FOR BHF USE

LL1

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: 0044768

Facility Name: PRESENCE MARYHAVEN N & R

Address: 1700 EAST LAKE AVE (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: (847) 729-1300 **Fax #** (847) 729-9620

HFS ID Number:

Date of Initial License for Current Owners: 03/01/00

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 MARYHAVEN N & R # 0044768 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	135	Skilled (SNF)	135	49,275	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	135	TOTALS	135	49,275	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	20,206	12,625	6,998	39,829	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,206	12,625	6,998	39,829	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.83%

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 03/01/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 6,468

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 MARYHAVEN N & R # 0044768 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	425,116	33,133	21,651	479,900		479,900		479,900			1
2	Food Purchase		304,346		304,346		304,346	(26,969)	277,377			2
3	Housekeeping	184,344		4,582	188,926		188,926		188,926			3
4	Laundry	101,403	60,342		161,745		161,745	(10,922)	150,823			4
5	Heat and Other Utilities			171,088	171,088		171,088	2,703	173,791			5
6	Maintenance	101,874	11,388	143,632	256,894		256,894	1,096	257,990			6
7	Other (specify):* Pastoral Care	41,200	672	6,375	48,247		48,247		48,247			7
8	TOTAL General Services	853,937	409,881	347,328	1,611,146		1,611,146	(34,092)	1,577,054			8
	B. Health Care and Programs											
9	Medical Director			70,566	70,566		70,566		70,566			9
10	Nursing and Medical Records	3,163,648	92,325	57,150	3,313,123		3,313,123	(14,882)	3,298,241			10
10a	Therapy	222	969	1,044,602	1,045,793		1,045,793		1,045,793			10a
11	Activities	141,383	7,495	524	149,402		149,402	809	150,211			11
12	Social Services	78,171	31		78,202		78,202		78,202			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,383,424	100,820	1,172,842	4,657,086		4,657,086	(14,073)	4,643,013			16
	C. General Administration											
17	Administrative	298,056	36,090	918,552	1,252,698		1,252,698	251,403	1,504,101			17
18	Directors Fees											18
19	Professional Services			15,537	15,537		15,537	(2,631)	12,906			19
20	Dues, Fees, Subscriptions & Promotions			20,762	20,762		20,762	3,046	23,808			20
21	Clerical & General Office Expenses			7,922	7,922		7,922	2,933	10,855			21
22	Employee Benefits & Payroll Taxes			1,341,258	1,341,258		1,341,258	31,328	1,372,586			22
23	Inservice Training & Education							802	802			23
24	Travel and Seminar			2,103	2,103		2,103	2,501	4,604			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(38,635)	(38,635)		(38,635)	179	(38,456)			26
27	Other (specify):*											27
28	TOTAL General Administration	298,056	36,090	2,267,499	2,601,645		2,601,645	289,561	2,891,206			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,535,417	546,791	3,787,669	8,869,877		8,869,877	241,396	9,111,273			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 MARYHAVEN N & R #0044768 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			500,870	500,870		500,870	(30,345)	470,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,712	124,712		124,712	3	124,715			32
33	Real Estate Taxes			10,895	10,895		10,895	(10,895)				33
34	Rent-Facility & Grounds							13,289	13,289			34
35	Rent-Equipment & Vehicles			47,875	47,875		47,875	1,086	48,961			35
36	Other (specify):*											36
37	**TOTAL Ownership**			684,352	684,352		684,352	(26,862)	657,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		744,202		744,202		744,202		744,202			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,836	275,836		275,836		275,836			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		744,202	275,836	1,020,038		1,020,038		1,020,038			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,535,417	1,290,993	4,747,857	10,574,267		10,574,267	214,534	10,788,801			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 MARYHAVEN N & R # 0044768 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	(28,175)	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	(10,922)	4		8
9	Non-Straightline Depreciation	3,505	30		9
10	Interest and Other Investment Income				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	(13,125)	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	(4,104)	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	(189,944)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (242,765)		$	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))**	$ (242,765)		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 MARYHAVEN N & R

ID# 0044768

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (14,882)	10	1
2	Real Estate Tax	(10,895)	33	2
3	Merger Related Home Office Allocation	(164,167)	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**	(189,944)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 **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	(28,175)	1,206	0	0	0	0	0	0	0	0	0	(26,969)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(10,922)	0	0	0	0	0	0	0	0	0	0	(10,922)	4
5	Heat and Other Utilities	0	2,703	0	0	0	0	0	0	0	0	0	2,703	5
6	Maintenance	0	1,096	0	0	0	0	0	0	0	0	0	1,096	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(39,097)	5,005	0	0	0	0	0	0	0	0	0	(34,092)	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	(14,882)	0	0	0	0	0	0	0	0	0	0	(14,882)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	809	0	0	0	0	0	0	0	0	0	809	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**	(14,882)	809	0	0	0	0	0	0	0	0	0	(14,073)	16
	C. General Administration													
17	Administrative	(164,167)	45,044	370,526	0	0	0	0	0	0	0	0	251,403	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,125)	10,494	0	0	0	0	0	0	0	0	0	(2,631)	19
20	Fees, Subscriptions & Promotions	(4,104)	7,150	0	0	0	0	0	0	0	0	0	3,046	20
21	Clerical & General Office Expenses	0	2,933	0	0	0	0	0	0	0	0	0	2,933	21
22	Employee Benefits & Payroll Taxes	0	31,328	0	0	0	0	0	0	0	0	0	31,328	22
23	Inservice Training & Education	0	802	0	0	0	0	0	0	0	0	0	802	23
24	Travel and Seminar	0	2,501	0	0	0	0	0	0	0	0	0	2,501	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	179	0	0	0	0	0	0	0	0	0	179	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(181,396)	100,431	370,526	0	0	0	0	0	0	0	0	289,561	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(235,375)	106,245	370,526	0	0	0	0	0	0	0	0	241,396	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 **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 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	3,505	0	(33,850)	0	0	0	0	0	0	0	0	(30,345)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3	0	0	0	0	0	0	0	0	3	32
33	Real Estate Taxes	(10,895)	0	0	0	0	0	0	0	0	0	0	(10,895)	33
34	Rent-Facility & Grounds	0	0	13,289	0	0	0	0	0	0	0	0	13,289	34
35	Rent-Equipment & Vehicles	0	0	1,086	0	0	0	0	0	0	0	0	1,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,390)	0	(19,472)	0	0	0	0	0	0	0	0	(26,862)	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)**	(242,765)	106,245	351,054	0	0	0	0	0	0	0	0	214,534	45

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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 Cai	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%	$ 1,206	$ 1,206	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,703	2,703	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,096	1,096	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	809	809	4
5	V	17	Admin - Misc. Other	283,200	Presence Life Connections	100.00%	163,415	(119,785)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	164,829	164,829	6
7	V	19	Professional Services		Presence Life Connections	100.00%	10,494	10,494	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	7,150	7,150	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	2,933	2,933	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	31,328	31,328	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	802	802	11
12	V	24	Travel		Presence Life Connections	100.00%	2,501	2,501	12
13	V	26	Insurance		Presence Life Connections	100.00%	179	179	13
14	Total			$ 283,200			$ 389,445	$ * 106,245	14

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

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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%	$ 1,999	$ 1,999	15
16	V	32	Interest		Presence Life Connections	100.00%	3	3	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	13,289	13,289	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,086	1,086	18
19	V	17	Admin Salaries		Presence Health	100.00%	185,959	185,959	19
20	V	30	Depreciation	63,727	Presence Health	100.00%	27,878	(35,849)	20
21	V	17	Admin Consulting,Other	635,352	Presence Health	100.00%	819,919	184,567	21
22	V	39	Ancillary Services - Other	744,202	Presence Senior Services Pharmacy	100.00%	744,202		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,443,281			$ 1,794,335	$ * 351,054	39

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

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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 MARYHAVEN N & R # 0044768 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 MARYHAVEN N & R # 0044768 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 MARYHAVEN N & R # 0044768 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	$	283,200	$ 1,206	1
2	5	Utilities	Management Fee Income	7,173,919	29	68,461		283,200	2,703	2
3	6	Maintenance - Other	Management Fee Income	7,173,919	29	27,769		283,200	1,096	3
4	11	Activities-Special Events	Management Fee Income	7,173,919	29	20,505		283,200	809	4
5	17	Admin - Misc. Other	Management Fee Income	7,173,919	29	4,139,560		283,200	163,415	5
6	17	Administrative Salaries	Management Fee Income	7,173,919	29	4,175,380	4,175,380	283,200	164,829	6
7	19	Professional Services	Management Fee Income	7,173,919	29	265,828		283,200	10,494	7
8	20	Dues,Subscriptions	Management Fee Income	7,173,919	29	181,120		283,200	7,150	8
9	21	Clerical Supplies	Management Fee Income	7,173,919	29	74,289		283,200	2,933	9
10	22	Employee Benefits	Management Fee Income	7,173,919	29	793,578		283,200	31,328	10
11	23	Education/Conference	Management Fee Income	7,173,919	29	20,317		283,200	802	11
12	24	Travel	Management Fee Income	7,173,919	29	63,365		283,200	2,501	12
13	26	Insurance	Management Fee Income	7,173,919	29	4,528		283,200	179	13
14	30	Depreciation	Management Fee Income	7,173,919	29	50,634		283,200	1,999	14
15	32	Interest	Management Fee Income	7,173,919	29	87		283,200	3	15
16	34	Rent - Facility	Management Fee Income	7,173,919	29	336,621		283,200	13,289	16
17	35	Rent - Equipment	Management Fee Income	7,173,919	29	27,511		283,200	1,086	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,280,091	$ 4,175,380		$ 405,822	25

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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	635,352	$ 185,959	1
2	30	Depreciation	Operating Expense	704,065	8	308,000		63,727	27,878	2
3	17	Admin Consulting,Other	Operating Expense	6,637,889	8	8,566,162		635,352	819,919	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		$ 1,033,756	25

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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			$	$		$ 744,202	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					$	$		$ 744,202	25

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Home Office Allocation						$	$			$ 3	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 3	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 3	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NA **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 MARYHAVEN N & R # 0044768 **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.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2008	8
	2009	9
	2010	10
	2011	11
	2012	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 MARYHAVEN N & R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044768

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 MARYHAVEN N & R # 0044768 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,762 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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	83,762	2000	$ 3,000,000	1
2					2
3	TOTALS	83,762		$ 3,000,000	3

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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	135		2000	1961	$ 5,932,922	$ 197,764	30	$ 197,764	$	$ 2,737,230	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	57,015	3,268	13	3,268		50,479	9
10	VARIOUS			2001	1,200,876	62,030	14	62,030		1,007,854	10
11	VARIOUS			2002	693,059	16,013	11	16,013		617,988	11
12	VARIOUS			2003	1,428	95	15	95		952	12
13	VARIOUS			2004	1,760	117	15	117		1,173	13
14	VARIOUS			2005	50,094	3,839	12	3,839		38,049	14
15	VARIOUS			2006	107,161	10,890	11	10,890		84,998	15
16	VARIOUS			2007	2,310	289	8	289		2,021	16
17	VARIOUS			2008	73,448	3,672	20	3,672		22,035	17
18	VARIOUS			2009	23,984	2,729	9	2,729		10,917	18
19											19
20	N/A			2010							20
21											21
22	INSTALLATION OF NEW WOOD LOOK FLOORIN			2011	4,598	460	10	460		920	22
23	SHEET VIYL WALL PROTECTOR FOR PATIENT			2011	2,450	245	10	245		490	23
24	INSTALLATION OF NEW WOOD LOOK FLOORIN			2011	11,756	1,176	10	1,176		2,351	24
25	INSTALLATION OF NEW WOOD LOOK FLOORIN			2011	10,934	1,093	10	1,093		2,187	25
26	SKIMCOAT 2 WALLS OF CINDERBLOCK & PREP			2011	9,680	1,936	5	1,936		3,872	26
27	MHNR - PRIVATE ROOM - SHADES, V			2011	15,401	3,080	5	3,080		6,160	27
28	TILING			2011	2,811	281	10	281		562	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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	INSTALL NEW DOORS, KEYPADS & OPERATOR	2012	$ 11,595	$ 773	15	$ 773	$	$ 1,160	37
38	EXCAVATE & INSTALL 2 STORM LINES TO NEA	2012	4,980	199	25	199		299	38
39	INSTALL W-786 ON WALL & ELEVATOR SIDE OF	2012	2,170	217	10	217		326	39
40	INSTALL BELBIEN ON WALLS IN FREIGHT ELEV	2012	6,300	630	10	630		945	40
41	NEW FLOOR FINISHING IN UNITS C & G	2012	1,380	138	10	138		207	41
42	FIRE ALARM SYSTREM PER VILLA	2012	5,800	580	10	580		870	42
43	EMERGENCY UNDERGROUND WATER MAIN B	2012	10,665	711	15	711		1,067	43
44	MAIN WATER REPAIRS - EMERGENCY	2012	7,749	517	15	517		775	44
45	MAIN WATER REPAIRS - EMERGENCY	2012	7,486	499	15	499		749	45
46	INSTALL FLOOR TILE IN MAIN KITCHEN	2012	10,980	1,098	10	1,098		1,647	46
47	STAIRWELL FIRE DOORS	2012	5,995	600	10	600		899	47
48	DOOR TO WALKIN FRIDGE	2012	3,049	305	10	305		457	48
49	MAIN KITCHEN AIR FLOW REPAIR	2012	1,996	998	2	998		1,497	49
50									50
51	NEW 1 200 GALLON STORAGE TANK	2013	7,500	188	20	376	188	188	51
52	WALK-IN COOLER, MODULAR SELF CONTAINE	2013	6,758	225	15	450	225	225	52
53	EAST RAMP EXIT - CONCRETE MUST BE BROK	2013	3,500	117	15	234	117	117	53
54	WALK-IN COOLER, MODULAR SELF CONTAINE	2013	1,287	43	15	86	43	43	54
55	HOT WATER TANK & RPZ INST	2013	16,650	833	10	1,666	833	833	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,317,527	$ 317,648		$ 319,054	$ 1,406	$ 4,602,542	70

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

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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	$ 1,106,405	$ 117,396	$ 117,396	$	11	$ 622,873	71
72	Current Year Purchases	33,879	2,099	4,198	2,099	9	2,099	72
73	Fully Depreciated Assets	1,204,441				8	1,172,362	73
74	Home Office Allocation		29,877	29,877				74
75	TOTALS	$ 2,344,725	$ 149,372	$ 151,471	$ 2,099		$ 1,797,334	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)	$ 13,662,252	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 467,020	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 470,525	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,505	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,399,876	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 MARYHAVEN N & R # 0044768 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				13,289			5
6								6
7	TOTAL				$ 13,289 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 48,961 Description: Nursing $19463, Administration $28366, Activities $46, Home Office $1086
    (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 MARYHAVEN N & R # 0044768 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 MARYHAVEN N & R # 0044768 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	$	7,244	$ 424,924	$	7,244	$ 424,924	1
2	Licensed Speech and Language Development Therapist	10a, 1&3	6 hrs	222	2,014	118,116		2,020	118,338	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		8,548	501,437		8,548	501,437	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				744,202		744,202	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Audiologist	10a, 1	6	222				6	222	12
13	Other (specify):									13
14	TOTAL			$ 444	17,806	$ 1,044,477	$ 744,202	17,818	$ 1,789,123	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE MARYHAVEN N & R **#** 0044768 **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	$ 13,484	$	1
2	Cash-Patient Deposits	9,224		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,217,012		3
4	Supply Inventory (priced at)	19,598		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)**	$ 2,259,318	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,935,798		13
14	Buildings, at Historical Cost	7,967,976		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,728,493		16
17	Accumulated Depreciation (book methods)	(6,399,876)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,232,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,491,709	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,939	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	742,751		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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**	3,747,056		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,712,746	$	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)**	$ 4,712,746	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,778,963	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,491,709	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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**	$ 5,300,607	1	
2	Restatements (describe):		2	
3			3	
4			4	
5	**Transition of Equity from CY 06/30 to FY 12/31/12**	(570,339)	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,730,268	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	48,695	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)**	$ 48,695	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)**	$ 4,778,963	24	*

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

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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	$ 5,954,550	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,954,550	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,538,310	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,538,310	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	28,175	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	990,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,882	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,922	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,044,873	23
	D. Non-Operating Revenue		
24	Contributions	6,625	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,625	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates		28
28a	Other Misc Income	78,604	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 78,604	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,622,962	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,611,146	31
32	Health Care	4,657,086	32
33	General Administration	2,601,645	33
	B. Capital Expense		
34	Ownership	684,352	34
	C. Ancillary Expense		
35	Special Cost Centers	744,202	35
36	Provider Participation Fee	275,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,574,267	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,695	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,695	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,722,018	44
45	Private Pay - Net Inpatient Revenue	3,135,092	45
46	Medicare - Net Inpatient Revenue	126,580	46
47	Other-(specify) Insurance	(29,140)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,954,550	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 MARYHAVEN N & R # 0044768 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	1,881	2,035	$ 102,345	$ 50.29	1
2	Assistant Director of Nursing	1,639	1,868	63,222	33.84	2
3	Registered Nurses	40,294	45,023	1,592,235	35.36	3
4	Licensed Practical Nurses	3,738	4,348	119,112	27.39	4
5	CNAs & Orderlies	81,454	90,766	1,239,169	13.65	5
6	CNA Trainees					6
7	Licensed Therapist		365	16,827	46.10	7
8	Rehab/Therapy Aides	8	38	621	16.34	8
9	Activity Director	1,813	2,113	54,522	25.80	9
10	Activity Assistants	6,422	7,084	85,942	12.13	10
11	Social Service Workers	2,770	3,162	78,542	24.84	11
12	Dietician	998	1,083	25,669	23.70	12
13	Food Service Supervisor	1,849	2,109	61,045	28.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,540	26,985	336,438	12.47	15
16	Dishwashers					16
17	Maintenance Workers	3,924	4,376	103,125	23.57	17
18	Housekeepers	13,688	15,518	183,042	11.80	18
19	Laundry	7,893	9,122	102,198	11.20	19
20	Administrator	1,922	2,117	100,210	47.34	20
21	Assistant Administrator					21
22	Other Administrative	5,776	6,246	97,730	15.65	22
23	Office Manager	1,598	1,663	34,364	20.66	23
24	Clerical	1,925	2,061	34,542	16.76	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	1,922	2,109	65,752	31.18	32
33	Other(specify) Pastoral Care	1,318	1,484	38,765	26.12	33
34	TOTAL (lines 1 - 33)	206,372	231,675	$ 4,535,417 *	$ 19.58	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	70,566	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)		$ 70,566		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 MARYHAVEN N & R # 0044768 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Orzada/Sara Szumski	Administrator		$ 100,210
Administrative Staff	Office Manager		34,364
Administrative Staff	Department Heads		34,265
Administrative Staff	Receptionists		63,465
Administrative Staff	Admissions		65,752
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 298,056

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 918,552
TOTAL (agree to Schedule V, line 17, col. 3)	$ 918,552
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 15,537
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,537

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,352
Unemployment Compensation Insurance	14,921
FICA Taxes	322,872
Employee Health Insurance	581,924
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	16,610
Life Insurance	(2,822)
Disability Insurance	33,147
Pension	276,524
Tuition Reimbursement	16,475
Other Benefits	6,255
Home Office Allocation	31,328
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,372,586

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 32)	
Patient Background Checks 150	
Employee Recruitment	
Dues & Subscription	16,658
Advertiosing & Public Relations	4,104
Home Office Allocation	7,150
Less: Public Relations Expense	( )
Non-allowable advertising	(4,104)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,808

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,103
Seminar Expense	
Home Office Allocation	2,501
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,604

**See instructions.

Facility Name & ID Number PRESENCE MARYHAVEN N & R # 0044768 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 MARYHAVEN N & R # 0044768 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 $7225**

(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. $ **36,294** 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. $ **275,836**
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. $ **28,175**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG**

(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.