	7
8	Delta City - Exterior Painting	2009	20,000		20	1,000	1,000	3,000	8
9	Delta City - Exterior Painting	2009	25,000		20	1,250	1,250	3,750	9
10	Delta City - Exterior Painting	2009	3,500		20	175	175	525	10
11	Delta City - Exterior Painting	2009	33,000		20	1,650	1,650	4,950	11
12	Asphalt Work	2010	2,548		20	127	127	255	12
13	Asphalt Work	2010	2,743		20	137	137	274	13
14	Water Valve Replacement	2010	2,553		20	128	128	255	14
15	Condenser Fan Motor & Thermostat	2010	3,344		20	167	167	334	15
16	Insulation	2010	2,720		20	136	136	272	16
17	Expansion Joints & Butterfly Valaves	2011	5,437		20	272	272	544	17
18	B&G Pump & Repipe	2011	2,774		20	139	139	277	18
19	Hvac Repairs	2011	3,367		20	168	168	337	19
20	Repair East Trane Chiller Mother Teresa Home	2011	5,053		20	253	253	253	20
21	Perform Burner Maintenance,Replace Modulating Motor, Boiler	2011	3,179		20	159	159	159	21
22	Chilled Water Pump And Motor Replacement	2011	2,543		20	127	127	127	22
23	Main Entrance Roof	2011	545		20	27	27	27	23
24	Lighting For Fv Dining Room	2011	664		20	33	33	33	24
25	Carpet For Fv Dining Room	2011	1,304		20	65	65	65	25
26	Main Entrance Roof	2011	545		20	27	27	27	26
27	Dining Room Chairs	2011	12,069		20	603	603	603	27
28	Maintenance Hours	2011	1,594		20	80	80	80	28
29	Maintenance Hours	2011	1,911		20	96	96	96	29
30	Roofing St. Clare And St. Joseph	2011	3,484		20	174	174	174	30
31	Maintenance Hours	2011	1,758		20	88	88	88	31
32	Maintenance Hours	2011	1,156		20	58	58	58	32
33	New Roof St. Clare And St. Joseph	2011	1,295		20	65	65	65	33
34	TOTAL (lines 1 thru 33)		\$ 7,841,499	\$ 367,316		\$ 282,462	\$ (84,854)	\$ 5,680,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Franciscan Village

0045419

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12B, Carried Forward		\$ 7,841,499	\$ 367,316		\$ 282,462	\$ (84,854)	\$ 5,680,167	1
2	Maintenance Hours	2011	1,542		20	77	77	77	2
3	Carpet - Chapel Hallways And Mezzanine	2011	1,907		20	95	95	95	3
4	Misc Building Supplies	2011	573		20	29	29	29	4
5	Roofing St. Joseph	2011	1,480		20	74	74	74	5
6	Misc Building Supplies	2011	673		20	34	34	34	6
7	Maintenance Hours	2011	1,468		20	73	73	73	7
8	Carpet - Upper Level	2011	1,843		20	92	92	92	8
9	Misc Building Supplies	2012	622		20	31	31	31	9
10	2 Furnaces	2012	744		20	37	37	37	10
11	Fireplace For Il Dining Room	2012	1,133		20	57	57	57	11
12	Maintenance Hours	2012	2,260		20	113	113	113	12
13	Misc Building Supplies	2012	557		20	28	28	28	13
14	Walk In Produce Cooler	2012	871		20	44	44	44	14
15	Maintenance Hours	2012	2,171		20	109	109	109	15
16	Misc Building Supplies	2012	1,295		20	65	65	65	16
17	Misc Building Supplies	2012	1,194		20	60	60	60	17
18	Maintenance Hours To Capital	2012	1,798		20	90	90	90	18
19	Capitalize Labor	2012	2,034		20	102	102	102	19
20	Lowes Misc Range, Ref	2012	2,091		20	105	105	105	20
21	Capitalize Labor	2012	1,629		20	81	81	81	21
22	Home Depot Credit Services Misc Building	2012	1,989		20	99	99	99	22
23	Stranton Mechanical Heat Exchanger Hvac	2012	731		20	37	37	37	23
24	Stanton Mech Replace Chilled Water Pump	2012	1,167		20	58	58	58	24
25	Capital Hours	2012	1,765		20	88	88	88	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,875,036	\$ 367,316		\$ 284,139	\$ (83,177)	\$ 5,681,844	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12C, Carried Forward		\$7,875,036	\$367,316		\$284,139	\$ (83,177)	\$5,681,844	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	TOTAL (lines 1 thru 33)		\$7,875,036	\$367,316		\$284,139	\$ (83,177)	\$5,681,844	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12D, Carried Forward		\$7,875,036	\$367,316		\$284,139	\$ (83,177)	\$5,681,844	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
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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)		\$7,875,036	\$367,316		\$284,139	\$ (83,177)	\$5,681,844	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		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	Building Company Information Continued		\$	\$		\$	\$	\$	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	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation
1	Related Party Information		\$	\$		\$	\$	\$
2	Buildings:							
3								
4								
5								
6								
7								
8	Leasehold Improvements:							
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
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29								
30								
31								
32								
33								
34								

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								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
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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 (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,200,985	\$	\$97,834	\$97,834	10	\$1,048,717	71
72	Current Year Purchases	9,890		494	494	10	989	72
73	Fully Depreciated Assets	146,103				10	146,103	73
74								74
75	TOTALS	\$1,356,977	\$	\$98,329	\$98,329		\$1,195,809	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		new bus chevy 3500	2010	\$54,645	\$	\$2,732	\$2,732	5	\$5,465	76
77		2007 Dodge Ram 2500 pick up - N	2010	2,857		143	143	5	286	77
78										78
79										79
80	TOTALS			\$57,502	\$	\$2,875	\$2,875		\$5,750	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)	\$9,583,221	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$367,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$385,343	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$18,027	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,883,403	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	FV noncare assets (1990 - 2012) - 1900	\$30,192,812	\$1,207,712	\$23,580,946	86
87	Beauty shop/pastoral offices - 1900	115,982	3,866	63,146	87
88	Chevy truck - 1900	21,723			88
89	Beauty shop equipment - 1900	7,073			89
90	Buses - 1900	113,954	11,395	119,649	90
91	TOTALS	\$30,451,544	\$1,222,974	\$23,763,742	91

G. Construction-in-Progress

	Description	Cost	
92	ILU Unit Rehab	\$223,321	92
93			93
94			94
95		\$223,321	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: N/A
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	Land Lease from FSC				202,441			5
6	Rental Income				(54,765)			6
7	TOTAL				\$147,676			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$
- Description:
- (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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 336,206	\$		\$ 336,206	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			125,645			125,645	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			433,310			433,310	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				493,098		493,098	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					73,754	104,570		178,324	13
14	TOTAL			\$		\$ 968,915	\$ 597,668		\$ 1,566,583	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 218,975	\$	1
2	Cash-Patient Deposits	8,222		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,463,146		3
4	Supply Inventory (priced at)	62,927		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	31,715		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	70,415		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,855,400	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	29,133,072		14
15	Leasehold Improvements, at Historical Cost	2,834,331		15
16	Equipment, at Historical Cost	6,934,389		16
17	Accumulated Depreciation (book methods)	(27,815,074)		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): See Attached Schedule	2,603,636		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,690,354	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,545,754	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 688,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,491,740		28
29	Short-Term Notes Payable	1,188,978		29
30	Accrued Salaries Payable	633,660		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	107,201		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,109,877	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,877,725		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17,877,725	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 24,987,602	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (9,441,848)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,545,754	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,874,133)	1
2	Restatements (describe):		2
3	Unrestricted Tansfer - FSCSC Affiliates	(1,722,411)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,596,544)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	154,696	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		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)	\$ 154,696	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)	\$ (9,441,848)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$16,359,835	1
2	Discounts and Allowances for all Levels	(1,912,977)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$14,446,858	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,915,050	6
7	Oxygen	8,251	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$1,923,301	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	10,433	12
13	Barber and Beauty Care	113,909	13
14	Non-Patient Meals	45,158	14
15	Telephone, Television and Radio	16,461	15
16	Rental of Facility Space	14,502	16
17	Sale of Drugs	476,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,024	19
20	Radiology and X-Ray	11,035	20
21	Other Medical Services	290,180	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$1,022,310	23
	D. Non-Operating Revenue		
24	Contributions	36,086	24
25	Interest and Other Investment Income***	36,411	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$72,497	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	95,615	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$95,615	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$17,560,581	30

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,462,872	31
32	Health Care	3,868,108	32
33	General Administration	3,404,198	33
	B. Capital Expense		
34	Ownership	2,563,110	34
	C. Ancillary Expense		
35	Special Cost Centers	4,855,166	35
36	Provider Participation Fee	252,431	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$17,405,885	40
41	Income before Income Taxes (line 30 minus line 40)**	154,696	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$154,696	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$1,212,790	44
45	Private Pay - Net Inpatient Revenue	10,190,523	45
46	Medicare - Net Inpatient Revenue	2,650,234	46
47	Other-(specify)	393,311	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$14,446,858	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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	1,721	1,929	\$ 82,227	\$ 42.63	1
2	Assistant Director of Nursing	1,896	2,000	70,017	35.01	2
3	Registered Nurses	26,659	28,222	772,257	27.36	3
4	Licensed Practical Nurses	26,305	27,155	683,944	25.19	4
5	CNAs & Orderlies	90,549	98,426	1,316,397	13.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,143	8,568	216,162	25.23	8
9	Activity Director	13,198	14,646	186,111	12.71	9
10	Activity Assistants	1,840	2,080	56,690	27.25	10
11	Social Service Workers	5,408	6,056	163,378	26.98	11
12	Dietician					12
13	Food Service Supervisor	7,258	8,061	81,347	10.09	13
14	Head Cook	9,596	10,688	149,129	13.95	14
15	Cook Helpers/Assistants	12,278	12,649	102,683	8.12	15
16	Dishwashers					16
17	Maintenance Workers	21,489	23,410	407,754	17.42	17
18	Housekeepers	22,782	25,241	253,809	10.06	18
19	Laundry					19
20	Administrator	2,642	2,853	146,346	51.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,444	19,978	320,747	16.06	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	628	687	9,553	13.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	82,431	88,719	1,409,439	15.89	33
34	TOTAL (lines 1 - 33)	351,267	381,368	\$ 6,427,990 *	\$ 16.86	34

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		\$		35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	19,880	10-03	38
39	Pharmacist Consultant	39	1,928	10-03	39
40	Physical Therapy Consultant	48	2,417	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,554	11-03	44
45	Social Service Consultant				45
46	Other(specify) Chaplin/Organist	\$35/Service	12,850	12-03	46
47	Senior Fit Therapy	Monthly	80,357	10a-03	47
48	Food Service Consultant	Monthly	223,343	01-03	48
49	TOTAL (lines 35 - 48)	138	\$ 373,329		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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
Robert Coon	Exec. Director	0.00%	\$ 119,039	Workers' Compensation Insurance	\$	367,156	IDPH License Fee	\$
Melody Stein	Administrator	0.00%	94,336	Unemployment Compensation Insurance		68,852	Advertising: Employee Recruitment	1,695
				FICA Taxes		475,745	Health Care Worker Background Check	
AL/IL Allocation			(67,029)	Employee Health Insurance		643,417	(Indicate # of checks performed 584)	11,644
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	19,408
				PTO Liability		99,061	Facility Licenses	9,498
				Life Insurance		10,256		
TOTAL (agree to Schedule V, line 17, col. 1)				Retirement Benefits		76,210	AL/IL Allocation	(13,475)
(List each licensed administrator separately.)			\$ 146,346	Employee Physicals		11,763		
B. Administrative - Other				Emp Benefits- Other		12,617	Less: Public Relations Expense	()
				Disability Insurance		24,185	Non-allowable advertising	()
Description			Amount				Yellow page advertising	(10,759)
Franciscan Sisters of Chicago Service Corp. - Shared Expenses			\$ 1,156,807					
AL/IL Allocation			(363,394)	TOTAL (agree to Schedule V, line 22, col.8)	\$	1,789,262	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,011
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 793,413	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Ernst & Young	Audit		\$ 31,031				In-State Travel	
Frost, Ruttenberg & Rothblatt	Accounting		7,000					
ProBusiness Services	Payroll Processing		20,865					
Ungaretti	Legal		844					
Gero Solutions	Consulting		478					
Foote,Meyers,Mielke,&Flower	Legal		25,887					
Ice Miller	Legal		623					
AL/IL Allocation			(27,244)				Seminar Expense	4,689
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 59,484				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,689

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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. LSN - \$8,819 & AAHSA - \$6,310
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,417 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 252,431
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ _____
- (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? None
d. Have vehicle usage logs been maintained? Yes
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?
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? N/A
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.