

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>07/01/2024</u> to <u>06/30/2025</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 Dr</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: _____																																																	
Date of Initial License for Current Owners: <u>4/19/1965</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Robert Rosenberger</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Matthew Larsh</u> <u>Signing Director</u></td></tr><tr><td>(Firm Name & Address) <u>CLA (CliftonLarsonAllen LLP)</u> <u>833 West Lincoln Hwy, Suite 210W, Schererville, IN 46375</u></td></tr><tr><td>(Telephone) <u>630-368-3666</u> Fax # <u>219-864-0055</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Robert Rosenberger</u>	(Title) <u>CFO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Matthew Larsh</u> <u>Signing Director</u>	(Firm Name & Address) <u>CLA (CliftonLarsonAllen LLP)</u> <u>833 West Lincoln Hwy, Suite 210W, Schererville, IN 46375</u>	(Telephone) <u>630-368-3666</u> Fax # <u>219-864-0055</u>																																				
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In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																																															
Name: <u>Matt Larsh, Signing Director</u>																																																	
Telephone Number: <u>630-368-3666</u> Email Address: _____																																																	

