FOR BHF USE

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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: 0044362

Facility Name: PRESENCE RESURRECTION N & R

Address: 1001 N GREENWOOD AVE (Number) PARK RIDGE (City) 60068 (Zip Code)

County: cook

Telephone Number: 847-685-2805 **Fax #** 847-692-2305

HFS ID Number:

Date of Initial License for Current Owners: 05/01/80

Type of Ownership:

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

IRS Exemption Code 501C3

In the event there are further questions about this report, please contact:
Name: 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 RESURRECTION N & R # 0044362 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	298	Skilled (SNF)	298	108,770	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	298	TOTALS	298	108,770	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	40,348	11,554	23,964	75,866	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,348	11,554	23,964	75,866	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.75%

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 03/26/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/26/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 298 and days of care provided 18,868

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 RESURRECTION N & R # 0044362 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	139,412	52,163	758,434	950,009		950,009		950,009			1
2	Food Purchase		624,638		624,638		624,638	(6,132)	618,506			2
3	Housekeeping	363,500	48,320	4,688	416,508		416,508		416,508			3
4	Laundry	161,672	56,344		218,016		218,016	(56,307)	161,709			4
5	Heat and Other Utilities			424,497	424,497		424,497	5,607	430,104			5
6	Maintenance	165,965	53,570	226,721	446,256		446,256	1,617	447,873			6
7	Other (specify):* Pastoral Care	115,344	1,820	6,914	124,078		124,078		124,078			7
8	TOTAL General Services	945,893	836,855	1,421,254	3,204,002		3,204,002	(55,215)	3,148,787			8
	B. Health Care and Programs											
9	Medical Director	33,922			33,922		33,922		33,922			9
10	Nursing and Medical Records	6,609,411	242,403	356,828	7,208,642		7,208,642	(83,126)	7,125,516			10
10a	Therapy	1,902		2,192,981	2,194,883		2,194,883		2,194,883			10a
11	Activities	200,451	4,556	4,389	209,396		209,396	911	210,307			11
12	Social Services	159,955	524	238	160,717		160,717		160,717			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,005,641	247,483	2,554,436	9,807,560		9,807,560	(82,215)	9,725,345			16
	C. General Administration											
17	Administrative	529,551	38,567	1,471,001	2,039,119		2,039,119	715,152	2,754,271			17
18	Directors Fees											18
19	Professional Services			66,617	66,617		66,617	41,338	107,955			19
20	Dues, Fees, Subscriptions & Promotions			19,336	19,336		19,336	13,067	32,403			20
21	Clerical & General Office Expenses			698	698		698	3,704	4,402			21
22	Employee Benefits & Payroll Taxes			2,287,133	2,287,133		2,287,133	77,565	2,364,698			22
23	Inservice Training & Education							569	569			23
24	Travel and Seminar			412	412		412	3,619	4,031			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			328,435	328,435		328,435	(537)	327,898			26
27	Other (specify):*											27
28	TOTAL General Administration	529,551	38,567	4,173,632	4,741,750		4,741,750	854,477	5,596,227			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,481,085	1,122,905	8,149,322	17,753,312		17,753,312	717,047	18,470,359			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 RESURRECTION N & R #0044362 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			508,937	508,937		508,937	(69,685)	439,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,045	127,045		127,045	(83,099)	43,946			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							42,273	42,273			34
35	Rent-Equipment & Vehicles			47,369	47,369		47,369	2,540	49,909			35
36	Other (specify):*											36
37	TOTAL Ownership			683,351	683,351		683,351	(107,971)	575,380			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,987,818		1,987,818		1,987,818		1,987,818			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			508,365	508,365		508,365		508,365			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,987,818	508,365	2,496,183		2,496,183		2,496,183			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,481,085	3,110,723	9,341,038	20,932,846		20,932,846	609,076	21,541,922			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 RESURRECTION N & R # 0044362 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	(7,476)	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	(56,307)	4		8
9	Non-Straightline Depreciation	10,389	30		9
10	Interest and Other Investment Income	(83,099)	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	(1,199)	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	(83,126)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (220,818)		$	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))**	$ (220,818)		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 RESURRECTION N & R

ID# 0044362

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (83,126)	10	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				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**	(83,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 **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	(7,476)	1,344	0	0	0	0	0	0	0	0	0	(6,132)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(56,307)	0	0	0	0	0	0	0	0	0	0	(56,307)	4
5	Heat and Other Utilities	0	5,607	0	0	0	0	0	0	0	0	0	5,607	5
6	Maintenance	0	1,617	0	0	0	0	0	0	0	0	0	1,617	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(63,783)	8,568	0	0	0	0	0	0	0	0	0	(55,215)	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	(83,126)	0	0	0	0	0	0	0	0	0	0	(83,126)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	911	0	0	0	0	0	0	0	0	0	911	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**	(83,126)	911	0	0	0	0	0	0	0	0	0	(82,215)	16
	C. General Administration													
17	Administrative	0	(31,948)	747,100	0	0	0	0	0	0	0	0	715,152	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	41,338	0	0	0	0	0	0	0	0	0	41,338	19
20	Fees, Subscriptions & Promotions	(1,199)	14,266	0	0	0	0	0	0	0	0	0	13,067	20
21	Clerical & General Office Expenses	0	3,704	0	0	0	0	0	0	0	0	0	3,704	21
22	Employee Benefits & Payroll Taxes	0	77,565	0	0	0	0	0	0	0	0	0	77,565	22
23	Inservice Training & Education	0	569	0	0	0	0	0	0	0	0	0	569	23
24	Travel and Seminar	0	3,619	0	0	0	0	0	0	0	0	0	3,619	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	(537)	0	0	0	0	0	0	0	0	0	(537)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,199)	108,576	747,100	0	0	0	0	0	0	0	0	854,477	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(148,108)	118,055	747,100	0	0	0	0	0	0	0	0	717,047	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 **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 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	10,389	0	(80,074)	0	0	0	0	0	0	0	0	(69,685)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(83,099)	0	0	0	0	0	0	0	0	0	0	(83,099)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	42,273	0	0	0	0	0	0	0	0	42,273	34
35	Rent-Equipment & Vehicles	0	0	2,540	0	0	0	0	0	0	0	0	2,540	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(72,710)	0	(35,261)	0	0	0	0	0	0	0	0	(107,971)	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)**	(220,818)	118,055	711,839	0	0	0	0	0	0	0	0	609,076	45

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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%	$ 1,344	$ 1,344	1
2	V	5	Utilities		Presence Life Connections	100.00%	5,607	5,607	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,617	1,617	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	911	911	4
5	V	17	Admin - Misc. Other	450,610	Presence Life Connections	100.00%	22,083	(428,527)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	396,579	396,579	6
7	V	19	Professional Services		Presence Life Connections	100.00%	41,338	41,338	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	14,266	14,266	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,704	3,704	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	77,565	77,565	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	569	569	11
12	V	24	Travel		Presence Life Connections	100.00%	3,619	3,619	12
13	V	26	Insurance			100.00%	(537)	(537)	13
14	Total			$ 450,610			$ 568,665	$ * 118,055	14

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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%	$ (59,870)	$ (59,870)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	42,273	42,273	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	2,540	2,540	18
19	V	17	Admin Salaries		Presence Health	100.00%	298,326	298,326	19
20	V	30	Depreciation	102,444	Presence Health	100.00%	82,240	(20,204)	20
21	V	17	Admin Consulting,Other	1,020,391	Presence Health	100.00%	1,469,165	448,774	21
22	V	39	Ancillary Services - Other	1,987,818	Presence Senior Services Pharmacy	100.00%	1,987,818		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			$ 3,110,653			$ 3,822,492	$ * 711,839	39

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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 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 RESURRECTION N & R # 0044362 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	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 RESURRECTION N & R # 0044362 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	$	450,610	$ 1,344	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		450,610	5,607	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		450,610	1,617	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		450,610	911	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		450,610	22,083	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	450,610	396,579	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		450,610	41,338	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		450,610	14,266	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		450,610	3,704	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		450,610	77,565	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		450,610	569	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		450,610	3,619	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		450,610	(537)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		450,610	(59,870)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		450,610	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		450,610	42,273	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		450,610	2,540	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,131	$ 4,162,833		$ 553,608	25

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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	1,020,391	$ 298,326	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		102,444	111,837	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		1,020,391	1,048,071	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		$ 1,458,234	25

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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			$	$		$ 1,987,818	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					$	$		$ 1,987,818	25

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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** 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							$	$			$	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 RESURRECTION N & R # 0044362 **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.**	$	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 2014 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:		
2009		8
2010		9
2011		10
2012		11
2013		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 RESURRECTION N & R COUNTY cook

FACILITY IDPH LICENSE NUMBER 0044362

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 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.			$	$
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 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 RESURRECTION N & R # 0044362 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior BRICK & BLOCK Frame STEEL Number of Stories 3+GROUND

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:
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	126,500	1983	$ 580,293	1
2					2
3	TOTALS	126,500		$ 580,293	3

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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	298			1982	$ 20,768	$	20	$	$	$ 20,768	4
5				1983	6,333,842		19			6,333,801	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1984	1,736,552		16			1,736,545	9
10	VARIOUS			1985	3,892		10			3,892	10
11	VARIOUS			1986	65,883		17			65,878	11
12	VARIOUS			1987	41,840	422	18	422		36,777	12
13	VARIOUS			1988	123,462		15			123,460	13
14	VARIOUS			1989	97,825		12			97,823	14
15	VARIOUS			1990	206,043		14			206,040	15
16	VARIOUS			1991	71,271		17			71,265	16
17	VARIOUS			1992	90,499		14			90,496	17
18	VARIOUS			1993	101,616		15			101,615	18
19	VARIOUS			1994	260,008		15			260,002	19
20	VARIOUS			1995	535,674		12			535,673	20
21	VARIOUS			1996	175,128	1,134	12	1,134		173,994	21
22	VARIOUS			1997	985,478	4,578	14	4,578		976,506	22
23	VARIOUS			1998	66,417		12			66,417	23
24	VARIOUS			1999	2,005	134	15	134		2,005	24
25	VARIOUS			2000	316,227	21,082	15	21,082		316,161	25
26	VARIOUS			2001	1,308,065	86,350	14	86,350		1,216,330	26
27	VARIOUS			2002	46,002	2,887	14	2,887		39,072	27
28	VARIOUS			2003	156,623	1,432	12	1,432		150,991	28
29	VARIOUS			2004	1,300	87	15	87		953	29
30	VARIOUS			2005	24,457	859	10	859		22,404	30
31	VARIOUS			2006	138,413	6,963	18	6,963		65,339	31
32	VARIOUS			2007	83,231	6,654	14	6,654		48,765	32
33	VARIOUS			2008	113,772	8,524	14	8,524		54,620	33
34	VARIOUS			2009	619,270	59,368	10	59,368		368,654	34
35	VARIOUS			2010	112,600	10,545	15	10,545		49,301	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 RESURRECTION N & R # 0044362 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	
37	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2011	$ 2,325	$ 233	10	$ 233	$	$ 930	37
38	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES IN	2011	10,866	435	25	435		1,739	38
39	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES IN	2011	7,892	316	25	316		1,263	39
40	1ST FLOOR INITIAL DESIGN STUDY	2011	5,000	250	20	250		1,000	40
41	4 SMOKE DAMPERS	2011	3,559	237	15	237		949	41
42	PROVIDE PLUMBING SERVICE TO INSTALL NEW PIPING	2011	9,500	380	25	380		1,140	42
43	PROVIDE PLUMBING SERVICE TO INSTALL BY-PASS PIPIN	2011	5,490	220	25	220		659	43
44	PROVIDE PLUMBING SERVICE TO INSTALL 14 DUAL CHEC	2011	3,400	136	25	136		408	44
45	FLOOR INSTALLATION IN UNIT # 235 & TEST UNIT	2011	2,395	240	10	240		719	45
46	INSTALLATION OF REMOTE ANNUNCIATOR FOR EMERGI	2011	6,087	507	12	507		1,522	46
47	ARCHITECTURAL SERVICES FOR C & D WING	2011	29,410	1,961	15	1,961		5,882	47
48	DESIGN FEES	2011	16,369	1,092	15	1,092		3,274	48
49									49
50	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2012	257	26	10	26		64	50
51	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2012	1,094	109	10	109		273	51
52	INSULATION OF DUCTWORK ON ROOF UNIT # 4	2012	7,933	529	15	529		1,322	52
53	EASYCARE 5 BED LAMINATE PANELS, ASSIST DEVICES	2012	57,420	3,828	15	3,828		9,570	53
54	ARCHITECTURAL SERVICES FOR C & D WING	2012	7,514	501	15	501		1,252	54
55	REVAMPING OF COMBUSTION AIR INTAKE DUCTWORK	2012	2,963	198	15	198		494	55
56	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD S	2012	13,703	685	20	685		1,713	56
57	FSES PREPARATION SURVEY	2012	3,960	264	15	264		660	57
58	DESIGN FEES	2012	10,481	699	15	699		1,747	58
59	SISTER BONAVENTURE CONSTRUCTION PROJECT	2012	108,487	5,424	20	5,424		13,561	59
60	SISTER BONAVENTURE PROJECT	2012	227,929	15,195	15	15,195		37,988	60
61	STANDARD HEAD SPRINKLERS TO RESPONSE SRINKLERS	2012	5,363	215	25	215		536	61
62	COMPLETE WALLS ABOVE CEILING IN ALL PATIENT ROO	2012	18,750	1,250	15	1,250		3,125	62
63	SISTER BONAVENTURE CONSTRUCTION PROJECT	2012	134,325	8,955	15	8,955		22,388	63
64	RPZ VALVES UPGRADE / INSTALLATION	2012	27,280	1,364	20	1,364		3,410	64
65	COMPLETE WALLS ABOVE CEILING IN ALL PATIENT ROO	2012	18,750	1,250	15	1,250		3,125	65
66	NEW STANDARD HEAD SPRINKLERS TO RESPONSE SRINK	2012	4,332	433	10	433		1,083	66
67	RHC - RNRC FSES - 2011	2012	1,809	121	15	121		302	67
68	DOMESTIC HOT WATER SYSTEM REPAIR	2012	12,950	863	15	863		2,158	68
69									69
70	TOTAL (lines 4 thru 69)		$ 14,605,756	$ 258,935		$ 258,935	$	$ 13,359,803	70

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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		$ 14,605,756	$ 258,935		$ 258,935	$	$ 13,359,803	1
2	COMPUTER/PHONE WIRING & TESTING SR. BONAVENTUI	2013	5,595	373	15	373		560	2
3	EM REPAIR NURSE CALL STATION ON 1ST. FLOOR A & B V	2013	23,200	1,547	15	1,547		2,320	3
4	NEW HEATING COIL FOR AHU IN MAIN KITCHEN	2013	13,516	1,352	10	1,352		2,027	4
5	FREE STANDING TUB FOR SPA-PLUS OTHER CHG's $6.50	2013	3,404	170	20	170		255	5
6	SISTER BONAVENTURE CONSTRUCTION PROJECT	2013	102,075	6,805	15	6,805		10,208	6
7	SISTER BONAVENTURE CONSTRUCTION PROJECT	2013	180,755	12,050	15	12,050		18,076	7
8	SISTER BONAVENTURE CONSTRUCTION PROJECT	2013	64,500	4,300	15	4,300		6,450	8
9	SISTER BONAVENTURE CONSTRUCTION PROJECT	2013	203,644	13,576	15	13,576		20,364	9
10	SISTER BONAVENTURE CONSTRUCTION PROJECT - FINAI	2013	30,000	2,000	15	2,000		3,000	10
11	SISTER BONAVENTURE PROJECT - INTERIOR DESIGNING	2013	80,000	5,333	15	5,333		8,000	11
12	SISTER BONAVENTURE PROJECT - INTERIOR DESIGNING	2013	71,952	4,797	15	4,797		7,195	12
13	SISTER BONAVENTURE PROJECT - INTERIOR DESIGNING	2013	1,550	103	15	103		155	13
14	SISTER BONAVENTURE PROJECT - INTERIOR DESIGNING	2013	1,690	113	15	113		169	14
15	ARCHITECTURAL SERVICES C & D WING	2013	7,875	525	15	525		788	15
16	ARCHITECTURAL SERVICES C & D WING	2013	630	42	15	42		63	16
17	ASSIST DEVICE (SIDE RAIL, HALF LENGTH)	2013	2,286	152	15	152		229	17
18	BASEMENT SPRINKLER INSTALLATION	2013	10,276	411	25	411		617	18
19	ARCHITECTURAL SERVICES FOR C & D WING -ZONING	2013	1,470	98	15	98		147	19
20	DESIGN MEETING COORDINATION & INTER DESIGNER - 1	2013	19,850	1,323	15	1,323		1,985	20
21	SIGNAGE FOR SISTER BONAVENTURE PROJECT	2013	1,747	175	10	175		262	21
22	SIGNAGE FOR SISTER BONAVENTURE PROJECT	2013	11,024	1,102	10	1,102		1,654	22
23	SIGNAGE FOR SISTER BONAVENTURE PROJECT	2013	1,759	176	10	176		264	23
24	SIGNAGE FOR SISTER BONAVENTURE PROJECT	2013	844	84	10	84		127	24
25	SIGNAGE FOR SISTER BONAVENTURE PROJECT	2013	915	92	10	92		137	25
26	INSTALL PROTECTIVE MESH ON STAIR RAILINGS	2013	3,825	383	10	383		574	26
27									27
28	CONVERSION OF 1-A WING & 3-B WING INTO SEMI PRIVA	2014	47,948	1,199	20	1,199		1,199	28
29	CONVERSION OF 1-A WING & 3-B WING INTO SEMI PRIVA	2014	47,983	1,200	20	1,200		1,200	29
30	CONVERSION OF 1-A WING & 3-B WING INTO SEMI PRIVA	2014	48,016	1,200	20	1,200		1,200	30
31	CONTROL BOX KIT	2014	499	17	15	17		17	31
32	FURNISH & INSTALL DOOR RESTRICTORS ON DOORS	2014	5,550	278	10	278		278	32
33	INSTALL NEW PVI 250 GALLON WATER HEATER	2014	43,015	2,151	10	2,151		2,151	33
34	TOTAL (lines 1 thru 33)		$ 15,643,149	$ 322,062		$ 322,062	$	$ 13,451,474	34

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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		$ 15,643,149	$ 322,062		$ 322,062	$	$ 13,451,474	1
2	INSTALLATION OF NEW SILENCER ASSET AND FLEX PIPI	2014	4,205	210	10	421	211	210	2
3	CARRIER 40 TON R-22 CONDENSING ROOFTOP AIR CONDI	2014	34,000	1,700	10	3,400	1,700	1,700	3
4	PATCHING PARKING LOT AND DRAIN	2014	5,400	180	15	360	180	180	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	TOTAL (lines 1 thru 33)		$ 15,686,754	$ 324,152		$ 326,243	$ 2,091	$ 13,453,564	34

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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	$ 551,778	$ 49,540	$ 49,534	$ (6)	11	$ 307,577	71
72	Current Year Purchases	206,143	8,304	16,608	8,304	11	8,304	72
73	Fully Depreciated Assets	2,722,956	24,497	24,497		8	2,722,956	73
74	Home Office Allocation		51,967	51,967				74
75	TOTALS	$ 3,480,877	$ 134,308	$ 142,606	$ 8,298		$ 3,038,837	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	1993 OLDSMOBILE 88-R (PAR	1993	$ 18,286	$	$	$	4	$ 18,286	76
77	RESIDENCE	1997 BUICK CENTURY SC CU	1997	18,343				4	18,343	77
78	RESIDENCE	2007 Ford Starcraft	2007	53,983				5	53,983	78
79										79
80	TOTALS			$ 90,612	$	$	$		$ 90,612	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)	$ 19,838,536	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 458,460	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 468,849	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,389	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,583,013	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 RESURRECTION N & R # 0044362 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				42,273			5
6								6
7	TOTAL				$ 42,273 **			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: $ 49,909 Description: Administration-$31,270, Nursing-$228, Dietary-$15,871, Home Office-$2540
    (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 RESURRECTION N & R # 0044362 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.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units		Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3		hrs	$	12,537	$	744,714	$	12,537	$ 744,714	1
2	Licensed Speech and Language Development Therapist	10a, 1&3	44	hrs	1,902	9,767		597,746		9,811	599,648	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a,3		hrs		14,319		850,521		14,319	850,521	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					1,987,818		1,987,818	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				$ 1,902	36,623	$	2,192,981	$ 1,987,818	36,667	$ 4,182,701	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 RESURRECTION N & R # 0044362 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	$ 469,320	$	1
2	Cash-Patient Deposits	18,968		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,970,916		3
4	Supply Inventory (priced at)	27,527		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	74,213		8
9	Other(specify):	47,500,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 54,060,944	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	580,293		13
14	Buildings, at Historical Cost	11,115,789		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,188,650		16
17	Accumulated Depreciation (book methods)	(16,583,008)		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)**	$ 3,301,724	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 57,362,668	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 733,172	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	870,744		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 Parties	1,497,180		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,101,096	$	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)**	$ 3,101,096	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 54,261,572	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 57,362,668	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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**	$ 54,543,639	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 54,543,639	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(282,067)	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)**	$ (282,067)	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)**	$ 54,261,572	24	*

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

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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	$ 12,873,276	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,873,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,039,311	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,039,311	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	23,542	13
14	Non-Patient Meals	7,476	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,474,424	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	83,126	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	56,307	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,644,875	23
	D. Non-Operating Revenue		
24	Contributions	3,231	24
25	Interest and Other Investment Income***	83,099	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 86,330	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Misc Income	6,987	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,650,779	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,204,002	31
32	Health Care	9,807,560	32
33	General Administration	4,741,750	33
	B. Capital Expense		
34	Ownership	683,351	34
	C. Ancillary Expense		
35	Special Cost Centers	1,987,818	35
36	Provider Participation Fee	508,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,932,846	40
41	**Income before Income Taxes (line 30 minus line 40)****	(282,067)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (282,067)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,004,912	44
45	Private Pay - Net Inpatient Revenue	1,601,556	45
46	Medicare - Net Inpatient Revenue	4,395,773	46
47	Other-(specify)	871,035	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,873,276	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 RESURRECTION N & R # 0044362 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	1,961	2,086	$ 100,440	$ 48.15	1
2	Assistant Director of Nursing	1,828	2,133	89,045	41.75	2
3	Registered Nurses	95,208	106,008	3,870,378	36.51	3
4	Licensed Practical Nurses	4,071	4,586	117,883	25.70	4
5	CNAs & Orderlies	145,756	162,060	2,205,664	13.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	143	143	2,108	14.74	8
9	Activity Director	1,659	1,959	64,169	32.76	9
10	Activity Assistants	10,031	11,253	137,060	12.18	10
11	Social Service Workers	7,197	8,009	158,707	19.82	11
12	Dietician	710	1,050	22,162	21.11	12
13	Food Service Supervisor	237	510	18,936	37.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,239	12,039	142,731	11.86	15
16	Dishwashers					16
17	Maintenance Workers	6,709	7,387	165,659	22.43	17
18	Housekeepers	24,373	28,388	363,851	12.82	18
19	Laundry	12,799	14,417	161,002	11.17	19
20	Administrator	1,861	2,086	127,995	61.36	20
21	Assistant Administrator					21
22	Other Administrative	16,121	17,539	262,009	14.94	22
23	Office Manager	1,865	2,086	40,131	19.24	23
24	Clerical	9,120	10,218	178,287	17.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	204	204	33,922	166.28	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	2,861	3,900	99,416	25.49	32
33	Other(specify) Pastoral Care	4,404	5,057	119,530	23.64	33
34	TOTAL (lines 1 - 33)	357,357	403,118	$ 8,481,085 *	$ 21.04	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				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)		$		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 RESURRECTION N & R # 0044362 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Farlee	Administrator		$ 127,995
Administrative Staff	Office Manager		40,131
Administrative Staff	Medical Director		
Administrative Staff	Receptionists		95,258
Administrative Staff	Administrative Asst		43,579
Administrative Staff	Admissions		99,416
Administrative Staff	Department Heads		123,172
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 529,551

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,471,001
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,471,001
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 4,787
Cielo - recruiter	Various	14,050
Beautician	Various	9,141
Postage	Various	4,810
Shredding/Storage	Various	7,509
Joint Commission	Various	7,435
IDPH Dues	Various	3,980
Publications	Various	4,293
Wandering units	Various	2,813
HR Plus	Various	2,675
Survey & Analytical Tools	Various	1,419
Outsourced Services	Various	3,705
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 66,617

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,990
Unemployment Compensation Insurance	19,856
FICA Taxes	606,344
Employee Health Insurance	1,026,256
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	77,565
Dental	24,379
Life Insurance	5,647
Disability Insurance	52,871
Pension	386,697
Tuition Reimbursement	23,920
Other Benefits	8,173
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,364,698

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 15)	
Patient Background Checks 699	
Dues & Subscription	18,137
Advertising & Public Relations	1,199
Home Office Allocation	14,266
Less: Public Relations Expense	( )
Non-allowable advertising	(1,199)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,403

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	412
Seminar Expense	
Home Office Allocation	3,619
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,031

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE RESURRECTION N & R # 0044362 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 RESURRECTION N & R # 0044362 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 $17,992**

(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? **11 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **109,286** 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. $ **508,365**
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. $ **7,476**

(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.