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: 0041731

Facility Name: PRESENCE ST ANNE CENTER

Address: 4405 HIGHCREST ROAD (Number) ROCKFORD (City) 61107 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 229-1999 **Fax #** (815) 229-1560

HFS ID Number:

Date of Initial License for Current Owners: 10/06/86

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 ST ANNE CENTER # 0041731 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	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	13,345	8,163	19,536	41,044	8
9	SNF/PED					9
10	ICF	6,573	4,020		10,593	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,918	12,183	19,536	51,637	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.03%

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 10/06/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/06/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 15,464

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 ST ANNE CENTER # 0041731 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 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	475,694	46,379	14,523	536,596		536,596		536,596			1
2	Food Purchase		411,738		411,738		411,738	1,859	413,597			2
3	Housekeeping	117,518	18,375		135,893		135,893		135,893			3
4	Laundry	8,899	11,520	141,496	161,915		161,915		161,915			4
5	Heat and Other Utilities			260,522	260,522		260,522	4,167	264,689			5
6	Maintenance	155,766	36,665	89,146	281,577		281,577	62,111	343,688			6
7	Other (specify):*	53,692	1,410	12,230	67,332		67,332		67,332			7
8	**TOTAL General Services**	811,569	526,087	517,917	1,855,573		1,855,573	68,137	1,923,710			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	4,582,196	465,474	16,895	5,064,565		5,064,565	(27,260)	5,037,305			10
10a	Therapy			1,683,947	1,683,947		1,683,947		1,683,947			10a
11	Activities	119,883	4,098	7,863	131,844		131,844	1,248	133,092			11
12	Social Services	114,202	140	697	115,039		115,039		115,039			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,816,281	469,712	1,730,402	7,016,395		7,016,395	(26,012)	6,990,383			16
	C. General Administration											
17	Administrative	558,386	29,382	1,193,461	1,781,229		1,781,229	(332,099)	1,449,130			17
18	Directors Fees											18
19	Professional Services			14,314	14,314		14,314	16,180	30,494			19
20	Dues, Fees, Subscriptions & Promotions			18,630	18,630		18,630	4,958	23,588			20
21	Clerical & General Office Expenses			37,070	37,070		37,070	(2,496)	34,574			21
22	Employee Benefits & Payroll Taxes			1,661,434	1,661,434		1,661,434	185,229	1,846,663			22
23	Inservice Training & Education							1,237	1,237			23
24	Travel and Seminar			10,708	10,708		10,708	3,857	14,565			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			208,851	208,851		208,851	276	209,127			26
27	Other (specify):*											27
28	**TOTAL General Administration**	558,386	29,382	3,144,468	3,732,236		3,732,236	(122,858)	3,609,378			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,186,236	1,025,181	5,392,787	12,604,204		12,604,204	(80,733)	12,523,471			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 ST ANNE CENTER #0041731 **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			532,418	532,418		532,418	23,131	555,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			323,591	323,591		323,591	173,100	496,691			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							62,488	62,488			34
35	Rent-Equipment & Vehicles			168,518	168,518		168,518	1,675	170,193			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,024,527	1,024,527		1,024,527	260,394	1,284,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,605,461		1,605,461		1,605,461	(711,055)	894,406			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	64,506	69,170		133,676		133,676	(99,367)	34,309			41
42	Provider Participation Fee			326,255	326,255		326,255		326,255			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	64,506	1,674,631	326,255	2,065,392		2,065,392	(810,422)	1,254,970			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,250,742	2,699,812	6,743,569	15,694,123		15,694,123	(630,761)	15,063,362			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 ST ANNE CENTER # 0041731 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(99,367)	41		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	34,480	30		9
10	Interest and Other Investment Income	(46,120)	32		10
11	Discounts, Allowances, Rebates & Refunds	(711,055)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(950)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				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	(6,066)	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	(286,451)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,115,529)		$	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))**	$ (1,115,529)		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 ST ANNE CENTER

ID# 0041731

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEVELOPMENT MISC	$ (6,068)	21	1
2	RADIOLOGY AND XRAY	(27,260)	10	2
3	Merger Related Home Office Allocation	(253,123)	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
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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**	(286,451)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST ANNE CENTER **#** 0041731 **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	0	1,859	0	0	0	0	0	0	0	0	0	1,859	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	4,167	0	0	0	0	0	0	0	0	0	4,167	5
6	Maintenance	0	1,690	60,421	0	0	0	0	0	0	0	0	62,111	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	7,716	60,421	0	0	0	0	0	0	0	0	68,137	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	(27,260)	0	0	0	0	0	0	0	0	0	0	(27,260)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,248	0	0	0	0	0	0	0	0	0	1,248	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**	(27,260)	1,248	0	0	0	0	0	0	0	0	0	(26,012)	16
	C. General Administration													
17	Administrative	(253,123)	69,450	(148,426)	0	0	0	0	0	0	0	0	(332,099)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,180	0	0	0	0	0	0	0	0	0	16,180	19
20	Fees, Subscriptions & Promotions	(6,066)	11,024	0	0	0	0	0	0	0	0	0	4,958	20
21	Clerical & General Office Expenses	(7,018)	4,522	0	0	0	0	0	0	0	0	0	(2,496)	21
22	Employee Benefits & Payroll Taxes	0	48,303	136,926	0	0	0	0	0	0	0	0	185,229	22
23	Inservice Training & Education	0	1,237	0	0	0	0	0	0	0	0	0	1,237	23
24	Travel and Seminar	0	3,857	0	0	0	0	0	0	0	0	0	3,857	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	276	0	0	0	0	0	0	0	0	0	276	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(266,207)	154,849	(11,500)	0	0	0	0	0	0	0	0	(122,858)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(293,467)	163,813	48,921	0	0	0	0	0	0	0	0	(80,733)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 **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	34,480	0	(11,349)	0	0	0	0	0	0	0	0	23,131	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46,120)	0	219,220	0	0	0	0	0	0	0	0	173,100	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	62,488	0	0	0	0	0	0	0	0	62,488	34
35	Rent-Equipment & Vehicles	0	0	1,675	0	0	0	0	0	0	0	0	1,675	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,640)	0	272,034	0	0	0	0	0	0	0	0	260,394	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	(711,055)	0	0	0	0	0	0	0	0	0	0	(711,055)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(99,367)	0	0	0	0	0	0	0	0	0	0	(99,367)	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	(810,422)	0	0	0	0	0	0	0	0	0	0	(810,422)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,115,529)	163,813	320,955	0	0	0	0	0	0	0	0	(630,761)	45

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Vill	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%	$ 1,859	$ 1,859	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,167	4,167	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,690	1,690	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	1,248	1,248	4
5	V	17	Admin - Misc. Other	436,656	Presence Life Connections	100.00%	251,963	(184,693)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	254,143	254,143	6
7	V	19	Professional Services		Presence Life Connections	100.00%	16,180	16,180	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	11,024	11,024	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	4,522	4,522	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	48,303	48,303	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,237	1,237	11
12	V	24	Travel		Presence Life Connections	100.00%	3,857	3,857	12
13	V	26	Insurance		Presence Life Connections	100.00%	276	276	13
14	Total			$ 436,656			$ 600,469	$ * 163,813	14

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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%	$ 3,082	$ 3,082	15
16	V	32	Interest		Presence Life Connections	100.00%	5	5	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	20,489	20,489	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,675	1,675	18
19	V	17	Admin Salaries		Presence Health	100.00%	167,788	167,788	19
20	V	22	Employee Benefits		Presence Health	100.00%	136,926	136,926	20
21	V	30	Depreciation	81,844	Presence Health	100.00%	67,413	(14,431)	21
22	V	34	Rent Facility		Presence Health	100.00%	41,999	41,999	22
23	V	17	Admin Consulting,Other	756,805	Presence Health	100.00%	74,327	(682,478)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	50,285	50,285	24
25	V	17	Information Systems - Other		Presence Health	100.00%	197,491	197,491	25
26	V	17	Admin Salaries		Presence Health	100.00%	47,182	47,182	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	70,839	70,839	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	60,421	60,421	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	467	467	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	219,215	219,215	30
31	V	39	Ancillary Services - Other	1,605,461	Presence Senior Services Pharmacy	100.00%	1,605,461		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,444,110			$ 2,765,065	$ * 320,955	39

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 ST ANNE CENTER # 0041731 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 ST ANNE CENTER # 0041731 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 ST ANNE CENTER # 0041731 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	$	436,656	$ 1,859	1
2	5	Utilities	Management Fee Income	7,173,919	29	68,461		436,656	4,167	2
3	6	Maintenance - Other	Management Fee Income	7,173,919	29	27,769		436,656	1,690	3
4	11	Activities-Special Events	Management Fee Income	7,173,919	29	20,505		436,656	1,248	4
5	17	Admin - Misc. Other	Management Fee Income	7,173,919	29	4,139,560		436,656	251,963	5
6	17	Administrative Salaries	Management Fee Income	7,173,919	29	4,175,380	4,175,380	436,656	254,143	6
7	19	Professional Services	Management Fee Income	7,173,919	29	265,828		436,656	16,180	7
8	20	Dues,Subscriptions	Management Fee Income	7,173,919	29	181,120		436,656	11,024	8
9	21	Clerical Supplies	Management Fee Income	7,173,919	29	74,289		436,656	4,522	9
10	22	Employee Benefits	Management Fee Income	7,173,919	29	793,578		436,656	48,303	10
11	23	Education/Conference	Management Fee Income	7,173,919	29	20,317		436,656	1,237	11
12	24	Travel	Management Fee Income	7,173,919	29	63,365		436,656	3,857	12
13	26	Insurance	Management Fee Income	7,173,919	29	4,528		436,656	276	13
14	30	Depreciation	Management Fee Income	7,173,919	29	50,634		436,656	3,082	14
15	32	Interest	Management Fee Income	7,173,919	29	87		436,656	5	15
16	34	Rent - Facility	Management Fee Income	7,173,919	29	336,621		436,656	20,489	16
17	35	Rent - Equipment	Management Fee Income	7,173,919	29	27,511		436,656	1,675	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,280,091	$ 4,175,380		$ 625,720	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	4,947,793	17	$ 1,096,956	$ 1,096,956	756,805	$ 167,788	1
2	22	Employee Benefits	Operating Expense	4,947,793	17	895,186		756,805	136,926	2
3	30	Depreciation	Operating Expense	535,127	17	440,774		81,844	67,413	3
4	34	Rent Facility	Operating Expense	4,947,793	17	274,581		756,805	41,999	4
5	17	Admin Consulting,Other	Operating Expense	4,947,793	17	485,930		756,805	74,327	5
6	17	Information Systems Salaries	Operating Expense	4,947,793	17	328,752	328,752	756,805	50,285	6
7	17	Information Systems - Other	Operating Expense	4,947,793	17	1,291,143		756,805	197,491	7
8	17	Admin Salaries	Direct Cost	4,947,793	17	308,463	308,463	756,805	47,182	8
9	17	Information Systems Salaries	Direct Cost	4,947,793	17	463,127	463,127	756,805	70,839	9
10	6	Information Systems - Equip Mai	Direct Cost	4,947,793	17	395,016		756,805	60,421	10
11	17	Admin Consulting,Other	Direct Cost	4,947,793	17	3,054		756,805	467	11
12	32	Admin - Interest Expense	Direct Cost	4,947,793	17	1,433,168		756,805	219,215	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					$ 7,416,150	$ 2,197,298		$ 1,134,353	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60914
Phone Number: (815)936-3644
Fax Number: (815)936-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,605,461	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					$	$		$ 1,605,461	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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						$	$			$ 219,220	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 219,220	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 219,220	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 ST ANNE CENTER # 0041731 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 ST ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

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 ST ANNE CENTER # 0041731 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel 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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1984	$ 639,976	1
2					2
3	TOTALS			$ 639,976	3

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	120		1986	1986	$ 3,516,907	$ 100,483	35	$ 100,483	$	$ 2,841,663	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,851,897	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	34,784	1,122	31	1,122		26,369	9
10	VARIOUS			1992	471		10			471	10
11	VARIOUS			1993	1,623		10			1,623	11
12	VARIOUS			1994	5,000		10			5,000	12
13	VARIOUS			1995	40,225	1,271	18	1,271		30,903	13
14	VARIOUS			1996	28,449		12			28,449	14
15	VARIOUS			1997	20,255		5			20,255	15
16	VARIOUS			1998	23,000		5			23,000	16
17	VARIOUS			1999	6,269		5			6,269	17
18	VARIOUS			2000	23,160		5			23,160	18
19	VARIOUS			2001	279,756	6,328	6	6,328		232,295	19
20	VARIOUS			2002	13,716	456	10	456		12,236	20
21	VARIOUS			2003	26,366	1,253	9	1,253		26,366	21
22	VARIOUS			2004	38,378	2,956	8	2,956		36,167	22
23	VARIOUS			2005	26,107	1,866	9	1,866		22,502	23
24	VARIOUS			2006	95,650	6,801	12	6,801		60,748	24
25	VARIOUS			2007	171,521	15,025	12	15,025		107,476	25
26	VARIOUS			2008	168,183	16,055	12	16,055		89,704	26
27	VARIOUS			2009	39,927	4,504	11	4,504		20,269	27
28											28
29	INSTALL WATER LINES IN CAFE			2010	6,420	642	10	642		2,247	29
30	GENERATORS			2010	10,824	2,165	5	2,165		7,577	30
31	WALL, TILE, AND SINKS			2010	10,686	1,069	10	1,069		3,740	31
32	SPA UNITS			2010	55,425	3,695	15	3,695		12,933	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 ST ANNE CENTER # 0041731 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	WATER HEATER SOUTH BASEMENT	2011	$ 5,512	$ 551	10	$ 551	$	$ 1,378	37
38	ROOFTOP CONDENSING UNIT	2011	32,862	2,191	15	2,191		5,477	38
39	PTAC UNITS QTY 10	2011	5,835	583	10	583		1,459	39
40	NEW BATHROOM FIXTURES	2011	3,989	199	20	199		499	40
41	NEW SPRINKLERHEADS	2011	2,940	588	5	588		1,470	41
42	AIR HANDLER SOUTH BASEMENT	2011	19,000	950	20	950		2,375	42
43	TILE FOR ADMIN OFFICE	2011	13,853	1,385	10	1,385		3,463	43
44	PARKING LOT REPAIRS	2011	25,885	3,236	8	3,236		8,089	44
45									45
46	BRANCH LINES&32 SPRINKLER HEADS. REPLACE PIPE	2012	60,212	2,409	25	2,409		3,613	46
47	CARPET IN SOUTHWEST F-WING & UNIT #56	2012	2,935	587	5	587		881	47
48	HVAC WORK FOR LIBRARY & SOUTH UNIT	2012	14,642	2,928	5	2,928		3,973	48
49									49
50	WATER HEATER	2013	16,087	804	10	1,608	804	804	50
51	FURNACE	2013	4,746	158	15	316	158	158	51
52	UPDATE THE GENERATOR	2013	31,322	3,132	5	6,264	3,132	3,132	52
53	STEAM TABLE	2013	4,411	221	10	442	221	221	53
54	FIRE SPRINKLER REPLACED IN OFFICE AREA	2013	8,574	171	25	342	171	171	54
55	STERLING 100,000 BTU - 100 DUCT FURN	2013	2,578	129	10	258	129	129	55
56	INSTALL VINYL PLANK IN 14 RESIDENT ROOMS IN THE F	2013	326,360	16,318	10	32,636	16,318	16,318	56
57	INTEGRATED ANTENNAS & LED TVS LOUNGE	2013	8,345	835	5	1,670	835	835	57
58	NORTH & SOUTH HALLWAY & TV LOUNGE WALL PAPER	2013	22,000	1,100	10	2,200	1,100	1,100	58
59	WEST LOUNGE ROOF TOP HVAC	2013	6,081	304	10	608	304	304	59
60	CANOPY	2013	73,700	2,457	15	4,914	2,457	2,457	60
61	CANOPY FIRE SPRINKLER	2013	3,980	80	25	160	80	80	61
62	WALL PAINT FOR F-HALL	2013	853	85	5	170	85	85	62
63	DESK TOP WATER PANEL	2013	964	96	5	192	96	96	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,063,019	$ 297,930		$ 323,820	$ 25,890	$ 5,551,886	70

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 1,438,497	$ 142,635	$ 142,635	$	11	$ 865,687	71
72	Current Year Purchases	191,738	8,590	17,180	8,590	11	8,590	72
73	Fully Depreciated Assets	433,478				6	427,009	73
74	Home Office Allocation		70,495	70,495				74
75	TOTALS	$ 2,063,713	$ 221,720	$ 230,310	$ 8,590		$ 1,301,286	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	MINI-VAN (LOU BACHRODT (	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOV	1999	23,172				3	23,172	77
78	PLANT ENGINEERING	REMOVAL & REPLACEMENT	2011	4,256	1,419	1,419		3	3,546	78
79										79
80	TOTALS			$ 70,928	$ 1,419	$ 1,419	$		$ 70,218	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,837,636	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 521,069	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 555,549	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,480	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,923,390	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 ST ANNE CENTER # 0041731 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				62,488			5
6								6
7	TOTAL				$ 62,488 **			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: $ 170,193 Description: Nursing $147002, Plant operations $2424, Administration $19093, Home office $1675
    (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 ST ANNE CENTER # 0041731 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 ST ANNE CENTER # 0041731 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	$	12,679	$ 741,747	$	12,679	$ 741,747	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,324	77,452		1,324	77,452	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		14,767	864,748		14,767	864,748	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				1,605,461		1,605,461	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			$	28,770	$ 1,683,947	$ 1,605,461	28,770	$ 3,289,408	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 ST ANNE CENTER # 0041731 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	$ 13,661,975	$	1
2	Cash-Patient Deposits	68,270		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	15,696,287		3
4	Supply Inventory (priced at)	800,313		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	385,660		7
8	Accounts Receivable (owners or related parties)	147,435		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 30,759,940	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,299,457		12
13	Land	4,046,124		13
14	Buildings, at Historical Cost	99,124,432		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	23,581,218		16
17	Accumulated Depreciation (book methods)	(69,655,808)		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**	333,555		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 69,728,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 100,488,918	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,064,524	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,175,855		28
29	Short-Term Notes Payable	73,289		29
30	Accrued Salaries Payable	3,854,754		30
31	Accrued Taxes Payable (excluding real estate taxes)	164,651		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,706,940		32
33	Accrued Interest Payable	10,831		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	8,866,479		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 23,917,323	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	894,135		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	510,572		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44	Deferred Lease Payable	32,265		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,875,716	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,793,039	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,695,879	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 100,488,918	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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**	$ 77,050,086	1	
2	Restatements (describe):		2	
3	**Transfer to Affiliates**	(4,370,200)	3	
4	**Adj. To reconcile consolidated equity & consolidated income**	1,815,168	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,495,054	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(56,326)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	496,473	11	
12	Expenditures for Specific Purposes	(239,322)	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)**	$ 200,825	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)**	$ 74,695,879	24	*

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 9,781,534	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,781,534	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,753,014	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,753,014	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	4,200	13
14	Non-Patient Meals	99,367	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,142,441	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,260	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,273,268	23
	D. Non-Operating Revenue		
24	Contributions	53,977	24
25	Interest and Other Investment Income***	46,120	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 100,097	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	711,055	28
28a	Misc Income	18,829	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 729,884	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,637,797	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,855,573	31
32	Health Care	7,016,395	32
33	General Administration	3,732,236	33
	B. Capital Expense		
34	Ownership	1,024,527	34
	C. Ancillary Expense		
35	Special Cost Centers	1,739,137	35
36	Provider Participation Fee	326,255	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,694,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	(56,326)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (56,326)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,802,289	44
45	Private Pay - Net Inpatient Revenue	2,498,534	45
46	Medicare - Net Inpatient Revenue	3,512,661	46
47	Other-(specify) Insurance	968,050	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,781,534	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 ST ANNE CENTER # 0041731 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	1,878	2,088	$ 97,873	$ 46.87	1
2	Assistant Director of Nursing	1,940	2,200	74,614	33.92	2
3	Registered Nurses	56,162	61,257	1,796,233	29.32	3
4	Licensed Practical Nurses	34,903	38,162	1,026,600	26.90	4
5	CNAs & Orderlies	98,559	107,050	1,345,795	12.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,747	8,362	106,914	12.79	8
9	Activity Director	1,918	2,080	33,822	16.26	9
10	Activity Assistants	7,094	7,703	86,195	11.19	10
11	Social Service Workers	5,694	6,185	113,331	18.32	11
12	Dietician	2,880	3,120	67,949	21.78	12
13	Food Service Supervisor	1,928	2,080	44,034	21.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,900	40,777	426,140	10.45	15
16	Dishwashers					16
17	Maintenance Workers	9,235	10,039	154,373	15.38	17
18	Housekeepers	11,224	12,088	119,211	9.86	18
19	Laundry	1,043	1,051	8,852	8.42	19
20	Administrator	1,836	2,080	124,685	59.94	20
21	Assistant Administrator	1,837	2,080	64,224	30.88	21
22	Other Administrative	8,222	9,209	148,180	16.09	22
23	Office Manager	1,712	2,080	47,212	22.70	23
24	Clerical	6,380	7,106	114,395	16.10	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	1,286	1,442	22,718	15.75	31
32	Other Health C: Admissions	5,598	5,902	174,085	29.50	32
33	Other(specify) Pastoral Care	2,337	2,445	53,307	21.80	33
34	TOTAL (lines 1 - 33)	309,313	336,586	$ 6,250,742 *	$ 18.57	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	104	$ 9,143	1,3	35
36	Medical Director	Monthly	21,000	9,3	36
37	Medical Records Consultant	35	2,422	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,228	11,3	44
45	Social Service Consultant	8	512	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	188	$ 35,305		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 ST ANNE CENTER # 0041731 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Administrator		$ 124,685
Administrative Staff	Office Manager		47,212
Administrative Staff	Human Resource		51,020
Administrative Staff	Receptionist		56,371
Administrative Staff	Admin Assistant		40,789
Betty Hillier	Asst. Administrator		64,224
Administrative Staff	Admissions		174,085
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 558,386

B. Administrative - Other

Description	Amount
Corporate Management Fee	$ 1,193,461
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,193,461
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 175
Survey & Analytical Tools	Various	3,485
Shredding	Various	975
Security	Various	9,100
Outsourced Services	Various	155
Collection Fee	Various	424
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 14,314

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 209,966
Unemployment Compensation Insurance	20,540
FICA Taxes	451,260
Employee Health Insurance	717,332
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	211,396
Life Insurance	2,100
Employee Recognition	1,152
Accident & Disability	27,173
Other Benefit Expense	20,515
Home Office Allocation	185,229
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,846,663

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 21)	
Patient Background Checks 680	
Employee Recruitment	75
Dues & Subscription	12,125
Advertising & Public Relations	6,430
Home Office Allocation	11,024
Less: Public Relations Expense	( )
Non-allowable advertising	(6,066)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,588

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	10,708
Seminar Expense	
Home Office Allocation	3,857
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,565

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 ST ANNE CENTER # 0041731 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 $9085**

(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. $ **58,248** 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. $ **326,255**
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. $ **99,367**

(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.