FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051490

Facility Name: PRESENCE BALLARD NURSING CTR

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

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: 5/31/11

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: GEORGE VIEU **Telephone Number:** 708-478-7943
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 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Michael R. Gordon
(Title) CFO, Vice President Finance

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,002	5,634	12,749	42,385	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,002	5,634	12,749	42,385	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.27%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/31/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 231 and days of care provided 7,658

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	31,814	29,991	551,910	613,715		613,715		613,715			1
2	Food Purchase		196,291		196,291		196,291		196,291			2
3	Housekeeping	320,710	57,906	3,883	382,499		382,499		382,499			3
4	Laundry	116,463	38,372	1,040	155,875		155,875		155,875			4
5	Heat and Other Utilities			307,577	307,577		307,577		307,577			5
6	Maintenance	92,243	38,081	157,353	287,677		287,677		287,677			6
7	Other (specify):* Pastoral Care	51,135	1,408	7,651	60,194		60,194		60,194			7
8	TOTAL General Services	612,365	362,049	1,029,414	2,003,828		2,003,828		2,003,828			8
	B. Health Care and Programs											
9	Medical Director			105,250	105,250		105,250		105,250			9
10	Nursing and Medical Records	6,512,765	639,255	483,034	7,635,054		7,635,054	(162,018)	7,473,036			10
10a	Therapy			1,217,208	1,217,208		1,217,208		1,217,208			10a
11	Activities	152,565	7,280	819	160,664		160,664		160,664			11
12	Social Services	90,514	17	89	90,620		90,620		90,620			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,755,844	646,552	1,806,400	9,208,796		9,208,796	(162,018)	9,046,778			16
	C. General Administration											
17	Administrative	435,822	36,728	971,879	1,444,429		1,444,429	711,581	2,156,010			17
18	Directors Fees											18
19	Professional Services			523,076	523,076		523,076		523,076			19
20	Dues, Fees, Subscriptions & Promotions			16,096	16,096		16,096	(286)	15,810			20
21	Clerical & General Office Expenses			2,748	2,748		2,748		2,748			21
22	Employee Benefits & Payroll Taxes			1,995,403	1,995,403		1,995,403		1,995,403			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,037	6,037		6,037		6,037			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,880	72,880		72,880		72,880			26
27	Other (specify):*											27
28	TOTAL General Administration	435,822	36,728	3,588,119	4,060,669		4,060,669	711,295	4,771,964			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,804,031	1,045,329	6,423,933	15,273,293		15,273,293	549,277	15,822,570			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR #0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			785,998	785,998		785,998	(68,923)	717,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,237	133,237		133,237	(42,980)	90,257			32
33	Real Estate Taxes			738,502	738,502		738,502		738,502			33
34	Rent-Facility & Grounds			18,000	18,000		18,000		18,000			34
35	Rent-Equipment & Vehicles			200,811	200,811		200,811		200,811			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,876,548	1,876,548		1,876,548	(111,903)	1,764,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,101,870		2,101,870		2,101,870		2,101,870			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			323,603	323,603		323,603		323,603			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		2,101,870	323,603	2,425,473		2,425,473		2,425,473			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,804,031	3,147,199	8,624,084	19,575,314		19,575,314	437,374	20,012,688			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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				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	13,538	30		9
10	Interest and Other Investment Income	(42,980)	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	(286)	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	(225,664)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (255,392)		$	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))**	$ (255,392)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESENCE BALLARD NURSING CTR

ID# 0051490

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill Amortization	$ (63,646)	30	1
2	Labs	(162,018)	10	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**	(225,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	(162,018)	0	0	0	0	0	0	0	0	0	0	(162,018)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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**	(162,018)	0	0	0	0	0	0	0	0	0	0	(162,018)	16
	C. General Administration													
17	Administrative	0	0	711,581	0	0	0	0	0	0	0	0	711,581	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(286)	0	0	0	0	0	0	0	0	0	0	(286)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(286)	0	711,581	0	0	0	0	0	0	0	0	711,295	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(162,304)	0	711,581	0	0	0	0	0	0	0	0	549,277	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE BALLARD NURSING CTR **#** 0051490 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(50,108)	0	(18,815)	0	0	0	0	0	0	0	0	(68,923)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,980)	0	0	0	0	0	0	0	0	0	0	(42,980)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(93,088)	0	(18,815)	0	0	0	0	0	0	0	0	(111,903)	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)	(255,392)	0	692,766	0	0	0	0	0	0	0	0	437,374	45

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	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 Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	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%	$ 0	$	1
2	V	5	Utilities		Presence Life Connections	100.00%	0		2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	0		3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	0		4
5	V	17	Admin - Misc. Other	1	Presence Life Connections	100.00%	0	(1)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	1	1	6
7	V	19	Professional Services		Presence Life Connections	100.00%	0		7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	0		8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	0		9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	0		10
11	V	23	Education/Conference		Presence Life Connections	100.00%	0		11
12	V	24	Travel		Presence Life Connections	100.00%	0		12
13	V	26	Insurance				0		13
14	Total			$ 1			$ 1	$ *	14

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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%	$ 0	$	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	0		17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	0		18
19	V	17	Admin Salaries		Presence Health	100.00%	284,143	284,143	19
20	V	30	Depreciation	95,401	Presence Health	100.00%	76,586	(18,815)	20
21	V	17	Admin Consulting,Other	971,879	Presence Health	100.00%	1,399,317	427,438	21
22	V	39	Ancillary Services - Other	2,101,870	Presence Senior Services Pharmacy	100.00%	2,101,870		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			$ 3,169,150			$ 3,861,916	$ * 692,766	39

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy T. Dowd	BOD	Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Patricia Gomez	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lod	Kankakee	Supportive Living	3
4	James C. Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Life Connect	Mokena	Management Comp.	4
5	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Senior Servic	Kankakee	Pharmacy	5
6	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	Joseph G. Hugar	BOD	Presence St Andrew Life Center	Niles	Presence Heritage Day	Kankakee	Adult Day Care	7
8	John Larson	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9	Sr. Marie Mason	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral H	Broadview	Parent	9
10	Sallie Miller	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Phyllis Nichols	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Lawrence R. Pankau	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Tim Phillippe	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14	Thomas E. Smith	BOD			Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Esta	Kankakee	Independent Living	30

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	4,729,991	29	$ 14,111	$	1	$ 0	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		1	0	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		1	0	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		1	0	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		1	0	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	1	1	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		1	0	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		1	0	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		1	0	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		1	0	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		1	0	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		1	0	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		1	0	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		1	0	14
15	32	Interest	Management Fee Income	4,729,991	29	0		1	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		1	0	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		1	0	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,131	$ 4,162,833		$ 1	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	5,276,287	8	$ 1,542,600	$ 1,542,600	971,879	$ 284,143	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		95,401	104,148	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		971,879	998,243	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					$ 7,566,137	$ 1,542,600		$ 1,386,534	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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: Des Plaines, IL 60016
Phone Number: (847-410-4900
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 2,101,870	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,101,870	25

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 685,780	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.)		$ 880,149	2
3. Under or (over) accrual (line 2 minus line 1).		$ 194,369	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 544,133	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.		$ 738,502	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011	654,088	10
2012	680,540	11
2013	880,149	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE BALLARD NURSING CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051490

CONTACT PERSON REGARDING THIS REPORT George Vieu

TELEPHONE 708-478-7943 FAX #: 708-478-5387

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	9300 Ballard Road, Des Plaines, IL	$ 880,149.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 880,149.00	$

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	52,917	2011	$ 2,480,000	1
2					2
3	TOTALS	52,917		$ 2,480,000	3

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2011		$ 10,666,682	$ 474,849	17	$ 474,849	$	$ 1,424,546	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	EMERGENCY REPAIRS TO SIDEWALK & TRENCH			2011	14,500	1,450	10	1,450		4,350	9
10	INSTALLATION OF 1 DROP 3RD FLOOR - 2 FOR API CLOCKS LOV			2011	2,131	142	15	142		426	10
11	EMERGENCY REPAIRS TO PARKING LOT			2011	2,300	230	10	230		690	11
12	NEW KITCHEN PIPING			2011	2,380	95	25	95		286	12
13	NEW SINKS			2011	3,810	191	20	191		572	13
14	ADDITIONAL COSTS TO COMPLETE 3RD MEDICAL GAS PROJEC			2011	35,300	2,353	15	2,353		7,060	14
15											15
16	NETWORK CABLE INSTALL 2 WEST & LOWER LE			2012	3,182	212	15	212		530	16
17	FLASHINGS TO UPPER ROOF			2012	3,760	251	15	251		627	17
18	NETWORK CABLE INSTALL 2 WEST & LOWER LE			2012	7,859	524	15	524		1,310	18
19	WALLS ABOVE CEILING IN PATIENT ROOMS			2012	18,800	1,253	15	1,253		3,133	19
20	SPRINKLER INSTALLATION SYSTEM			2012	20,000	800	25	800		2,000	20
21	SPRINKLER INSTALLATION SYSTEM			2012	5,817	233	25	233		582	21
22	BRICK PATIO			2012	4,800	240	20	240		600	22
23	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	63,000	4,200	15	4,200		10,500	23
24	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	50,400	3,360	15	3,360		8,400	24
25	INSTALL NEW WOOD PLANKS IN 2ND. FLOOR H			2012	42,009	2,801	15	2,801		7,002	25
26	EMERGENCY BOILER			2012	17,090	1,139	15	1,139		2,848	26
27	L & M FOR 2ND. FLOOR MEDICAL GAS & ELECTR			2012	12,600	840	15	840		2,100	27
28	BALLARD THIRD FLOOR MATERIALS & LABOR			2012	8,400	560	15	560		1,400	28
29	INSTALL OUTLETS & CABLE CONNECTIONS FOR			2012	6,810	454	15	454		1,135	29
30	HANGING DRYWALL, PATCHING & PAINTING 1 W			2012	6,000	400	15	400		1,000	30
31	BALLARD THIRD FLOOR MATERIALS & LABOR			2012	3,340	223	15	223		557	31
32	INSTALL NEW WOOD PLANKS IN 2ND. FLOOR H			2012	857	57	15	57		143	32
33	NEW FLOORING IN HALLWAY OF 3 WEST, 1			2012	41,316	4,132	10	4,132		10,329	33
34	NEW FLOORING IN HALLWAY OF 3 WEST, 1			2012	8,719	872	10	872		2,180	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,051,862	$ 501,861		$ 501,861	$	$ 1,494,306	1
2	SPRINKLER INSTALLATION PROJECT	2013	175,211	7,008	25	7,008		10,513	2
3	3RD FLOOR FIRE DAMPER INSTALLATION	2013	71,638	4,776	15	4,776		7,164	3
4	SPRINKLER INSTALLATION PROJECT	2013	36,801	1,472	25	1,472		2,208	4
5	NEW CARPET WITH WOOD PLANK FLOORING 12 PATIEN	2013	33,588	3,359	10	3,359		5,038	5
6	INSTALL PLASTIC LAMINATE WALL & BASE CABINETSCp	2013	4,155	277	15	277		416	6
7	DRYWALLED & PATCHED ABOVE CEILING 36 UNITS ON 2	2013	9,120	608	15	608		912	7
8	PATCHING, PAINTING & DRYWALL WORK ON 18 UNITS A	2013	17,052	1,137	15	1,137		1,705	8
9	BASEMENT MATERIALS AND LABOR & SECOND FLOOR	2013	82,983	5,532	15	5,532		8,298	9
10	BASEMENT MATERIALS AND LABOR & SECOND FLOOR	2013	3,736	249	15	249		374	10
11	BALLARD REHAB. NEW LL LOC INSTALL ONE STD DROPS	2013	7,409	494	15	494		741	11
12	BASEMENT MATERIALS AND LABOR & SECOND FLOOR	2013	90,212	6,014	15	6,014		9,021	12
13	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	16,495	1,099	15	1,099		1,650	13
14	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	12,208	814	15	814		1,221	14
15	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	32,571	2,171	15	2,171		3,257	15
16	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	36,854	2,457	15	2,457		3,685	16
17	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	5,906	394	15	394		591	17
18	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	17	1	15	1		2	18
19	PROFESSIONAL SERVICES - LEGAL (BALLARD PROJECT)	2013	2,118	141	15	141		212	19
20	REFURBISHING OF EIGHT STAINED GLASS PANELS	2013	804	54	15	54		80	20
21	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	21
22	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	22
23	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	23
24	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	24
25	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	25
26	BANNER-PLUS OTHER CHG's $2.28	2013	112	7	15	7		11	26
27	BANNER-PLUS OTHER CHG's $2.27	2013	112	7	15	7		11	27
28	STATIONS OF THE CROSS-SET OF 14-SIENNA-PLUS OTHER	2013	3,882	259	15	259		388	28
29	REFURBISHING OF EIGHT STAINED GLASS PANELS	2013	2,411	161	15	161		241	29
30	RECEIVE/DELIVER/INSTALLATION	2013	1,288	86	15	86		129	30
31	ALTAR - 60" W X 28" D X 39" H - SIENNA-PLUS OTHER CHG	2013	2,452	163	15	163		245	31
32	LECTERN W/ONE INSIDE SHELF 22" X 16" X 45" - SIENNA-P	2013	1,384	92	15	92		138	32
33	NEW FLOOR FINISHING ON 2ND. FLOOR - HALLWAY & UN	2013	3,369	674	5	674		1,011	33
34	TOTAL (lines 1 thru 33)		$ 11,706,310	$ 541,402		$ 541,402	$	$ 1,553,623	34

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 11,706,310	$ 541,402		$ 541,402	$	$ 1,553,623	1
2	NEW FLOOR FINISHING ON 2ND. FLR - HALLWAY & UNITS	2013	3,370	674	5	674		1,011	2
3	NEW FIRE PANEL	2013	14,144	943	15	943		1,414	3
4	NEW HEATER REFRACTORY, BURNERS AND BRACKETS	2013	5,100	340	15	340		510	4
5	SUMP PUMP - WEIL PUMP 4 inch DISCHARGE 2HP	2013	4,047	270	15	270		405	5
6	WALL REPAIRS - PATCH AND SEAL ALL SMOKE WALLS	2013	11,500	767	15	767		1,150	6
7	ON SITE BLDG REVIEW & FSES PREPARATION & MILEAG	2013	3,282	219	15	219		328	7
8	INSTALLED FIRE DAMPER PER IDPH TAG	2013	8,884	592	15	592		888	8
9									9
10	INSTALL ELECTRIC FOR NEW FIRE PANEL & NEW DEVIC	2014	1,900	63	15	127	64	63	10
11	PLUMBING SVC TO REPAIR DRAIN&VENT IN DIALYSIS RM	2014	15,200	380	20	760	380	380	11
12	REPLACE CARPET W/VINYL FLOOR IN RESIDENT ROOMS	2014	93,143	4,657	10	9,314	4,657	4,657	12
13	FIRE INSULATION FOR SMOKE WALLS THROUGH BLDG	2014	7,800	260	15	520	260	260	13
14	FURNISH & INSTALL 3 DOOR RESTRICTORS	2014	4,470	149	15	298	149	149	14
15	SEALING OF NEW FLOORING IN RESIDENT ROOMS	2014	8,844	442	10	884	442	442	15
16	INSTALL BOILER & PUMP CONTROLLER	2014	2,595	52	25	104	52	52	16
17	INSTALL OF FIRESTOP SYSTEMS IN BASEMENT, 1ST FL	2014	8,800	110	40	220	110	110	17
18	SIMPLEX HEAT DETECTOR & INSTALL IN ELEVATOR RO	2014	2,950	148	10	295	147	148	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)		$ 11,902,339	$ 551,468		$ 557,729	$ 6,261	$ 1,565,590	34

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 591,050	$ 68,226	$ 68,244	$ 18	9	$ 147,371	71
72	Current Year Purchases	124,281	7,257	14,514	7,257	11	7,257	72
73	Fully Depreciated Assets							73
74	Home Office Allocation		104,148	104,148				74
75	TOTALS	$ 715,331	$ 179,631	$ 186,906	$ 7,275		$ 154,628	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,097,670	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 731,099	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 744,635	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,536	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,720,218	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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							5
6								6
7	TOTAL				$ **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 200,811 Description: Administration $19871, Nursing $13984, Plant $542, Dietary $480, Chargeable $161324, Respiratory Care $
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$	9,546	$ 567,015	$	9,546	$ 567,015	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,289	78,866		1,289	78,866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		9,618	571,327		9,618	571,327	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				2,101,870		2,101,870	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			$	20,453	$ 1,217,208	$ 2,101,870	20,453	$ 3,319,078	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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,710	$	1
2	Cash-Patient Deposits	6,980		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,255,286		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,263,976	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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 (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,263,976	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 317,373	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	816,186		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	26,322,934		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 27,456,493	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 27,456,493	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (23,192,517)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,263,976	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (18,146,232)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (18,146,232)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,046,285)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (5,046,285)	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)**	$ (23,192,517)	24 *

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

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 4,759,892	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,759,892	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,056,494	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,056,494	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	(13,932)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,896,717	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	162,018	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,044,803	23
	D. Non-Operating Revenue		
24	Contributions	2,235	24
25	Interest and Other Investment Income***	42,980	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45,215	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Misc Income	(377,375)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (377,375)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,529,029	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,003,828	31
32	Health Care	9,208,796	32
33	General Administration	4,060,669	33
	B. Capital Expense		
34	Ownership	1,876,548	34
	C. Ancillary Expense		
35	Special Cost Centers	2,101,870	35
36	Provider Participation Fee	323,603	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,575,314	40
41	**Income before Income Taxes (line 30 minus line 40)****	(5,046,285)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (5,046,285)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,679,660	44
45	Private Pay - Net Inpatient Revenue	(338,942)	45
46	Medicare - Net Inpatient Revenue	1,046,108	46
47	Other-(specify)	373,066	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,759,892	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	3,539	3,942	$ 194,069	$ 49.23	1
2	Assistant Director of Nursing	1,651	1,939	69,040	35.61	2
3	Registered Nurses	79,919	88,920	2,916,506	32.80	3
4	Licensed Practical Nurses	60,888	67,923	1,773,510	26.11	4
5	CNAs & Orderlies	96,125	105,393	1,406,386	13.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,842	1,976	51,423	26.02	9
10	Activity Assistants	6,415	7,275	98,922	13.60	10
11	Social Service Workers	4,075	4,521	91,970	20.34	11
12	Dietician	187	202	2,568	12.71	12
13	Food Service Supervisor	178	444	13,995	31.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,780	3,389	39,442	11.64	15
16	Dishwashers					16
17	Maintenance Workers	4,716	5,449	91,870	16.86	17
18	Housekeepers	25,053	28,192	313,222	11.11	18
19	Laundry	8,988	9,780	112,278	11.48	19
20	Administrator	1,040	1,088	72,130	66.30	20
21	Assistant Administrator	586	892	44,633	50.04	21
22	Other Administrative	10,926	11,801	217,266	18.41	22
23	Office Manager	1,862	1,967	39,415	20.04	23
24	Clerical	6,731	7,464	100,579	13.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,850	1,989	37,119	18.66	31
32	Other Health C: Admissions	1,857	1,959	62,378	31.84	32
33	Other(specify) Pastoral Care	1,721	1,999	55,310	27.67	33
34	TOTAL (lines 1 - 33)	321,929	358,504	$ 7,804,031 *	$ 21.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	105,250	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 105,250		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 BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vensus Perez/Stephen Nussbaum	Administrator		$ 72,130
Administrative Staff	Asst Administrator		44,633
Administrative Staff	Office Manager		39,415
Administrative Staff	Department Heads		127,366
Administrative Staff	Receptionists		47,749
Administrative Staff	Administrative Asst		42,151
Administrative Staff	Admissions		62,378
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 435,822

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 971,879
TOTAL (agree to Schedule V, line 17, col. 3)	$ 971,879
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 32,504
Gain/Loss on Sale		357,208
AFFILIATED DIALYSIS		25,949
Beautician		5,493
Survey & Analytical Tools		2,758
Seletc Rehab		99,164
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 523,076

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,338
Unemployment Compensation Insurance	20,540
FICA Taxes	558,679
Employee Health Insurance	865,893
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	
Dental	21,170
Life Insurance	4,610
Disability Insurance	46,260
Pension	339,470
Tuition Reimbursement	21,381
Other Benefits	12,062
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,995,403

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 38)	
Patient Background Checks 340	
Dues & Subscriptions	15,810
Advertising & Public Relations	286
Home Office Allocation	
Less: Public Relations Expense	( )
Non-allowable advertising	(286)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,810

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,827
Seminar Expense	4,210
Home Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,037

**See instructions.

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRESENCE BALLARD NURSING CTR # 0051490 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 $13933**

(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? **9 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **77,068** 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. $ **323,603**
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? **N/A** Indicate the amount. $

(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 of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.