FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0041046

Facility Name: Presence Cor Mariae Center

Address: 3330 Maria Linden Drive (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7416 **Fax #** (815) 877-4299

HFS ID Number:

Date of Initial License for Current Owners: 06/01/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) CFO, VP of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,718	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	89	Sheltered Care (SC)	89	32,485	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,203	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,855	11,036	9,957	25,848	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		24,241		24,241	12
13	DD 16 OR LESS					13
14	TOTALS	4,855	35,277	9,957	50,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.61%

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 - None

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/05/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/05/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 73 and days of care provided 8,008

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	503,696	78,001	15,853	597,550		597,550		597,550			1
2	Food Purchase		410,989		410,989		410,989	3,010	413,999			2
3	Housekeeping	164,467	37,640	226	202,333		202,333		202,333			3
4	Laundry	29,656	5,199	99,836	134,691		134,691		134,691			4
5	Heat and Other Utilities			280,102	280,102		280,102	5,727	285,829			5
6	Maintenance	128,239	52,946	90,727	271,912		271,912	80,210	352,122			6
7	Other (specify):* Pastoral Care	32,747	3,074	16,232	52,053		52,053	(4,573)	47,480			7
8	TOTAL General Services	858,805	587,849	502,976	1,949,630		1,949,630	84,374	2,034,004			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	2,590,641	268,580	72,976	2,932,197		2,932,197		2,932,197			10
10a	Therapy			1,034,449	1,034,449		1,034,449		1,034,449			10a
11	Activities	282,913	10,611	7,637	301,161		301,161	4,309	305,470			11
12	Social Services	84,526	491	2,444	87,461		87,461		87,461			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,958,080	279,682	1,138,506	4,376,268		4,376,268	4,309	4,380,577			16
	C. General Administration											
17	Administrative	483,067	46,146	1,000,604	1,529,817		1,529,817	(443,260)	1,086,557			17
18	Directors Fees											18
19	Professional Services			24,011	24,011		24,011	53,850	77,861			19
20	Dues, Fees, Subscriptions & Promotions			20,227	20,227		20,227	416	20,643			20
21	Clerical & General Office Expenses			56,121	56,121		56,121	4,832	60,953			21
22	Employee Benefits & Payroll Taxes			1,029,262	1,029,262		1,029,262	223,010	1,252,272			22
23	Inservice Training & Education			3,795	3,795		3,795	938	4,733			23
24	Travel and Seminar			13,641	13,641		13,641	5,628	19,269			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			173,754	173,754		173,754	(641)	173,113			26
27	Other (specify):*											27
28	TOTAL General Administration	483,067	46,146	2,321,415	2,850,628		2,850,628	(155,227)	2,695,401			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,299,952	913,677	3,962,897	9,176,526		9,176,526	(66,544)	9,109,982			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 Presence Cor Mariae Center #0041046 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			446,133	446,133		446,133	55,784	501,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							247,322	247,322			32
33	Real Estate Taxes			2,484	2,484		2,484		2,484			33
34	Rent-Facility & Grounds							29,683	29,683			34
35	Rent-Equipment & Vehicles			21,847	21,847		21,847	1,880	23,727			35
36	Other (specify):*											36
37	**TOTAL Ownership**			470,464	470,464		470,464	334,669	805,133			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			646,227	646,227		646,227	(360,257)	285,970			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,519	196,519		196,519		196,519			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			842,746	842,746		842,746	(360,257)	482,489			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,299,952	913,677	5,276,107	10,489,736		10,489,736	(92,132)	10,397,604			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 Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(663)	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	3,012	30		9
10	Interest and Other Investment Income	(13,862)	32		10
11	Discounts, Allowances, Rebates & Refunds	(360,257)	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	(2,493)	30		17
18	Fines and Penalties	(1,430)	21		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				24
25	Fund Raising, Advertising and Promotional	(7,938)	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)**	$ (383,631)		$	30

BHF USE ONLY								
48		49		50		51		52

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)	296,072		34
35	Other- Attach Schedule	(4,573)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 291,499		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (92,132)		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.		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

Presence Cor Mariae Center

ID# 0041046

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (4,573)	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**	(4,573)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Presence Cor Mariae Center **#** 0041046 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	(663)	3,673	0	0	0	0	0	0	0	0	0	3,010	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	5,727	0	0	0	0	0	0	0	0	0	5,727	5
6	Maintenance	0	2,150	78,060	0	0	0	0	0	0	0	0	80,210	6
7	Other (specify):*	(4,573)	0	0	0	0	0	0	0	0	0	0	(4,573)	7
8	**TOTAL General Services**	(5,236)	11,550	78,060	0	0	0	0	0	0	0	0	84,374	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	4,309	0	0	0	0	0	0	0	0	0	4,309	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	4,309	0	0	0	0	0	0	0	0	0	4,309	16
	C. General Administration													
17	Administrative	0	(379,056)	(64,204)	0	0	0	0	0	0	0	0	(443,260)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	32,139	21,711	0	0	0	0	0	0	0	0	53,850	19
20	Fees, Subscriptions & Promotions	(7,938)	8,354	0	0	0	0	0	0	0	0	0	416	20
21	Clerical & General Office Expenses	(1,430)	6,262	0	0	0	0	0	0	0	0	0	4,832	21
22	Employee Benefits & Payroll Taxes	0	59,593	163,417	0	0	0	0	0	0	0	0	223,010	22
23	Inservice Training & Education	0	938	0	0	0	0	0	0	0	0	0	938	23
24	Travel and Seminar	0	5,628	0	0	0	0	0	0	0	0	0	5,628	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	(641)	0	0	0	0	0	0	0	0	0	(641)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,368)	(266,783)	120,924	0	0	0	0	0	0	0	0	(155,227)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,604)	(250,924)	198,984	0	0	0	0	0	0	0	0	(66,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Presence Cor Mariae Center # 0041046 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	519	0	55,265	0	0	0	0	0	0	0	0	55,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,862)	0	261,184	0	0	0	0	0	0	0	0	247,322	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	29,683	0	0	0	0	0	0	0	0	29,683	34
35	Rent-Equipment & Vehicles	0	0	1,880	0	0	0	0	0	0	0	0	1,880	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,343)	0	348,012	0	0	0	0	0	0	0	0	334,669	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	(360,257)	0	0	0	0	0	0	0	0	0	0	(360,257)	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**	(360,257)	0	0	0	0	0	0	0	0	0	0	(360,257)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(388,204)	(250,924)	546,996	0	0	0	0	0	0	0	0	(92,132)	45

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
		Presence Our Lady of Victory	Bourbonnais	Presence Service C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Ca	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 3,673	$ 3,673	1
2	V	5	Utilities		Presence Life Connections	100.00%	5,727	5,727	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,150	2,150	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	4,309	4,309	4
5	V	17	Admin - Misc. Other	708,096	Presence Life Connections	100.00%	12,804	(695,292)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	316,236	316,236	6
7	V	19	Professional Services		Presence Life Connections	100.00%	32,139	32,139	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	8,354	8,354	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	6,262	6,262	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	59,593	59,593	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	938	938	11
12	V	24	Travel		Presence Life Connections	100.00%	5,628	5,628	12
13	V	26	Insurance		Presence Life Connections	100.00%	(641)	(641)	13
14	Total			$ 708,096			$ 457,172	$ * (250,924)	14

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Presence Life Connections	100.00%	$ 3,037	$ 3,037	15
16	V	32	Interest		Presence Life Connections	100.00%	94,807	94,807	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	29,683	29,683	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,880	1,880	18
19	V	17	Admin Salaries	93,704	Presence Health	100.00%	99,244	5,540	19
20	V	22	Employee Benefits		Presence Health	100.00%	52,437	52,437	20
21	V	30	Depreciation		Presence Health	100.00%	52,228	52,228	21
22	V	19	Admin Consulting,Other		Presence Health	100.00%	21,711	21,711	22
23	V	17	Information Systems Salaries	198,804	Presence Health	100.00%	41,135	(157,669)	23
24	V	22	Information Systems Benefits		Presence Health	100.00%	32,027	32,027	24
25	V	17	Information Systems - Other		Presence Health	100.00%	29,391	29,391	25
26	V	17	Admin Salaries		Presence Health	100.00%	20,237	20,237	26
27	V	22	Employee Benefits		Presence Health	100.00%	26,226	26,226	27
28	V	17	Information Systems Salaries		Presence Health	100.00%	38,297	38,297	28
29	V	22	Information Systems Benefits		Presence Health	100.00%	52,727	52,727	29
30	V	6	Information Systems - Equip Maint		Presence Health	100.00%	78,060	78,060	30
31	V	32	Admin - Interest Expense		Presence Health	100.00%	166,377	166,377	31
32	V	39	Ancillary Services - Other	646,227	Presence Senior Services Pharmacy	100.00%	646,227		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 938,735			$ 1,485,731	$ * 546,996	39

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compar	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Car	Northlake	Independent Living	13
14					Presence Ambulatory S	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Esta	Kankakee	Independent Living	30

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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									$		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 Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

Name of Related Organization: Presence Life Connections
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL 60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	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	2	Food	Management Fee Income	7,895,880	23	$ 40,958	$	708,096	$ 3,673	1
2	5	Utilities	Management Fee Income	7,895,880	23	63,861		708,096	5,727	2
3	6	Maintenance - Other	Management Fee Income	7,895,880	23	23,977		708,096	2,150	3
4	11	Activities-Special Events	Management Fee Income	7,895,880	23	48,049		708,096	4,309	4
5	17	Admin - Misc. Other	Management Fee Income	7,895,880	23	142,773		708,096	12,804	5
6	17	Administrative Salaries	Management Fee Income	7,895,880	23	3,526,307	3,526,307	708,096	316,236	6
7	19	Professional Services	Management Fee Income	7,895,880	23	358,375		708,096	32,139	7
8	20	Dues,Subscriptions	Management Fee Income	7,895,880	23	93,150		708,096	8,354	8
9	21	Clerical Supplies	Management Fee Income	7,895,880	23	69,822		708,096	6,262	9
10	22	Employee Benefits	Management Fee Income	7,895,880	23	664,511		708,096	59,593	10
11	23	Education/Conference	Management Fee Income	7,895,880	23	10,463		708,096	938	11
12	24	Travel	Management Fee Income	7,895,880	23	62,753		708,096	5,628	12
13	26	Insurance	Management Fee Income	7,895,880	23	(7,150)		708,096	(641)	13
14	30	Depreciation	Management Fee Income	7,895,880	23	33,862		708,096	3,037	14
15	32	Interest	Management Fee Income	7,895,880	23	1,057,182		708,096	94,807	15
16	34	Rent - Facility	Management Fee Income	7,895,880	23	330,990		708,096	29,683	16
17	35	Rent - Equipment	Management Fee Income	7,895,880	23	20,962		708,096	1,880	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,540,845	$ 3,526,307		$ 586,579	25

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

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

	1 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	17	Admin Salaries	Operating Expense	936,340	10	$ 991,694	$ 991,694	93,704	$ 99,244	1
2	22	Employee Benefits	Operating Expense	936,340	10	523,983		93,704	52,437	2
3	30	Depreciation	Operating Expense	936,340	10	521,887		93,704	52,228	3
4	34	Rent Facility	Operating Expense	936,340	10	216,946		93,704	21,711	4
5	19	Admin Consulting,Other	Operating Expense	936,340	10	411,047		93,704	41,135	5
6	17	Information Systems Salaries	Operating Expense	1,983,972	10	319,617	319,617	198,804	32,027	6
7	22	Information Systems Benefits	Operating Expense	1,983,972	10	293,305		198,804	29,391	7
8	17	Information Systems - Other	Operating Expense	1,983,972	10	201,957		198,804	20,237	8
9	17	Admin Salaries	Direct Cost	936,340	10	262,066	262,066	93,704	26,226	9
10	17	Information Systems Salaries	Direct Cost	1,983,972	10	382,190	382,190	198,804	38,297	10
11	6	Information Systems - Equip Mai	Direct Cost	1,983,972	10	526,191		198,804	52,727	11
12	19	Admin Consulting,Other	Direct Cost	936,340	10	780,014		93,704	78,060	12
13	32	Admin - Interest Expense	Direct Cost	936,340	10	1,662,527		93,704	166,377	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,093,424	$ 1,955,567		$ 710,097	25

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

Name of Related Organization: Presence Senior Services Pharmacy
Street Address: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60914
Phone Number: (815)936-3644
Fax Number: (815)936-3238

	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	39	Ancillary Services - Other	Direct Allocation			$	$		$ 646,227	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					$	$		$ 646,227	25

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Home Office Allocation						$	$			$ 261,184	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 261,184	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 261,184	15

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

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

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (174)	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.)		$ 1,324	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,498	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 986	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.		$ 2,484	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	1,094	8
	2008	1,157	9
	2009	1,224	10
	2010	1,274	11
	2011	1,324	12

	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Presence Cor Mariae Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	153B004C 12-09-104-035	Comm SE Cor LT Imperial	$ 1,324.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,324.00	$

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 X _____ NO

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.

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1995	$ 670,894	1
2					2
3	TOTALS			$ 670,894	3

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		1997	1997	$ 2,508,246	$ 62,711	40	$ 62,711	$	$ 956,148	4
5	10		2005	2005	944,355	37,774	25	37,774		281,451	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1995	1,206,813	41,794	16	41,794		764,631	9
10	VARIOUS			1996	366,570	14,133	15	14,133		311,890	10
11	VARIOUS			1997	251,717	9,143	12	9,143		217,675	11
12	VARIOUS			1998	174,397	5,239	12	5,239		93,190	12
13	VARIOUS			1999	10,976		6			10,976	13
14	VARIOUS			2000	39,900		6			39,900	14
15	VARIOUS			2001	48,414	835	9	835		41,318	15
16	VARIOUS			2002	118,018	6,931	10	6,931		99,179	16
17	VARIOUS			2003	122,240	2,808	9	2,808		120,728	17
18	VARIOUS			2004	106,296	8,592	9	8,592		90,086	18
19	VARIOUS			2005	68,501	6,075	11	6,075		48,128	19
20	VARIOUS			2006	115,365	9,815	11	9,815		63,974	20
21	VARIOUS			2007	63,026	5,033	10	5,033		34,803	21
22	VARIOUS			2008	187,396	13,131	11	13,131		59,089	22
23											23
24	BOILER INSTALLATION			2009	16759	838	20	838		2933	24
25	PATIO PROJECT			2009	73176	4878	15	4878		15148	25
26	FIX BROILER			2009	3810	544	7	544		2041	26
27	CARPETING			2009	5965	1193	5	1193		4176	27
28	KITCHEN HOOD WIRING			2009	2795	280	10	280		978	28
29	PARTIAL RE-ROOF			2009	17740	1774	10	1774		6209	29
30	CARPETING FOR 9 MED APTS, 2 SM APTS, & 1 LG APT			2009	12466	2493	5	2493		8726	30
31	PATIO PROJECT / EXTERNAL BE			2009	131151	6558	20	6558		22178	31
32	PATCH PARKING LOT			2009	18336	2292	8	2292		8022	32
33	DEDUCTION FOR NON-CARE ASSETS				(12,466)	(2,493)	-5	(2,493)		(8,726)	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 Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
37	INSTALL SHOWER/HARDWARE	2010	$ 9379	$ 938	10	$ 938	$	$ 2812	37
38	AUTO MATIC DOOR OPENER ON SKILLED CONNECTOR	2010	3433	343	10	343		858	38
39	WATER MAIN REPAIR	2010	14831	2119	7	2119		6356	39
40	ROOF INSTALLATION PEAK / NORTH STAIRWELL / SOUT	2010	21410	2141	10	2141		5353	40
41	NATURAL OAK VINYL FLOORING FOR 11 RESIDENT ROOM	2010	22480	2248	10	2248		5620	41
42	PATCH AREA OF WATER BREAK	2010	3797	380	10	380		949	42
43	ELEVATOR REPAIRS	2010	38450	1923	20	1923		4133	43
44	WATER HEATER KITCHEN	2010	9341	934	10	934		1868	44
45									45
46									46
47	INFRA STRUCTURE FOR WALL MOUNTED COMPUTERS	2011	5253	263	20	263		394	47
48	SPRINKLER PROJECT	2011	463250	18530	25	18530		26734	48
49	PARKING LOT EXPANSION	2011	13332	1667	8	1667		2500	49
50	VINYL FLOORING (CORRIDOR TO SKILLED UNIT)	2011	31880	3188	10	3188		4782	50
51	CODE ALERT EXIT ALARM	2011	3767	251	15	251		377	51
52									52
53									53
54	CENTRAL SHOWER ROOM FIXTURES	2012	23195	1160	10	2320	**1,160**	1160	54
55	NEW CARPET, CABINETRY, SINK & FAUCET IN PRIEST KITCH	2012	14168	472	15	945	**472**	472	55
56	NEW FLOORING IN THE 2ND FLOOR DINING ROOM	2012	5000	250	10	500	**250**	250	56
57	SMOKE BARRIER WALL IN THE ATTIC BETWEEN NORTH & E	2012	14072	352	20	704	**352**	352	57
58	FURNISH AND REPLACE SKILLED UNIT WATER HEATER	2012	7976	399	10	798	**399**	399	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)**		**$ 7,306,976.04**	**$ 279,927**		**$ 282,560**	**$ 2,633**	**$ 3,360,220**	70

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 1,909,035	$ 163,334	$ 163,334	$	11	$ 1,237,353	71
72	Current Year Purchases	9,309	379	758	379	11	379	72
73	Fully Depreciated Assets	392,692				6	393,613	73
74	Home Office Allocation		55,265	55,265				74
75	TOTALS	$ 2,311,036	$ 218,978	$ 219,357	$ 379		$ 1,631,345	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	PLANT ENGINEERING	1991 CHEVROLET FLEETSIDE I	1995	$ 14,000	$	$	$	5	$ 14,000	76
77	PLANT ENGINEERING	2000 FORD ELDORADO -CAP 15	2000	42,500				10	42,500	77
78										78
79										79
80	TOTALS			$ 56,500	$	$	$		$ 56,500	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)	$ 10,345,406	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 498,905	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 501,917	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,012	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,048,065	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.

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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				29,683			5
6								6
7	TOTAL				$ 29,683 **			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 ☒ X NO Terms: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 81,613 Description: Nursing $57,886; Administration $21, 847; Home Office $1,880
    (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.

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	$			

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.

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	8,335	$ 468,938	$	8,335	$ 468,938	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,657	98,996		1,657	98,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		8,018	466,515		8,018	466,515	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				646,227		646,227	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			$	18,010	$ 1,034,449	$ 646,227	18,010	$ 1,680,676	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.

STATE OF ILLINOIS

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 13,086,787	$	1
2	Cash-Patient Deposits	87,303		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	19,569,971		3
4	Supply Inventory (priced at)	652,763		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,531		6
7	Other Prepaid Expenses	114,653		7
8	Accounts Receivable (owners or related parties)	152,567		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 33,665,575	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,629,961		12
13	Land	6,033,932		13
14	Buildings, at Historical Cost	86,623,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,565,514		16
17	Accumulated Depreciation (book methods)	(62,295,376)		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 (spe **Deferred Comp**	418,087		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 58,975,342	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 92,640,917	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,316,095	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,097,772		28
29	Short-Term Notes Payable	69,804		29
30	Accrued Salaries Payable	3,738,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,523,338		32
33	Accrued Interest Payable	9,580		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Due to Related Party**	819,992		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,735,600	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	969,488		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	418,087		42
	Other Long-Term Liabilities(specify):			
43	**Conditional Asset Retirement**	438,744		43
44	**Deferred Lease Payable**	28,912		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,855,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,590,831	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 77,050,086	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 92,640,917	$	48

***(See instructions.)**

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 71,119,277	1	
2	Restatements (describe):		2	
3	**Transfer to Affiliates**	(967,209)	3	
4	**Adj. To reconcile consolidated equity & consolidated income**	3,237,779	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,389,847	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	707,520	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	3,067,950	11	
12	Expenditures for Specific Purposes	(115,231)	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)**	$ 3,660,239	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)**	$ 77,050,086	24	*

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

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,163,463	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,163,463	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,971,071	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,971,071	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	512	13
14	Non-Patient Meals	663	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	593,041	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,786	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 604,002	23
	D. Non-Operating Revenue		
24	Contributions	22,299	24
25	Interest and Other Investment Income***	13,862	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,161	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	360,257	28
28a	Misc Income/Gain Loss SOFA	62,302	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 422,559	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,197,256	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,949,630	31
32	Health Care	4,376,268	32
33	General Administration	2,850,628	33
	B. Capital Expense		
34	Ownership	470,464	34
	C. Ancillary Expense		
35	Special Cost Centers	646,227	35
36	Provider Participation Fee	196,519	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,489,736	40
41	**Income before Income Taxes (line 30 minus line 40)****	707,520	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 707,520	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 662,641	44
45	Private Pay - Net Inpatient Revenue	5,107,611	45
46	Medicare - Net Inpatient Revenue	1,878,389	46
47	Other-(specify) Insurance	514,822	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,163,463	49

* **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 Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,004	2,080	$ 86,218	$ 41.45	1
2	Assistant Director of Nursing	1,744	1,944	56,751	29.19	2
3	Registered Nurses	18,863	20,395	594,929	29.17	3
4	Licensed Practical Nurses	28,346	30,850	766,079	24.83	4
5	CNAs & Orderlies	75,759	79,886	951,318	11.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,514	2,958	36,882	12.47	8
9	Activity Director	1,872	2,080	39,849	19.16	9
10	Activity Assistants	22,260	23,408	242,622	10.36	10
11	Social Service Workers	4,533	4,923	84,724	17.21	11
12	Dietician	590	612	15,514	25.35	12
13	Food Service Supervisor	1,808	2,080	48,787	23.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	40,953	43,334	434,921	10.04	15
16	Dishwashers					16
17	Maintenance Workers	5,735	6,288	128,359	20.41	17
18	Housekeepers	15,749	17,315	164,109	9.48	18
19	Laundry	3,124	3,249	29,388	9.05	19
20	Administrator	1,932	2,080	122,438	58.86	20
21	Assistant Administrator	1,552	1,948	57,707	29.62	21
22	Other Administrative	8,754	9,402	139,256	14.81	22
23	Office Manager	1,988	2,080	47,243	22.71	23
24	Clerical	4,710	5,026	67,437	13.42	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 C: Admissions	5,615	6,219	149,126	23.98	32
33	Other(specify) Pastoral	1,304	1,516	36,295	23.94	33
34	TOTAL (lines 1 - 33)	251,709	269,673	$ 4,299,952 *	$ 15.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 7,511	1,3	35
36	Medical Director	70	21,000	9,3	36
37	Medical Records Consultant	22	2,121	10,3	37
38	Nurse Consultant				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	34	2,646	11,3	44
45	Social Service Consultant	34	2,148	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	$ 35,426		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Wester-Peters	Administrator		$ 122,438
Administrative Staff	Office Manager		47,243
Administrative Staff	Human Resource		43,680
Administrative Staff	Receptionist		25,444
Administrative Staff	Admin Asst		37,429
Administrative Staff	Admissions		149,126
Administrative Staff	Asst Administrator		57,707
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 483,067

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 93,704
Corp Service IS Fee	198,804
Mgmt Fee	419,196
Mgmt Fee Interest	288,900
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,000,604

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 3,277
Collection Fee	Various	3,320
Survey & Analytical Tools	Various	3,270
Shredding/Storage	Various	1,785
Security	Various	9,603
Outsourced Services	Various	1,255
Interpreter	Various	356
Living Design	Various	1,145
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 24,011

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 118,740
Unemployment Compensation Insurance	20,339
FICA Taxes	313,419
Employee Health Insurance	402,580
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	13,322
Pension	132,773
Employee Recognition	
Executive Benefots	3,830
Employee Screening	24,259
Home Office Allocation	223,010
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,252,272

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 42)	
Patient Background Checks 250	
Employee Recruitment	1,025
Dues & Subscription	9,746
Advertiosing & Public Relations	9,456
Home Office Allocation	8,354
Less: Public Relations Expense	( )
Non-allowable advertising	(7,938)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,643

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,183
In-State Travel	11,458
Seminar Expense	
Home Office Allocation	5,628
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,269

**See instructions.

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Presence Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $5271**

(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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,962** 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. $ **196,519**
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. $ **663**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
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**

(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.