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: 0044792

Facility Name: PRESENCE VILLA SCALABRINI N&R

Address: 480 NORTH WOLF ROAD (Number) NORTHLAKE (City) 60164 (Zip Code)

County: COOK

Telephone Number: (708) 562-0040 **Fax #** (708) 562-5180

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
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 VILLA SCALABRINI N&R # 0044792 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	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,345	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	31,822	10,303	18,243	60,368	8
9	SNF/PED					9
10	ICF	15,674	5,075		20,749	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,496	15,378	18,243	81,117	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.84%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A-NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 03/01/00

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 16,762

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 VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	588,323	99,594	9,699	697,616		697,616		697,616			1
2	Food Purchase		559,711		559,711		559,711	(7,061)	552,650			2
3	Housekeeping	296,998	105,726	250	402,974		402,974		402,974			3
4	Laundry	179,056	124,882	500	304,438		304,438	(26,463)	277,975			4
5	Heat and Other Utilities			345,655	345,655		345,655	4,905	350,560			5
6	Maintenance	179,863	27,002	541,272	748,137		748,137	1,990	750,127			6
7	Other (specify):* Pastoral Care	163,924	10,171	579	174,674		174,674		174,674			7
8	TOTAL General Services	1,408,164	927,086	897,955	3,233,205		3,233,205	(26,629)	3,206,576			8
	B. Health Care and Programs											
9	Medical Director			119,402	119,402		119,402		119,402			9
10	Nursing and Medical Records	6,124,285	273,959	69,063	6,467,307		6,467,307	(38,052)	6,429,255			10
10a	Therapy	2,040	31,827	2,117,684	2,151,551		2,151,551		2,151,551			10a
11	Activities	170,302	33,259	1,026	204,587		204,587	1,469	206,056			11
12	Social Services	155,463	470	1,521	157,454		157,454		157,454			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,452,090	339,515	2,308,696	9,100,301		9,100,301	(36,583)	9,063,718			16
	C. General Administration											
17	Administrative	399,535	27,567	1,646,760	2,073,862		2,073,862	444,415	2,518,277			17
18	Directors Fees											18
19	Professional Services			2,669	2,669		2,669	19,046	21,715			19
20	Dues, Fees, Subscriptions & Promotions			33,889	33,889		33,889	8,693	42,582			20
21	Clerical & General Office Expenses			9,036	9,036		9,036	5,323	14,359			21
22	Employee Benefits & Payroll Taxes			2,437,287	2,437,287		2,437,287	56,857	2,494,144			22
23	Inservice Training & Education							1,456	1,456			23
24	Travel and Seminar			1,962	1,962		1,962	4,540	6,502			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(32,697)	(32,697)		(32,697)	324	(32,373)			26
27	Other (specify):*											27
28	TOTAL General Administration	399,535	27,567	4,098,906	4,526,008		4,526,008	540,654	5,066,662			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,259,789	1,294,168	7,305,557	16,859,514		16,859,514	477,442	17,336,956			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 VILLA SCALABRINI N&R #0044792 **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			749,901	749,901		749,901	(45,358)	704,543			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			194,569	194,569		194,569	(107,290)	87,279			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							24,118	24,118			34
35	Rent-Equipment & Vehicles			144,319	144,319		144,319	1,971	146,290			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,088,789	1,088,789		1,088,789	(126,559)	962,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,646,573		1,646,573		1,646,573		1,646,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			532,253	532,253		532,253		532,253			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,646,573	532,253	2,178,826		2,178,826		2,178,826			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,259,789	2,940,741	8,926,599	20,127,129		20,127,129	350,883	20,478,012			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 VILLA SCALABRINI N&R # 0044792 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	(9,249)	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	(26,463)	4		8
9	Non-Straightline Depreciation	26,398	30		9
10	Interest and Other Investment Income	(107,296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,284)	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	(336,001)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (456,895)		$	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))**	$ (456,895)		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 VILLA SCALABRINI N&R

ID# 0044792

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (38,052)	10	1
2	Merger Related Home Office Allocation	(297,949)	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**	(336,001)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 **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	(9,249)	2,188	0	0	0	0	0	0	0	0	0	(7,061)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(26,463)	0	0	0	0	0	0	0	0	0	0	(26,463)	4
5	Heat and Other Utilities	0	4,905	0	0	0	0	0	0	0	0	0	4,905	5
6	Maintenance	0	1,990	0	0	0	0	0	0	0	0	0	1,990	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(35,712)	9,083	0	0	0	0	0	0	0	0	0	(26,629)	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	(38,052)	0	0	0	0	0	0	0	0	0	0	(38,052)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,469	0	0	0	0	0	0	0	0	0	1,469	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**	(38,052)	1,469	0	0	0	0	0	0	0	0	0	(36,583)	16
	C. General Administration													
17	Administrative	(297,949)	81,750	660,614	0	0	0	0	0	0	0	0	444,415	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,046	0	0	0	0	0	0	0	0	0	19,046	19
20	Fees, Subscriptions & Promotions	(4,284)	12,977	0	0	0	0	0	0	0	0	0	8,693	20
21	Clerical & General Office Expenses	0	5,323	0	0	0	0	0	0	0	0	0	5,323	21
22	Employee Benefits & Payroll Taxes	0	56,857	0	0	0	0	0	0	0	0	0	56,857	22
23	Inservice Training & Education	0	1,456	0	0	0	0	0	0	0	0	0	1,456	23
24	Travel and Seminar	0	4,540	0	0	0	0	0	0	0	0	0	4,540	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	324	0	0	0	0	0	0	0	0	0	324	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(302,233)	182,273	660,614	0	0	0	0	0	0	0	0	540,654	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(375,997)	192,825	660,614	0	0	0	0	0	0	0	0	477,442	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 **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	26,398	0	(71,756)	0	0	0	0	0	0	0	0	(45,358)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(107,296)	0	6	0	0	0	0	0	0	0	0	(107,290)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	24,118	0	0	0	0	0	0	0	0	24,118	34
35	Rent-Equipment & Vehicles	0	0	1,971	0	0	0	0	0	0	0	0	1,971	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(80,898)	0	(45,661)	0	0	0	0	0	0	0	0	(126,559)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(456,895)	192,825	614,953	0	0	0	0	0	0	0	0	350,883	45

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 2,188	$ 2,188	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,905	4,905	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,990	1,990	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	1,469	1,469	4
5	V	17	Admin - Misc. Other	513,984	Presence Life Connections	100.00%	296,584	(217,400)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	299,150	299,150	6
7	V	19	Professional Services		Presence Life Connections	100.00%	19,046	19,046	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	12,977	12,977	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	5,323	5,323	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	56,857	56,857	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,456	1,456	11
12	V	24	Travel		Presence Life Connections	100.00%	4,540	4,540	12
13	V	26	Insurance		Presence Life Connections	100.00%	324	324	13
14	Total			$ 513,984			$ 706,809	$ * 192,825	14

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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%	$ 3,628	$ 3,628	15
16	V	32	Interest		Presence Life Connections	100.00%	6	6	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	24,118	24,118	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,971	1,971	18
19	V	17	Admin Salaries		Presence Health	100.00%	331,548	331,548	19
20	V	30	Depreciation	134,007	Presence Health	100.00%	58,623	(75,384)	20
21	V	17	Admin Consulting,Other	1,132,776	Presence Health	100.00%	1,461,842	329,066	21
22	V	39	Ancillary Services - Other	1,646,573	Presence Senior Services Pharmacy	100.00%	1,646,573		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,913,356			$ 3,528,309	$ * 614,953	39

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R # 0044792 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	$	513,984	$ 2,188	1
2	5	Utilities	Management Fee Income	7,173,919	29	68,461		513,984	4,905	2
3	6	Maintenance - Other	Management Fee Income	7,173,919	29	27,769		513,984	1,990	3
4	11	Activities-Special Events	Management Fee Income	7,173,919	29	20,505		513,984	1,469	4
5	17	Admin - Misc. Other	Management Fee Income	7,173,919	29	4,139,560		513,984	296,584	5
6	17	Administrative Salaries	Management Fee Income	7,173,919	29	4,175,380	4,175,380	513,984	299,150	6
7	19	Professional Services	Management Fee Income	7,173,919	29	265,828		513,984	19,046	7
8	20	Dues,Subscriptions	Management Fee Income	7,173,919	29	181,120		513,984	12,977	8
9	21	Clerical Supplies	Management Fee Income	7,173,919	29	74,289		513,984	5,323	9
10	22	Employee Benefits	Management Fee Income	7,173,919	29	793,578		513,984	56,857	10
11	23	Education/Conference	Management Fee Income	7,173,919	29	20,317		513,984	1,456	11
12	24	Travel	Management Fee Income	7,173,919	29	63,365		513,984	4,540	12
13	26	Insurance	Management Fee Income	7,173,919	29	4,528		513,984	324	13
14	30	Depreciation	Management Fee Income	7,173,919	29	50,634		513,984	3,628	14
15	32	Interest	Management Fee Income	7,173,919	29	87		513,984	6	15
16	34	Rent - Facility	Management Fee Income	7,173,919	29	336,621		513,984	24,118	16
17	35	Rent - Equipment	Management Fee Income	7,173,919	29	27,511		513,984	1,971	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,280,091	$ 4,175,380		$ 736,532	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Presence Health
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (815)806-2327
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	6,637,889	8	$ 1,942,819	$ 1,942,819	1,132,776	$ 331,548	1
2	30	Depreciation	Operating Expense	704,065	8	308,000		134,007	58,623	2
3	17	Admin Consulting,Other	Operating Expense	6,637,889	8	8,566,162		1,132,776	1,461,842	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,816,981	$ 1,942,819		$ 1,852,013	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Presence Senior Services Pharmacy
Street Address: 100 North River Road
City / State / Zip Code: DesPlaines, IL 60016
Phone Number: (847-410-4900
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,646,573	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					$	$		$ 1,646,573	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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						$	$			$ 6	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 6	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 6	15

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

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

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044792

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 VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: N/A
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	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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	253		2000		$ 7,510,695	$ 250,248	19	$ 250,248	$	$ 3,465,771	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2001	22,045		10			22,045	9
10	VARIOUS			2002	7,030	180	15	180		6,357	10
11	VARIOUS			2003	60,584	3,546	10	3,546		55,291	11
12	VARIOUS			2004	104,281	7,801	14	7,801		86,862	12
13	VARIOUS			2005	125,857	8,201	10	8,201		100,230	13
14	VARIOUS			2006	2,030,638	102,369	16	102,369		824,002	14
15	VARIOUS			2007	114,355	5,997	17	5,997		45,561	15
16	VARIOUS			2008	112,297	6,246	15	6,246		45,554	16
17	VARIOUS			2009	232,410	32,981	9	32,981		163,302	17
18											18
19	Install Flooring System in Resident Bathrooms Unit F			2010	4,500	450	10	450		1,800	19
20	Furnish & Install Tone/Visual Nurse Call System			2010	24,961	3,566	7	3,566		14,264	20
21	Installation of new electrical feeds & boosters			2010	5,600	560	10	560		2,240	21
22	Booster Heater			2010	4,041	404	10	404		1,616	22
23	Furnish + Install Tone/Visual Nurse Call System			2010	1,314	188	7	188		751	23
24	ELEVATOR # 2 PISTON /CYLINDER REPLACEME			2010	15,977	799	20	799		3,135	24
25	HEAT EXCHANGER IN BOILER ROOM			2010	15,235	1,016	15	1,016		3,995	25
26	INSTALL WIRING, AMPLIFIER SPEAKERS FOR M			2010	16,861	3,372	5	3,372		13,264	26
27	COMED SMART IDEAS - MATERIAL FOR LIGHTIN			2010	553	55	10	55		167	27
28	COMED SMART IDEAS - MATERIAL FOR LIGHTIN			2010	3,327	333	10	333		1,078	28
29	COMED SMART IDEAS - MATERIAL FOR LIGHTIN			2010	10,468	1,047	10	1,047		3,167	29
30	STONHARD FLOORING. UNIT C AND G N			2010	14,900	1,490	10	1,490		4,497	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 VILLA SCALABRINI N&R # 0044792 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	NEW SIDE ENTRY TUB FOR UNIT	2011	$ 15,577	$ 1,558	10	$ 1,558	$	$ 4,791	37
38	HEAT EXCHANGER IN BOILER ROOM	2011	7,115	356	20	356		1,067	38
39	HEAT EXCHANGER IN BOILER ROOM	2011	8,136	407	20	407		1,220	39
40	ADD SPRINKLERS TO COMMON AREA RESTRO	2011	2,500	100	25	100		300	40
41	EMEGENCY REPAIRS IN KITCHEN PLUMBING A	2011	3,085	154	20	154		463	41
42	WANDERGUARD SYSTEM IN 3 UNIT	2011	2,400	240	10	240		720	42
43	WANDERGUARD SYSTEM IN 3 UNIT	2011	6,550	655	10	655		1,965	43
44	DOORS & INSTALL NEW HARDWARE & NE	2011	5,380	538	10	538		1,614	44
45	INSTALL MAGNETIC DOOR HOLDERS ON MULT	2011	15,250	1,525	10	1,525		4,575	45
46	INSTALL FIRE PUMPS ALARM SIGNAL	2011	7,265	727	10	727		2,180	46
47	FLOOR IN UNITS E AND D @ LO	2011	9,483	948	10	948		1,897	47
48	FLOOR IN UNITS E AND D @ LO	2011	4,832	483	10	483		966	48
49	FLOOR IN UNITS E AND D @ LO	2011	10,670	1,067	10	1,067		2,134	49
50	FLOOR IN UNITS E AND D @ LO	2011	10,643	1,064	10	1,064		2,129	50
51	ENGINEERING & SPRINKLER DESIGN FOR 2013	2011	19,580	783	25	783		1,566	51
52	ARCHITECTURAL SERVICE FOR LOWER LEVEL	2011	23,445	1,563	15	1,563		3,126	52
53	REMOVE TILE & BASEBOARD IN HALLWAY & CL	2011	9,500	633	15	633		1,267	53
54	INSTALL DRYWALL FOR NEW WALLS & PAINT W	2011	14,500	967	15	967		1,933	54
55	ENGINEERING & SPRINKLER DESIGN FOR 2013	2011	19,581	1,305	15	1,305		2,611	55
56	OPTION # 1 - BOILER REPAIR NEW BURNER & IN	2011	16,450	1,097	15	1,097		2,193	56
57	INSTALLED 4 NEW CONDENSER FAN MOTOS BL	2011	4,901	327	15	327		653	57
58	EM ICE MACHINE REPAIR	2011	2,360	472	5	472		944	58
59	INTERIOR OF 4 ELEVATORS	2011	15,772	1,577	10	1,577		3,154	59
60	INSTALL FLOORING IN COMMON	2011	24,012	2,401	10	2,401		4,802	60
61	FLOOR PREP FOR HALLWAY FLOO	2011	5,377	538	10	538		1,075	61
62	EMERGENCY REPAIRS OF HEATING SYSTEM	2011	2,265	227	10	227		453	62
63	EMERGENCY REPAIR OF FIRE ALRAM SYSTEM	2011	2,642	264	10	264		528	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,707,200	$ 452,825		$ 452,825	$	$ 4,915,275	70

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,707,200	$ 452,825		$ 452,825	$	$ 4,915,275	1
2	NEW FLOOR FINISHING IN UNITS C & G	2012	2,751	550	5	550		825	2
3	# 3 BOILER REPAIRS - INSTALL BURNER HEAD &	2012	9,475	948	10	948		1,421	3
4	INSTALLED CONDENSING UNIT-ADDED LINE DR	2012	2,265	151	15	151		227	4
5	SIGMA SPECTRUM NON-WIRELESS PUMP	2012	12,800	1,280	10	1,280		1,920	5
6	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	30,000	2,000	15	2,000		3,000	6
7	PHYSICAL THERAPY ROOM RENOVATIONS / PE	2012	8,500	567	15	567		850	7
8	6 MECHO V MANUAL SHADES IN HALLWAY BY S	2012	2,621	262	10	262		393	8
9	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	45,000	3,000	15	3,000		4,500	9
10	ARCHITECTURAL SERVICE FOR LOWER LEVEL	2012	5,471	365	15	365		547	10
11	WINDOW TREATMENTS & CUBICLE CURTAINS F	2012	18,740	1,874	10	1,874		2,811	11
12	INSTALLATION OF 80 GALLON ELECTRICAL WA	2012	6,500	650	10	650		975	12
13	INSTALLATION OF 9 STANDARD DROPS & RELO	2012	6,675	445	15	445		667	13
14	NEW SPRINKLER SYSTEM THERAPY ROOM	2012	7,500	300	25	300		450	14
15	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	24,283	1,619	15	1,619		2,428	15
16	TRI W G MOTORIZED BARIATRIC HI-LO MAT TAB	2012	9,095	606	15	606		910	16
17	TRI W-G 6 MOTORIZED BAIATRIC HI-LO PARALL	2012	12,185	812	15	812		1,219	17
18	TOTAL BODY CYCLE	2012	4,262	284	15	284		426	18
19	UNWEIGHTING SYSTEM	2012	7,150	477	15	477		715	19
20	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE	2012	1,595	106	15	106		160	20
21	LANDICE REHABILITATION TREADMILL	2012	5,290	353	15	353		529	21
22	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE	2012	518	35	15	35		52	22
23	SPRINKLER INSTALLATION SYSTEM	2012	30,000	1,200	25	1,200		1,800	23
24	REPLACE KITCHEN FLOORING - PORTION/DISH	2012	31,500	1,575	20	1,575		2,363	24
25	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	28,078	1,872	15	1,872		2,808	25
26	REPLACE 2 MOTOR CONTROL PANELS & CIRCU	2012	17,200	1,147	15	1,147		1,720	26
27	KITCHEN PANEL BOARD REPLACEMENT	2012	3,165	211	15	211		317	27
28	NEW FLOORING FOR PT ROOM & SURROUNDIN	2012	1,545	155	10	155		232	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,041,364	$ 475,669		$ 475,669	$	$ 4,949,540	34

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,041,364	$ 475,669		$ 475,669	$	$ 4,949,540	1
2	SPRINKLER INSTALLATION PROJECT - FINAL PA	2013	262,193	5,244	25	10,488	5,244	5,244	2
3	SPRINKLER INSTALLATION PROJECT	2013	166,239	3,325	25	6,650	3,325	3,325	3
4	SPRINKLER INSTALLATION PROJECT	2013	100,000	2,000	25	4,000	2,000	2,000	4
5	SPRINKLER INSTALLATION PROJECT	2013	77,699	1,554	25	3,108	1,554	1,554	5
6	SPRINKLER INSTALLATION PROJECT	2013	75,000	1,500	25	3,000	1,500	1,500	6
7	SPRINKLER INSTALLATION PROJECT	2013	57,000	1,140	25	2,280	1,140	1,140	7
8	8 RESIDENT ROOM FLOORING, FURNITURE & LIGHTING I	2013	25,932	864	15	1,728	864	864	8
9	60 RUSKIN FIRE DAMPERS CEILING MOUNT	2013	14,100	470	15	940	470	470	9
10	A-BUILDING REPLACEMENT OF A/C COMPRESS	2013	10,785	360	15	720	360	360	10
11	INSTALLATION OF DOORS IN CONFERENCE RO	2013	9,180	306	15	612	306	306	11
12	REMOVE CARPET IN B-WING & INSTALL NEW WOOD PLA	2013	16,800	840	10	1,680	840	840	12
13	RELOCATION OF NURSE CALL LIGHT DUE TO IN	2013	7,604	380	10	760	380	380	13
14	RELOCATE NURSE CALL SYSTEM PULL BOX & R	2013	4,300	215	10	430	215	215	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,196	$ 493,867		$ 512,065	$ 18,198	$ 4,967,738	34

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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	$ 1,133,799	$ 111,791	$ 111,791	$	10	$ 631,151	71
72	Current Year Purchases	150,726	8,200	16,400	8,200	10	8,200	72
73	Fully Depreciated Assets	2,324,603				8	2,255,048	73
74	Home Office Allocation		62,251	62,251				74
75	TOTALS	$ 3,609,128	$ 182,242	$ 190,442	$ 8,200		$ 2,894,399	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	RESIDENCE CARE	2004 CARGO VAN	2004	$ 20,358	$ 2,036	$ 2,036	$	10	$ 18,322	76
77										77
78										78
79										79
80	TOTALS			$ 20,358	$ 2,036	$ 2,036	$		$ 18,322	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)	$ 16,997,682	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 678,145	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 704,543	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,398	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,880,459	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 VILLA SCALABRINI N&R # 0044792 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				24,118			5
6								6
7	TOTAL				$ 24,118 **			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: $ 146,290 Description: Nursing $88119, Administration $48878, Dietary $4028, Rehab $3006, Enviromental Services $288, Home Of
    (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 VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R # 0044792 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	$	15,158	$ 889,640	$	15,158	$ 889,640	1
2	Licensed Speech and Language Development Therapist	10a, 1&3	51 hrs	2,040	3,806	223,375		3,857	225,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		17,118	1,004,669		17,118	1,004,669	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				1,646,573		1,646,573	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			$ 2,040	36,082	$ 2,117,684	$ 1,646,573	36,133	$ 3,766,297	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 VILLA SCALABRINI N&R # 0044792 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	$ 740,680	$	1
2	Cash-Patient Deposits	43,782		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,252,931		3
4	Supply Inventory (priced at)	20,537		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,057,930	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	9,862,616		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,678,258		16
17	Accumulated Depreciation (book methods)	(7,880,460)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Deferred Comp**			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,160,414	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,218,344	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 631,925	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,372,512		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Due to Related Party**	(1,734,557)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 269,880	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Conditional Asset Retirement**			43
44	**Deferred Lease Payable**			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 269,880	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,948,464	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,218,344	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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**	$ 14,939,508	1	
2	Restatements (describe):		2	
3			3	
4			4	
5	**Transition of Equity from CY 06/30 to FY 12/31/12**	(667,937)	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,271,571	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	676,893	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 676,893	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)**	$ 14,948,464	24	*

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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	$ 11,483,862	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,483,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,163,158	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,163,158	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,249	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,918,245	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,052	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	26,463	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,992,009	23
	D. Non-Operating Revenue		
24	Contributions	8,381	24
25	Interest and Other Investment Income***	107,296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115,677	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates		28
28a	Other Misc Income	49,316	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49,316	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,804,022	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,233,205	31
32	Health Care	9,100,301	32
33	General Administration	4,526,008	33
	B. Capital Expense		
34	Ownership	1,088,789	34
	C. Ancillary Expense		
35	Special Cost Centers	1,646,573	35
36	Provider Participation Fee	532,253	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,127,129	40
41	**Income before Income Taxes (line 30 minus line 40)****	676,893	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 676,893	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,274,391	44
45	Private Pay - Net Inpatient Revenue	3,090,385	45
46	Medicare - Net Inpatient Revenue	1,841,331	46
47	Other-(specify) Insurance	277,755	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,483,862	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 VILLA SCALABRINI N&R # 0044792 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	1,858	2,083	$ 103,306	$ 49.59	1
2	Assistant Director of Nursing	1,891	2,083	99,614	47.82	2
3	Registered Nurses	86,363	97,559	3,483,874	35.71	3
4	Licensed Practical Nurses	5,567	6,324	174,618	27.61	4
5	CNAs & Orderlies	151,354	167,325	2,177,466	13.01	5
6	CNA Trainees					6
7	Licensed Therapist		166	7,259	43.73	7
8	Rehab/Therapy Aides	2,736	2,996	39,848	13.30	8
9	Activity Director	1,708	1,969	43,212	21.95	9
10	Activity Assistants	10,777	11,769	128,246	10.90	10
11	Social Service Workers	9,253	10,345	185,582	17.94	11
12	Dietician	3,460	3,935	81,577	20.73	12
13	Food Service Supervisor	1,949	2,199	59,051	26.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,332	39,982	462,025	11.56	15
16	Dishwashers					16
17	Maintenance Workers	7,875	8,878	182,498	20.56	17
18	Housekeepers	22,412	24,980	300,774	12.04	18
19	Laundry	13,486	15,072	159,466	10.58	19
20	Administrator	2,008	2,166	127,209	58.73	20
21	Assistant Administrator					21
22	Other Administrative	9,078	10,158	179,079	17.63	22
23	Office Manager	1,766	1,908	38,154	20.00	23
24	Clerical	6,876	7,285	108,209	14.85	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	2,008	2,191	55,093	25.15	32
33	Other(specify) Pastoral Care	2,015	2,240	63,629	28.41	33
34	TOTAL (lines 1 - 33)	380,772	423,613	$ 8,259,789 *	$ 19.50	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	429	$ 18,817	1,2&3	35
36	Medical Director	Monthly	119,402	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	69	4,255	11,2	44
45	Social Service Consultant	30	1,720	12,2&3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	528	$ 144,194		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 VILLA SCALABRINI N&R # 0044792 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator		$ 127,209
Administrative Staff	Office Manager		38,154
Administrative Staff	Department Heads		19,025
Administrative Staff	Receptionists		103,112
Administrative Staff	Administrative Asst		56,942
Administrative Staff	Admissions		55,093
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 399,535

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,646,760
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,646,760
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 2,669
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,669

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 134,863
Unemployment Compensation Insurance	26,722
FICA Taxes	591,499
Employee Health Insurance	1,055,176
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	29,611
Life Insurance	(5,309)
Disability Insurance	59,223
Pension	504,956
Tuition Reimbursement	29,365
Other Benefits	11,181
Home Office Allocation	56,857
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,494,144

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 54)	
Patient Background Checks 340	
Employee Recruitment	
Dues & Subscription	29,605
Advertiosing & Public Relations	4,284
Home Office Allocation	12,977
Less: Public Relations Expense	( )
Non-allowable advertising	(4,284)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,582

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,962
Seminar Expense	
Home Office Allocation	4,540
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,502

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE VILLA SCALABRINI N&R # 0044792 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 VILLA SCALABRINI N&R # 0044792 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 $14821**

(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. $ **99,298** 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. $ **532,253**
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. $ **9,249**

(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.