FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0051490

Facility Name: PRESENCE BALLARD NURSING CTR

Address: 9300 BALLARD ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: (847) 294-2300 **Fax #** (847) 299-4012

HFS ID Number:

Date of Initial License for Current Owners: 05/31/11

Type of Ownership:

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

IRS Exemption Code 501C3

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 01/01/2013 to 12/31/2013 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, Vice President 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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	231	Skilled (SNF)	231	84,315	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	231	TOTALS	231	84,315	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	27,156	5,262	17,503	49,921	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,156	5,262	17,503	49,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.21%

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 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/31/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 231 and days of care provided 13,109

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	448,573	15,271	539	464,383		464,383		464,383			1
2	Food Purchase		217,973		217,973		217,973	2,691	220,664			2
3	Housekeeping	367,762	59,336	12,500	439,598		439,598		439,598			3
4	Laundry	119,894	31,788		151,682		151,682		151,682			4
5	Heat and Other Utilities			217,205	217,205		217,205	6,168	223,373			5
6	Maintenance	100,906	46,618	172,509	320,033		320,033	2,502	322,535			6
7	Other (specify):* Pastoral Care	56,117	1,503	7,995	65,615		65,615		65,615			7
8	TOTAL General Services	1,093,252	372,489	410,748	1,876,489		1,876,489	11,361	1,887,850			8
	B. Health Care and Programs											
9	Medical Director			197,713	197,713		197,713		197,713			9
10	Nursing and Medical Records	7,304,299	976,625	418,099	8,699,023		8,699,023	(145,430)	8,553,593			10
10a	Therapy		6,131	1,555,479	1,561,610		1,561,610		1,561,610			10a
11	Activities	162,297	5,372	438	168,107		168,107	1,847	169,954			11
12	Social Services	130,867	13		130,880		130,880		130,880			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,597,463	988,141	2,171,729	10,757,333		10,757,333	(143,583)	10,613,750			16
	C. General Administration											
17	Administrative	536,316	57,879	1,951,687	2,545,882		2,545,882	489,400	3,035,282			17
18	Directors Fees											18
19	Professional Services			15,119	15,119		15,119	22,519	37,638			19
20	Dues, Fees, Subscriptions & Promotions			18,122	18,122		18,122	15,160	33,282			20
21	Clerical & General Office Expenses			1,290	1,290		1,290	6,693	7,983			21
22	Employee Benefits & Payroll Taxes			2,561,182	2,561,182		2,561,182	71,496	2,632,678			22
23	Inservice Training & Education							1,830	1,830			23
24	Travel and Seminar			6,228	6,228		6,228	5,709	11,937			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(39,677)	(39,677)		(39,677)	408	(39,269)			26
27	Other (specify):*											27
28	TOTAL General Administration	536,316	57,879	4,513,951	5,108,146		5,108,146	613,215	5,721,361			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,227,031	1,418,509	7,096,428	17,741,968		17,741,968	480,993	18,222,961			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 BALLARD NURSING CTR #0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			729,739	729,739		729,739	(74,070)	655,669			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,081	100,081		100,081	(73,940)	26,141			32
33	Real Estate Taxes			685,780	685,780		685,780		685,780			33
34	Rent-Facility & Grounds			26,000	26,000		26,000	30,327	56,327			34
35	Rent-Equipment & Vehicles			383,719	383,719		383,719	2,479	386,198			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,925,319	1,925,319		1,925,319	(115,204)	1,810,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,723,677		2,723,677		2,723,677		2,723,677			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			347,444	347,444		347,444		347,444			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,723,677	347,444	3,071,121		3,071,121		3,071,121			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,227,031	4,142,186	9,369,191	22,738,408		22,738,408	365,789	23,104,197			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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	(60)	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	33,457	30		9
10	Interest and Other Investment Income	(73,948)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	19		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	(1,158)	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	(583,739)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (626,878)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (626,878)		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 BALLARD NURSING CTR

ID# 0051490

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill Amortization	$ (63,646)	30	1
2	Labs	(145,430)	10	2
3	Merger Related Home Office Allocation	(374,663)	17	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**	(583,739)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(60)	2,751	0	0	0	0	0	0	0	0	0	2,691	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	6,168	0	0	0	0	0	0	0	0	0	6,168	5
6	Maintenance	0	2,502	0	0	0	0	0	0	0	0	0	2,502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(60)	11,421	0	0	0	0	0	0	0	0	0	11,361	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	(145,430)	0	0	0	0	0	0	0	0	0	0	(145,430)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,847	0	0	0	0	0	0	0	0	0	1,847	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**	(145,430)	1,847	0	0	0	0	0	0	0	0	0	(143,583)	16
	C. General Administration													
17	Administrative	(374,663)	102,798	761,265	0	0	0	0	0	0	0	0	489,400	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,430)	23,949	0	0	0	0	0	0	0	0	0	22,519	19
20	Fees, Subscriptions & Promotions	(1,158)	16,318	0	0	0	0	0	0	0	0	0	15,160	20
21	Clerical & General Office Expenses	0	6,693	0	0	0	0	0	0	0	0	0	6,693	21
22	Employee Benefits & Payroll Taxes	0	71,496	0	0	0	0	0	0	0	0	0	71,496	22
23	Inservice Training & Education	0	1,830	0	0	0	0	0	0	0	0	0	1,830	23
24	Travel and Seminar	0	5,709	0	0	0	0	0	0	0	0	0	5,709	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	408	0	0	0	0	0	0	0	0	0	408	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(377,251)	229,201	761,265	0	0	0	0	0	0	0	0	613,215	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(522,741)	242,469	761,265	0	0	0	0	0	0	0	0	480,993	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE BALLARD NURSING CTR **#** 0051490 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,189)	0	(43,881)	0	0	0	0	0	0	0	0	(74,070)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73,948)	0	8	0	0	0	0	0	0	0	0	(73,940)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	30,327	0	0	0	0	0	0	0	0	30,327	34
35	Rent-Equipment & Vehicles	0	0	2,479	0	0	0	0	0	0	0	0	2,479	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(104,137)	0	(11,067)	0	0	0	0	0	0	0	0	(115,204)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(626,878)	242,469	750,198	0	0	0	0	0	0	0	0	365,789	45

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. ☐ 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%	$ 2,751	$ 2,751	1
2	V	5	Utilities		Presence Life Connections	100.00%	6,168	6,168	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,502	2,502	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	1,847	1,847	4
5	V	17	Admin - Misc. Other	646,320	Presence Life Connections	100.00%	372,945	(273,375)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	376,173	376,173	6
7	V	19	Professional Services		Presence Life Connections	100.00%	23,949	23,949	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	16,318	16,318	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	6,693	6,693	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	71,496	71,496	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,830	1,830	11
12	V	24	Travel		Presence Life Connections	100.00%	5,709	5,709	12
13	V	26	Insurance		Presence Life Connections	100.00%	408	408	13
14	Total			$ 646,320			$ 888,789	$ * 242,469	14

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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%	$ 4,562	$ 4,562	15
16	V	32	Interest		Presence Life Connections	100.00%	8	8	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	30,327	30,327	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	2,479	2,479	18
19	V	17	Admin Salaries		Presence Health	100.00%	382,063	382,063	19
20	V	30	Depreciation	86,115	Presence Health	100.00%	37,672	(48,443)	20
21	V	17	Admin Consulting,Other	1,305,367	Presence Health	100.00%	1,684,569	379,202	21
22	V	39	Ancillary Services - Other	2,723,677	Presence Senior Services Pharmacy	100.00%	2,723,677		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			$ 4,115,159			$ 4,865,357	$ * 750,198	39

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	JO-ANN COSTANTINO	BOD						1
2	NANCY T. DOWD	BOD						2
3	FLORIDA FREEMAN	BOD						3
4	PATRICIA GOMEZ	BOD						4
5	JAMES C. HAGEN	BOD						5
6	LUCIA JONES	BOD						6
7	TERESA (TESS) KWIATKOWSKI	BOD						7
8	CONNIE S. MARCH	BOD						8
9	SR. MARIE MASON	BOD						9
10	SALLIE MILLER	BOD						10
11	PHYLLIS NICHOLS	BOD						11
12	LAWRENCE R. PANKAU	BOD						12
13	PAUL SKIEM	BOD						13
14	THOMAS E. SMITH	BOD						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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: 18927 Hickory Creek Dr, Ste 300
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	7,173,919	29	$ 30,538	$	646,320	$ 2,751	1
2	5	Utilities	Management Fee Income	7,173,919	29	68,461		646,320	6,168	2
3	6	Maintenance - Other	Management Fee Income	7,173,919	29	27,769		646,320	2,502	3
4	11	Activities-Special Events	Management Fee Income	7,173,919	29	20,505		646,320	1,847	4
5	17	Admin - Misc. Other	Management Fee Income	7,173,919	29	4,139,560		646,320	372,945	5
6	17	Administrative Salaries	Management Fee Income	7,173,919	29	4,175,380	4,175,380	646,320	376,173	6
7	19	Professional Services	Management Fee Income	7,173,919	29	265,828		646,320	23,949	7
8	20	Dues,Subscriptions	Management Fee Income	7,173,919	29	181,120		646,320	16,318	8
9	21	Clerical Supplies	Management Fee Income	7,173,919	29	74,289		646,320	6,693	9
10	22	Employee Benefits	Management Fee Income	7,173,919	29	793,578		646,320	71,496	10
11	23	Education/Conference	Management Fee Income	7,173,919	29	20,317		646,320	1,830	11
12	24	Travel	Management Fee Income	7,173,919	29	63,365		646,320	5,709	12
13	26	Insurance	Management Fee Income	7,173,919	29	4,528		646,320	408	13
14	30	Depreciation	Management Fee Income	7,173,919	29	50,634		646,320	4,562	14
15	32	Interest	Management Fee Income	7,173,919	29	87		646,320	8	15
16	34	Rent - Facility	Management Fee Income	7,173,919	29	336,621		646,320	30,327	16
17	35	Rent - Equipment	Management Fee Income	7,173,919	29	27,511		646,320	2,479	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,280,091	$ 4,175,380		$ 926,165	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (815)806-2327
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	17	Admin Salaries	Operating Expense	6,637,889	8	$ 1,942,819	$ 1,942,819	1,305,367	$ 382,063	1
2	30	Depreciation	Operating Expense	704,065	8	308,000		86,115	37,672	2
3	17	Admin Consulting,Other	Operating Expense	6,637,889	8	8,566,162		1,305,367	1,684,569	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					$ 10,816,981	$ 1,942,819		$ 2,104,304	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: 100 North River Road
City / State / Zip Code: DesPlaines, IL 60016
Phone Number: (847-410-4900
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	39	Ancillary Services - Other	Direct Allocation			$	$		$ 2,723,677	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					$	$		$ 2,723,677	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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						$	$			$ 8	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 8	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 8	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 685,780	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.		$ 685,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011	654,088	11
2012	680,540	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE BALLARD NURSING CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051490

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	9300 Ballard Road, Des Plaines, IL	$ 680,540.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 680,540.00	$

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 _____ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,917 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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. [ ] (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	52,917	2011	$ 2,480,000	1
2					2
3	TOTALS	52,917		$ 2,480,000	3

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	231		2011		$ 10,666,682	$ 474,849	17	$ 474,849	$	$ 949,697	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FILL CRACKS AND UNEVEN SIDEWALK & TRENCHES			2011	14,500	1,450	10	1,450		2,900	9
10	INSTALLATION OF 1 DROP 3RD FLOOR - 2 FOR			2011	2,131	142	15	142		284	10
11	FILL CRACKS IN PARKING LOT			2011	2,300	230	10	230		460	11
12	KITCHEN PIPING			2011	2,380	95	25	95		190	12
13	NEW SINKS			2011	3,810	191	20	191		381	13
14	THIRD MEDIC			2011	35,300	2,353	15	2,353		4,707	14
15											15
16	NETWORK CABLE INSTALL 2 WEST & LOWER LE			2012	3,182	212	15	212		318	16
17	FLASHINGS TO UPPER ROOF			2012	3,760	251	15	251		376	17
18	NETWORK CABLE INSTALL 2 WEST & LOWER LE			2012	7,859	524	15	524		786	18
19	WALLS ABOVE CEILING IN PATIENT ROOMS			2012	18,800	1,253	15	1,253		1,880	19
20	SPRINKLER INSTALLATION SYSTEM			2012	20,000	800	25	800		1,200	20
21	SPRINKLER INSTALLATION SYSTEM			2012	5,817	233	25	233		349	21
22	BRICK PATIO			2012	4,800	240	20	240		360	22
23	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	63,000	4,200	15	4,200		6,300	23
24	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	50,400	3,360	15	3,360		5,040	24
25	INSTALL NEW WOOD PLANKS IN 2ND. FLOOR H			2012	42,009	2,801	15	2,801		4,201	25
26	EMERGENCY BOILER			2012	17,090	1,139	15	1,139		1,709	26
27	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	12,600	840	15	840		1,260	27
28	BALLARD THIRD FLOOR MATERIALS & LABOR			2012	8,400	560	15	560		840	28
29	INSTALL OUTLETS & CABLE CONNECTIONS FOR			2012	6,810	454	15	454		681	29
30	HANGING DRYWALL, PATCHING & PAINTING 1 W			2012	6,000	400	15	400		600	30
31	BALLARD THIRD FLOOR MATERIALS & LABOR			2012	3,340	223	15	223		334	31
32	INSTALL NEW WOOD PLANKS IN 2ND. FLOOR H			2012	857	57	15	57		86	32
33	NEW FLOORING IN HALLWAY OF 3 WEST, 1			2012	41,316	4,132	10	4,132		6,197	33
34	NEW FLOORING IN HALLWAY OF 3 WEST, 1			2012	8,719	872	10	872		1,308	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	SPRINKLER INSTALLATION SYSTEM	2013	$ 175,211	$ 3,504	25	$ 7,008	$ 3,504	$ 3,504	37
38	SPRINKLER INSTALLATION SYSTEM	2013	36,801	736	25	1,472	736	736	38
39	BASEMENTMATERIALS & LABOR @ BALLARD REHAB	2013	90,212	3,007	15	6,014	3,007	3,007	39
40	BASEMENTMATERIALS & LABOR @ BALLARD REHAB	2013	82,983	2,766	15	5,532	2,766	2,766	40
41	3RD FLOOR FIRE DAMPER INSTALLATION	2013	71,638	2,388	15	4,776	2,388	2,388	41
42	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	36,854	1,228	15	2,456	1,228	1,228	42
43	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	32,571	1,086	15	2,172	1,086	1,086	43
44	PATCHING, PAINTING & DRYWALL WORK ON 18	2013	17,052	568	15	1,136	568	568	44
45	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	16,495	550	15	1,100	550	550	45
46	NEW FIRE PANEL	2013	14,144	471	15	942	471	471	46
47	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	12,208	407	15	814	407	407	47
48	WALL - PATCH AND SEAL ALL SMOKE	2013	11,500	383	15	766	383	383	48
49	DRYWALLED & PATCHED ABOVE CEILING 36 UN	2013	9,120	304	15	608	304	304	49
50	INSTALLED FIRE DAMPER PER IDPH TAG	2013	8,884	296	15	592	296	296	50
51	BALLARD REHAB. NEW LL LOC INSTALL ONE ST	2013	7,409	247	15	494	247	247	51
52	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	5,906	197	15	394	197	197	52
53	L & M HEATER REFRACTORY, BUR	2013	5,100	170	15	340	170	170	53
54	INSTALL PLASTIC LAMINATE WALL & BASE CAB	2013	4,155	139	15	278	139	139	54
55	SUMP PUMP - WEIL PUMP 4 inch DISCHARGE 2H	2013	4,047	135	15	270	135	135	55
56	STATIONS OF THE CROSS-SET OF 14-SIENNA-P	2013	3,882	129	15	258	129	129	56
57	BASEMENT MATERIALS & LABOR & 2ND. FLO	2013	3,736	125	15	250	125	125	57
58	ON SITE BUILDING REVIEW & FSES PREPARATI	2013	3,282	109	15	218	109	109	58
59	ALTAR - 60" W X 28" D X 39" H - SIENNA-PLUS OT	2013	2,452	82	15	164	82	82	59
60	REFURBISHING OF EIGHT STAINED GLASS PAN	2013	2,411	80	15	160	80	80	60
61	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	2,118	71	15	142	71	71	61
62	LECTERN W/ONE INSIDE SHELF 22" X 16" X 45" -	2013	1,384	46	15	92	46	46	62
63	RECEIVE/DELIVER/INSTALLATION	2013	1,288	43	15	86	43	43	63
64	REFURBISHING OF EIGHT STAINED GLASS PAN	2013	804	27	15	54	27	27	64
65	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	65
66	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	66
67	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,715,845	$ 521,167		$ 540,473	$ 19,306	$ 1,011,750	70

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Totals from Page 12A, Carried Forward		$ 11,715,845	$ 521,167		$ 540,473	$ 19,306	$ 1,011,750	1
2	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	2
3	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	3
4	BANNER-PLUS OTHER CHG's $2.28	2013	112	4	15	8	4	4	4
5	BANNER-PLUS OTHER CHG's $2.27	2013	112	4	15	8	4	4	5
6	PROFESSIONAL SERVICES - LEGAL (BALLARD P	2013	17	1	15	2	1	1	6
7	REPLACE CARPET WITH WOOD PLANK FLOORI	2013	33,588	1,679	10	3,358	1,679	1,679	7
8	NEW FLOOR FINISHING ON 2ND. FLOOR - HALL	2013	3,370	337	5	674	337	337	8
9	NEW FLOOR FINISHING ON 2ND. FLOOR - HALL	2013	3,369	337	5	674	337	337	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)		$ 11,756,637	$ 523,537		$ 545,213	$ 21,676	$ 1,014,120	34

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 333,105	$ 44,660	$ 44,660	$	7	$ 67,174	71
72	Current Year Purchases	254,145	11,781	23,562	11,781	12	11,781	72
73	Fully Depreciated Assets	3,800				10	190	73
74	Home Office Allocation		42,234	42,234				74
75	TOTALS	$ 591,050	$ 98,675	$ 110,456	$ 11,781		$ 79,145	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,827,687	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 622,212	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 655,669	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,457	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,093,265	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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				30,327			5
6								6
7	TOTAL				$ 30,327 **			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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 386,198 Description: Nursing $15441, Administration $21344, Chargeable $323189, Plant Operations $3517, Respiratory Care $20
(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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	11,377	$ 665,873	$	11,377	$ 665,873	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,758	102,902		1,758	102,902	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		13,434	786,292		13,434	786,292	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				2,723,677		2,723,677	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			$	26,569	$ 1,555,067	$ 2,723,677	26,569	$ 4,278,744	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (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	$	$	1
2	Cash-Patient Deposits	9,139		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,097,668		3
4	Supply Inventory (priced at)	33,826		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,140,633	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,480,000		13
14	Buildings, at Historical Cost	10,380,476		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,134,018		16
17	Accumulated Depreciation (book methods)	(1,093,266)		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**			22
23	Other(specify): **Intangibles**	2,256,303		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,157,531	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 20,298,164	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 684,329	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	218,370		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	781		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Due to Related Party**	37,540,916		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 38,444,396	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Conditional Asset Retirement**			43
44	**Deferred Lease Payable**			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 38,444,396	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (18,146,232)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 20,298,164	$	48

*(See instructions.)

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (11,777,189)	1
2	Restatements (describe):		2
3	**Prior Year Audit Adjustments**	(440,169)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (12,217,358)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,928,874)	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)**	$ (5,928,874)	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)**	$ (18,146,232)	24 *

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 2,780,766	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,780,766	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,455,271	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,455,271	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		13
14	Non-Patient Meals	60	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,321,988	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	145,430	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,467,478	23
	D. Non-Operating Revenue		
24	Contributions	855	24
25	Interest and Other Investment Income***	73,948	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74,803	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates		28
28a	Other Misc Income	31,216	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,216	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,809,534	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,876,489	31
32	Health Care	10,757,333	32
33	General Administration	5,108,146	33
	B. Capital Expense		
34	Ownership	1,925,319	34
	C. Ancillary Expense		
35	Special Cost Centers	2,723,677	35
36	Provider Participation Fee	347,444	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,738,408	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,928,874)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,928,874)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,475,733	44
45	Private Pay - Net Inpatient Revenue	(166,499)	45
46	Medicare - Net Inpatient Revenue	1,409,806	46
47	Other-(specify) Insurance	61,726	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,780,766	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1,854	2,128	$ 102,832	$ 48.32	1
2	Assistant Director of Nursing	1,596	1,791	62,891	35.12	2
3	Registered Nurses	140,208	158,203	5,064,848	32.01	3
4	Licensed Practical Nurses	6,819	7,586	235,719	31.07	4
5	CNAs & Orderlies	105,574	116,580	1,528,838	13.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,806	6,643	119,386	17.97	8
9	Activity Director	1,861	2,131	54,490	25.57	9
10	Activity Assistants	7,114	8,153	109,265	13.40	10
11	Social Service Workers	6,887	7,637	148,403	19.43	11
12	Dietician	3,468	3,917	81,163	20.72	12
13	Food Service Supervisor	1,997	2,128	66,996	31.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,595	26,118	302,865	11.60	15
16	Dishwashers					16
17	Maintenance Workers	5,782	6,595	105,860	16.05	17
18	Housekeepers	28,530	33,588	384,472	11.45	18
19	Laundry	9,572	11,012	124,739	11.33	19
20	Administrator	1,872	2,080	117,519	56.50	20
21	Assistant Administrator	1,764	1,964	84,332	42.94	21
22	Other Administrative	13,081	14,307	249,170	17.42	22
23	Office Manager	1,547	1,637	32,310	19.74	23
24	Clerical	7,050	7,883	102,349	12.98	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	1,856	2,054	37,507	18.26	31
32	Other Health C: Admissions	1,981	2,144	52,985	24.71	32
33	Other(specify) Pastoral Care	1,833	2,136	58,092	27.20	33
34	TOTAL (lines 1 - 33)	381,647	428,415	$ 9,227,031 *	$ 21.54	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		$		35
36	Medical Director	Monthly	197,713	9,3	36
37	Medical Records Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 197,713		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	1,520	39,793	10,3	52
53	TOTAL (lines 50 - 52)	1,520	$ 39,793		53

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Roach	Administrator		$ 117,519
Administrative Staff	Asst Administrator		84,332
Administrative Staff	Office Manager		32,310
Administrative Staff	Department Heads		77,204
Administrative Staff	Receptionists		131,250
Administrative Staff	Administrative Asst		40,716
Administrative Staff	Admissions		52,985
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 536,316

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,951,687
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,951,687
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 15,030
Survey & Analytical Tools	Various	89
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,119

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 140,457
Unemployment Compensation Insurance	27,559
FICA Taxes	657,970
Employee Health Insurance	1,071,163
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	30,578
Life Insurance	(6,375)
Disability Insurance	61,334
Pension	509,435
Tuition Reimbursement	30,280
Other Benefits	38,781
Home Office Allocation	71,496
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,632,678

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 59)	
Patient Background Checks 419	
Employee Recruitment	
Dues & Subscription	16,965
Advertiosing & Public Relations	1,157
Home Office Allocation	16,318
Less: Public Relations Expense	( )
Non-allowable advertising	(1,158)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,282

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,358
In-State Travel	4,870
Seminar Expense	
Home Office Allocation	5,709
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,937

**See instructions.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 $12016**

(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. $ **34,556** 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. $ **347,444**
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. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **60**

(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 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.