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: 0041871

Facility Name: PRESENCE ST JOSEPH CENTER

Address: 659 E JEFFERSON ST (Number) FREEPORT (City) 61032 (Zip Code)

County: STEPHENSON

Telephone Number: (815) 232-6181 **Fax #** (815) 232-6143

HFS ID Number:

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2013 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 JOSEPH CENTER # 0041871 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 05/21/13

	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)	130	47,450	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	120	TOTALS	130	47,450	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	19,289	10,309	7,484	37,082	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,289	10,309	7,484	37,082	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.15%

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 07/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 130 and days of care provided 4,388

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 JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	400,867	16,017	9,295	426,179		426,179		426,179			1
2	Food Purchase		214,309		214,309		214,309	(52,555)	161,754			2
3	Housekeeping	112,044	22,821		134,865		134,865		134,865			3
4	Laundry		3,996	118,273	122,269		122,269		122,269			4
5	Heat and Other Utilities			191,352	191,352		191,352	2,329	193,681			5
6	Maintenance	139,109	30,186	90,473	259,768		259,768	34,719	294,487			6
7	Other (specify):* Pastoral Care	43,990	1,297	1,350	46,637		46,637		46,637			7
8	TOTAL General Services	696,010	288,626	410,743	1,395,379		1,395,379	(15,507)	1,379,872			8
	B. Health Care and Programs											
9	Medical Director			12,050	12,050		12,050		12,050			9
10	Nursing and Medical Records	2,482,247	162,265	27,191	2,671,703		2,671,703		2,671,703			10
10a	Therapy			486,174	486,174		486,174		486,174			10a
11	Activities	88,363	1,024	4,026	93,413		93,413	698	94,111			11
12	Social Services	44,071	21	648	44,740		44,740		44,740			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,614,681	163,310	530,089	3,308,080		3,308,080	698	3,308,778			16
	C. General Administration											
17	Administrative	269,912	13,455	667,115	950,482		950,482	(185,636)	764,846			17
18	Directors Fees											18
19	Professional Services			6,072	6,072		6,072	9,044	15,116			19
20	Dues, Fees, Subscriptions & Promotions			13,877	13,877		13,877	5,331	19,208			20
21	Clerical & General Office Expenses			38,740	38,740		38,740	(19,354)	19,386			21
22	Employee Benefits & Payroll Taxes			1,236,449	1,236,449		1,236,449	103,538	1,339,987			22
23	Inservice Training & Education							691	691			23
24	Travel and Seminar			4,512	4,512		4,512	2,156	6,668			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,164	117,164		117,164	154	117,318			26
27	Other (specify):*											27
28	TOTAL General Administration	269,912	13,455	2,083,929	2,367,296		2,367,296	(84,076)	2,283,220			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,580,603	465,391	3,024,761	7,070,755		7,070,755	(98,885)	6,971,870			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 JOSEPH CENTER #0041871 **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			395,658	395,658		395,658	46,182	441,840			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,883	180,883		180,883	93,537	274,420			32
33	Real Estate Taxes			118,956	118,956		118,956		118,956			33
34	Rent-Facility & Grounds							34,930	34,930			34
35	Rent-Equipment & Vehicles			10,459	10,459		10,459	936	11,395			35
36	Other (specify):*											36
37	**TOTAL Ownership**			705,956	705,956		705,956	175,585	881,541			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		488,090		488,090		488,090	(318,684)	169,406			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			278,540	278,540		278,540		278,540			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		488,090	278,540	766,630		766,630	(318,684)	447,946			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,580,603	953,481	4,009,257	8,543,341		8,543,341	(241,984)	8,301,357			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 JOSEPH CENTER # 0041871 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	(53,594)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	62,696	30		9
10	Interest and Other Investment Income	(29,001)	32		10
11	Discounts, Allowances, Rebates & Refunds	(318,684)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(10,171)	30		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	(792)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(39)	20		28
29	Other-Attach Schedule	(163,372)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (512,957)		$	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))**	$ (512,957)		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 JOSEPH CENTER

ID# 0041871

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEVELOPMENT MISC	$ (21,882)	21	1
2	Merger Related Home Office Allocation	(141,490)	17	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(163,372)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST JOSEPH CENTER **#** 0041871 **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	(53,594)	1,039	0	0	0	0	0	0	0	0	0	(52,555)	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	2,329	0	0	0	0	0	0	0	0	0	2,329	5
6	Maintenance	0	945	33,774	0	0	0	0	0	0	0	0	34,719	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(53,594)	4,313	33,774	0	0	0	0	0	0	0	0	(15,507)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	698	0	0	0	0	0	0	0	0	0	698	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	698	0	0	0	0	0	0	0	0	0	698	16
	C. General Administration													
17	Administrative	(141,490)	38,821	(82,967)	0	0	0	0	0	0	0	0	(185,636)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,044	0	0	0	0	0	0	0	0	0	9,044	19
20	Fees, Subscriptions & Promotions	(831)	6,162	0	0	0	0	0	0	0	0	0	5,331	20
21	Clerical & General Office Expenses	(21,882)	2,528	0	0	0	0	0	0	0	0	0	(19,354)	21
22	Employee Benefits & Payroll Taxes	0	27,000	76,538	0	0	0	0	0	0	0	0	103,538	22
23	Inservice Training & Education	0	691	0	0	0	0	0	0	0	0	0	691	23
24	Travel and Seminar	0	2,156	0	0	0	0	0	0	0	0	0	2,156	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	154	0	0	0	0	0	0	0	0	0	154	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(164,203)	86,556	(6,429)	0	0	0	0	0	0	0	0	(84,076)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,797)	91,567	27,345	0	0	0	0	0	0	0	0	(98,885)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **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	52,525	0	(6,343)	0	0	0	0	0	0	0	0	46,182	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,001)	0	122,538	0	0	0	0	0	0	0	0	93,537	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	34,930	0	0	0	0	0	0	0	0	34,930	34
35	Rent-Equipment & Vehicles	0	0	936	0	0	0	0	0	0	0	0	936	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	23,524	0	152,061	0	0	0	0	0	0	0	0	175,585	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	(318,684)	0	0	0	0	0	0	0	0	0	0	(318,684)	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**	(318,684)	0	0	0	0	0	0	0	0	0	0	(318,684)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(512,957)	91,567	179,406	0	0	0	0	0	0	0	0	(241,984)	45

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Ca	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 1,039	$ 1,039	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,329	2,329	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	945	945	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	698	698	4
5	V	17	Admin - Misc. Other	244,080	Presence Life Connections	100.00%	140,841	(103,239)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	142,060	142,060	6
7	V	19	Professional Services		Presence Life Connections	100.00%	9,044	9,044	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	6,162	6,162	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	2,528	2,528	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	27,000	27,000	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	691	691	11
12	V	24	Travel		Presence Life Connections	100.00%	2,156	2,156	12
13	V	26	Insurance		Presence Life Connections	100.00%	154	154	13
14	Total			$ 244,080			$ 335,647	$ * 91,567	14

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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%	$ 1,723	$ 1,723	15
16	V	32	Interest		Presence Life Connections	100.00%	3	3	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	11,453	11,453	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	936	936	18
19	V	17	Admin Salaries		Presence Health	100.00%	93,789	93,789	19
20	V	22	Employee Benefits		Presence Health	100.00%	76,538	76,538	20
21	V	30	Depreciation	45,747	Presence Health	100.00%	37,681	(8,066)	21
22	V	34	Rent Facility		Presence Health	100.00%	23,477	23,477	22
23	V	17	Admin Consulting,Other	423,035	Presence Health	100.00%	41,547	(381,488)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	28,108	28,108	24
25	V	17	Information Systems - Other		Presence Health	100.00%	110,392	110,392	25
26	V	17	Admin Salaries		Presence Health	100.00%	26,374	26,374	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	39,597	39,597	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	33,774	33,774	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	261	261	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	122,535	122,535	30
31	V	39	Ancillary Services - Other	488,090	Presence Senior Services Pharmacy	100.00%	488,090		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 956,872			$ 1,136,278	$ * 179,406	39

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 JOSEPH CENTER # 0041871 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 JOSEPH CENTER # 0041871 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 JOSEPH CENTER # 0041871 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	$	244,080	$ 1,039	1
2	5	Utilities	Management Fee Income	7,173,919	29	68,461		244,080	2,329	2
3	6	Maintenance - Other	Management Fee Income	7,173,919	29	27,769		244,080	945	3
4	11	Activities-Special Events	Management Fee Income	7,173,919	29	20,505		244,080	698	4
5	17	Admin - Misc. Other	Management Fee Income	7,173,919	29	4,139,560		244,080	140,841	5
6	17	Administrative Salaries	Management Fee Income	7,173,919	29	4,175,380	4,175,380	244,080	142,060	6
7	19	Professional Services	Management Fee Income	7,173,919	29	265,828		244,080	9,044	7
8	20	Dues,Subscriptions	Management Fee Income	7,173,919	29	181,120		244,080	6,162	8
9	21	Clerical Supplies	Management Fee Income	7,173,919	29	74,289		244,080	2,528	9
10	22	Employee Benefits	Management Fee Income	7,173,919	29	793,578		244,080	27,000	10
11	23	Education/Conference	Management Fee Income	7,173,919	29	20,317		244,080	691	11
12	24	Travel	Management Fee Income	7,173,919	29	63,365		244,080	2,156	12
13	26	Insurance	Management Fee Income	7,173,919	29	4,528		244,080	154	13
14	30	Depreciation	Management Fee Income	7,173,919	29	50,634		244,080	1,723	14
15	32	Interest	Management Fee Income	7,173,919	29	87		244,080	3	15
16	34	Rent - Facility	Management Fee Income	7,173,919	29	336,621		244,080	11,453	16
17	35	Rent - Equipment	Management Fee Income	7,173,919	29	27,511		244,080	936	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,280,091	$ 4,175,380		$ 349,762	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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	423,035	$ 93,789	1
2	22	Employee Benefits	Operating Expense	4,947,793	17	895,186		423,035	76,538	2
3	30	Depreciation	Operating Expense	535,127	17	440,774		45,747	37,681	3
4	34	Rent Facility	Operating Expense	4,947,793	17	274,581		423,035	23,477	4
5	17	Admin Consulting,Other	Operating Expense	4,947,793	17	485,930		423,035	41,547	5
6	17	Information Systems Salaries	Operating Expense	4,947,793	17	328,752	328,752	423,035	28,108	6
7	17	Information Systems - Other	Operating Expense	4,947,793	17	1,291,143		423,035	110,392	7
8	17	Admin Salaries	Direct Cost	4,947,793	17	308,463	308,463	423,035	26,374	8
9	17	Information Systems Salaries	Direct Cost	4,947,793	17	463,127	463,127	423,035	39,597	9
10	6	Information Systems - Equip Mai	Direct Cost	4,947,793	17	395,016		423,035	33,774	10
11	17	Admin Consulting,Other	Direct Cost	4,947,793	17	3,054		423,035	261	11
12	32	Admin - Interest Expense	Direct Cost	4,947,793	17	1,433,168		423,035	122,535	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		$ 634,073	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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			$	$		$ 488,090	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					$	$		$ 488,090	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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						$	$			$ 122,538	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 122,538	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 122,538	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 JOSEPH CENTER **#** 0041871 **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.)		$ 118,956	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.		$ 118,956	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 JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

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

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	To be Determined		$ 118,956.00	$ 118,956.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,956.00	$ 118,956.00

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,080 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		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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			1996	$ 2,500,000	$ 62,500	40	$ 62,500	$	$ 1,093,750	4
5	10			2013	3,002,792	38,646	35	77,292	38,646	38,646	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698	2,227	13	2,227		66,450	11
12	VARIOUS			2001	19,599	262	10	262		17,632	12
13	VARIOUS			2002	28,187	722	13	722		25,049	13
14	VARIOUS			2003	77,509	4,109	11	4,109		72,162	14
15	VARIOUS			2004	16,330	627	10	627		15,457	15
16	VARIOUS			2005	93,561	6,799	12	6,799		58,939	16
17	VARIOUS			2006	34,761	2,322	10	2,322		24,323	17
18	VARIOUS			2007	154,464	11,454	12	11,454		79,216	18
19	VARIOUS			2008	219,347	18,468	14	18,468		102,915	19
20	VARIOUS			2009	153,368	13,288	12	13,288		59,004	20
21											21
22	CLF HOBAN HALL HOT WATER HEATERS AND			2010	2,750	275	10	275		963	22
23	PAINTING OF HALLWAYS IN NURSING HOME			2010	3,001	600	5	600		2,100	23
24	HVAC AIR DAMPER CONTROL MOTORS			2010	7,660	1,532	5	1,532		5,362	24
25	PHASE 3 FOR BOILER			2010	5,100	255	20	255		893	25
26	HUMIDIFIER SYSTEM - HONEYWELL STEAM			2010	5,960	745	8	745		2,608	26
27	CULTURE CHANGE			2010	27,077	1,805	15	1,805		6,318	27
28	PARKING LOT SEAL			2010	59,821	7,478	8	7,478		26,172	28
29	DEDUCTION FOR NON-CARE ASSETS			2010	(2,750)	(275)	-10	(275)		(963)	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 ST JOSEPH CENTER # 0041871 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	FIRE CODE SAFETY DOORS SYSTEM	2011	$ 4,214	$ 281	15	$ 281	$	$ 702	37
38	FIRE ALARM & SMOKE DETECTOR WIRING	2011	13,175	1,318	10	1,318		3,294	38
39	SECURITY SYSTEM	2011	6,350	635	10	635		1,587	39
40	CARPET	2011	5,303	1,061	5	1,061		2,651	40
41	PAINTING	2011	3,174	635	5	635		1,587	41
42	CLF - 4 FIRE DOORS	2011	7,260	484	15	484		1,210	42
43	COVER TO EDGE OF THIRD STORY	2011	4,268	427	10	427		1,067	43
44	B WING COMPRESSOR	2011	4,976	332	15	332		498	44
45	DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(484)	-15	(484)		(1,210)	45
46									46
47	N/A	2012							47
48									48
49	CLF - INSTALL NEW VINYL PLANKING FLOOR	2013	3,478	174	10	348	174	174	49
50	"A" WING COMPRESSOR	2013	2,754	115	12	230	115	115	50
51	DESIGN & BUILD TABERNACLE FOR CHAPEL	2013	4,599	153	15	306	153	153	51
52	PARKING LOT SEALED & GRINDING JOINTS	2013	9,350	2,338	2	4,676	2,338	2,338	52
53	LANDSCAPPING	2013	1,500	75	10	150	75	75	53
54	ARCHITECTURAL SERVICES 12 ROOM RENO	2013	422,588	5,282	40	10,564	5,282	5,282	54
55	CLF - FLOORING	2013	149,568	7,478	10	14,956	7,478	7,478	55
56	LIGHTING & 16 PORT DKT INTERFACE	2013	3,297	165	10	330	165	165	56
57	ROLLER SHADES	2013	2,051	205	5	410	205	205	57
58	WANDER SYSTEM FOR DINING ROOM	2013	4,240	212	10	424	212	212	58
59	WALL MOUNT DISPENSER DOUBLE ROLL	2013	1,029	74	7	148	74	74	59
60	CEILING TILES FOR OCEANVIEW	2013	2,846	142	10	284	142	142	60
61	ADD CELL PHONE CAPABILITY	2013	2,972	149	10	298	149	149	61
62	DOOR ENTRANCE & STORM	2013	6,855	229	15	458	229	229	62
63	FIRE DOORS	2013	2,828	71	20	142	71	71	63
64	FIRE ALARM SYSTEM MODIFICATION	2013	2,735	55	25	110	55	55	64
65	RESHAPE EXISTING STONE & ASPHALT NEW	2013	25,973	1,623	8	3,246	1,623	1,623	65
66	DEDUCTION FOR NON-CARE ASSETS	2013	(149,568)	(7,478)	-10	(14,956)	(7,478)	(7,478)	66
67	DEDUCTION FOR NON-CARE ASSETS	2013	(3,478)	(174)	-10	(348)	(174)	(174)	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,029,067	$ 189,416		$ 238,950	$ 49,534	$ 1,724,025	70

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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	$ 1,153,407	$ 110,565	$ 110,565	$	11	$ 627,948	71
72	Current Year Purchases	262,858	13,162	26,324	13,162	10	13,162	72
73	Fully Depreciated Assets	566,048				5	566,048	73
74	Home Office Allocation		39,404	39,404				74
75	TOTALS	$ 1,982,313	$ 163,131	$ 176,293	$ 13,162		$ 1,207,158	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	TOTAL			$ 203,524	$ 26,597	$ 26,597	$		$ 161,110	76
77	*SEE VEHICLE ATTACHMENT									77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 203,524	$ 26,597	$ 26,597	$		$ 161,110	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)	$ 10,614,904	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 379,144	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 441,840	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,696	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,092,293	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.

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5
76	PLANT ENGINEERING	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$ 0
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123	0
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275	0
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649	0
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155	12,039
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232	14,558
80	TOTALS			$ 203,524	$ 26,597

Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
$ 0	$ 0	5	$ 24,090	76
0	0	3	23,123	77
0	0	4	34,275	78
0	0	4	15,649	79
12,039	0	4	42,136	79
14,558	0	4	21,837	79
$ 26,597	$ 0		$ 161,110	80

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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				34,930			5
6								6
7	TOTAL				$ 34,930 **			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: $ 11,395 Description: Nursing $1568, Plant Operations $74, Administration $8817, Home office $936
    (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 JOSEPH CENTER # 0041871 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 JOSEPH CENTER # 0041871 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	$	3,744	$ 219,050	$	3,744	$ 219,050	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		370	21,635		370	21,635	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		4,192	245,489		4,192	245,489	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				488,090		488,090	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			$	8,306	$ 486,174	$ 488,090	8,306	$ 974,264	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 JOSEPH CENTER **#** 0041871 **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 JOSEPH CENTER # 0041871 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**	2,369,713	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 75,049,599	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(610,871)	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)**	$ (353,720)	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 JOSEPH CENTER # 0041871 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	$ 6,049,698	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,049,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	631,130	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 631,130	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	1,620	13
14	Non-Patient Meals	53,998	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	802,171	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 857,789	23
	D. Non-Operating Revenue		
24	Contributions	42,254	24
25	Interest and Other Investment Income***	29,001	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 71,255	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	318,684	28
28a	Other Misc Income	3,914	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 322,598	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,932,470	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,395,379	31
32	Health Care	3,308,080	32
33	General Administration	2,367,296	33
	B. Capital Expense		
34	Ownership	705,956	34
	C. Ancillary Expense		
35	Special Cost Centers	488,090	35
36	Provider Participation Fee	278,540	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,543,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	(610,871)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (610,871)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,591,982	44
45	Private Pay - Net Inpatient Revenue	1,936,060	45
46	Medicare - Net Inpatient Revenue	877,186	46
47	Other-(specify) Insurance	644,470	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,049,698	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 JOSEPH CENTER # 0041871 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	1,792	2,080	$ 77,436	$ 37.23	1
2	Assistant Director of Nursing	1,680	2,080	66,128	31.79	2
3	Registered Nurses	17,306	18,620	477,612	25.65	3
4	Licensed Practical Nurses	27,231	30,071	676,191	22.49	4
5	CNAs & Orderlies	82,665	89,267	1,024,367	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,697	5,136	68,738	13.38	8
9	Activity Director	1,880	1,996	28,881	14.47	9
10	Activity Assistants	5,427	5,947	61,214	10.29	10
11	Social Service Workers	2,936	3,223	44,283	13.74	11
12	Dietician	387	416	10,747	25.83	12
13	Food Service Supervisor	1,816	2,080	46,437	22.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,142	35,631	347,419	9.75	15
16	Dishwashers					16
17	Maintenance Workers	9,059	9,903	140,379	14.18	17
18	Housekeepers	11,042	12,071	111,943	9.27	18
19	Laundry					19
20	Administrator	1,908	2,080	89,856	43.20	20
21	Assistant Administrator					21
22	Other Administrative	7,825	8,369	128,022	15.30	22
23	Office Manager	356	400	7,617	19.04	23
24	Clerical	6,153	6,775	84,410	12.46	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	2,448	2,719	44,417	16.34	32
33	Other(specify) Pastoral Care	1,721	1,873	44,506	23.76	33
34	TOTAL (lines 1 - 33)	221,471	240,737	$ 3,580,603 *	$ 14.87	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	96	$ 7,190	1,3	35
36	Medical Director	Monthly	12,050	9,3	36
37	Medical Records Consultant	34	2,401	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	9	648	11,3	44
45	Social Service Consultant	9	648	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	148	$ 22,937		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 JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 89,856
Administrative Staff	Bookkeeper		32,380
Administrative Staff	Human Resource		45,444
Administrative Staff	Receptionist		50,198
Administrative Staff	Office Manager		7,617
Administrative Staff	Admin Assistant		
Administrative Staff	Admissions		44,417
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 269,912

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 667,115
TOTAL (agree to Schedule V, line 17, col. 3)	$ 667,115
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal		$ 0
Survey & Analytical Tools		3,120
Shredding		427
Living Design		930
Storage		525
Outsourced Services		1,010
Collection Fee		60
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,072

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,076
Unemployment Compensation Insurance	10,604
FICA Taxes	260,867
Employee Health Insurance	672,452
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	131,707
Life Insurance	1,713
Employee Recognition	115
Disability	28,606
Other Benefit Expense	13,309
Home Office Allocation	103,538
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,339,987

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 50)	
Patient Background Checks 297	
Employee Recruitment	3,472
Dues & Subscription	9,395
Advertiosing & Public Relations	1,010
Home Office Allocation	6,162
Less: Public Relations Expense	( )
Non-allowable advertising	(792)
Yellow page advertising	(39)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,208

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,512
Seminar Expense	
Home Office Allocation	2,156
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,668

**See instructions.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 JOSEPH CENTER # 0041871 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 $6112**

(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. $ **35,004** 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. $ **278,540**
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. $ **53,998**

(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.