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: 0044776

Facility Name: PRESENCE ST ANDREW LIFE CTR

Address: 7000 NORTH NEWARK (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: 847-947-8332 **Fax #** 847-647-7073

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			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 ST ANDREW LIFE CTR # 0044776 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5	154	Sheltered Care (SC)	154	56,210	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	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					8
9	SNF/PED					9
10	ICF	8,956	6,413		15,369	10
11	ICF/DD					11
12	SC		38,313		38,313	12
13	DD 16 OR LESS					13
14	TOTALS	8,956	44,726		53,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.37%

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

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

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

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

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

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

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

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

Medicare Intermediary N/A

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 ST ANDREW LIFE CTR # 0044776 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	36,929	21,932	467,508	526,369		526,369	(375,671)	150,698			1
2	Food Purchase		413,616		413,616		413,616	(303,892)	109,724			2
3	Housekeeping	185,087	5,586	1,059	191,732		191,732	(136,840)	54,892			3
4	Laundry	45,047	32,536	3,781	81,364		81,364	(14,759)	66,605			4
5	Heat and Other Utilities			334,859	334,859		334,859	(238,990)	95,869			5
6	Maintenance	206,082	15,842	234,418	456,342		456,342	(325,693)	130,649			6
7	Other (specify):* Pastoral Care	70,158	14,074	1,064	85,296		85,296		85,296			7
8	TOTAL General Services	543,303	503,586	1,042,689	2,089,578		2,089,578	(1,395,845)	693,733			8
	B. Health Care and Programs											
9	Medical Director	10,815			10,815		10,815		10,815			9
10	Nursing and Medical Records	1,039,323	20,029	11,156	1,070,508		1,070,508		1,070,508			10
10a	Therapy	319			319		319		319			10a
11	Activities	100,286	5,070	449	105,805		105,805		105,805			11
12	Social Services	51,310		2,400	53,710		53,710		53,710			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*	588,958	8,882	1,281	599,121		599,121	(599,121)				15
16	TOTAL Health Care and Programs	1,791,011	33,981	15,286	1,840,278		1,840,278	(599,121)	1,241,157			16
	C. General Administration											
17	Administrative	281,210	14,600	340,455	636,265		636,265	249,271	885,536			17
18	Directors Fees											18
19	Professional Services			223,847	223,847		223,847		223,847			19
20	Dues, Fees, Subscriptions & Promotions			24,442	24,442		24,442	(17,717)	6,725			20
21	Clerical & General Office Expenses			1,725	1,725		1,725		1,725			21
22	Employee Benefits & Payroll Taxes			762,682	762,682		762,682	(182,179)	580,503			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,503	2,503		2,503		2,503			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			103,556	103,556		103,556		103,556			26
27	Other (specify):*											27
28	TOTAL General Administration	281,210	14,600	1,459,210	1,755,020		1,755,020	49,375	1,804,395			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,615,524	552,167	2,517,185	5,684,876		5,684,876	(1,945,591)	3,739,285			29

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR #0044776 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			698,043	698,043		698,043	(140,416)	557,627			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,943	131,943		131,943	(5,452)	126,491			32
33	Real Estate Taxes			32,719	32,719		32,719	(32,719)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,488	12,488		12,488		12,488			35
36	Other (specify):*											36
37	TOTAL Ownership			875,193	875,193		875,193	(178,587)	696,606			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,685		188,685		188,685		188,685			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,228	117,228		117,228		117,228			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		188,685	117,228	305,913		305,913		305,913			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,615,524	740,852	3,509,606	6,865,982		6,865,982	(2,124,178)	4,741,804			45

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	(8,693)	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	(14,759)	4		8
9	Non-Straightline Depreciation	10,679	30		9
10	Interest and Other Investment Income	(5,452)	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	(145,039)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,717)	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	(2,186,412)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,367,393)		$	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))**	$ (2,367,393)		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

STATE OF ILLINOIS **Page 5A**

PRESENCE ST ANDREW LIFE CTR

ID# **0044776**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Tax	$ (32,719)	33	1
2				2
3	Assisted Living - Salaries	(588,958)	15	3
4	Assisted Living - Benefits	(182,179)	22	4
5	Assisted Living - Supplies	(8,882)	15	5
6	Assisted Living - Other	(1,281)	15	6
7				7
8	Assisted/Ind Living - Meals/Supplies	(295,199)	2	8
9	Assisted/Ind Living - Maintenance/OH	(325,693)	6	9
10	Assisted/Ind Living - Utilities	(238,990)	5	10
11	Assisted/Ind Living - Housekeeping	(136,840)	3	11
12	Assisted/Ind Living - Dietary	(375,671)	1	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**	(2,186,412)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 **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	(375,671)	0	0	0	0	0	0	0	0	0	0	(375,671)	1
2	Food Purchase	(303,892)	0	0	0	0	0	0	0	0	0	0	(303,892)	2
3	Housekeeping	(136,840)	0	0	0	0	0	0	0	0	0	0	(136,840)	3
4	Laundry	(14,759)	0	0	0	0	0	0	0	0	0	0	(14,759)	4
5	Heat and Other Utilities	(238,990)	0	0	0	0	0	0	0	0	0	0	(238,990)	5
6	Maintenance	(325,693)	0	0	0	0	0	0	0	0	0	0	(325,693)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,395,845)	0	0	0	0	0	0	0	0	0	0	(1,395,845)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	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):*	(599,121)	0	0	0	0	0	0	0	0	0	0	(599,121)	15
16	**TOTAL Health Care and Programs**	(599,121)	0	0	0	0	0	0	0	0	0	0	(599,121)	16
	C. General Administration													
17	Administrative	0	0	249,271	0	0	0	0	0	0	0	0	249,271	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	(17,717)	0	0	0	0	0	0	0	0	0	0	(17,717)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(182,179)	0	0	0	0	0	0	0	0	0	0	(182,179)	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**	(199,896)	0	249,271	0	0	0	0	0	0	0	0	49,375	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,194,862)	0	249,271	0	0	0	0	0	0	0	0	(1,945,591)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 **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	(134,360)	0	(6,056)	0	0	0	0	0	0	0	0	(140,416)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,452)	0	0	0	0	0	0	0	0	0	0	(5,452)	32
33	Real Estate Taxes	(32,719)	0	0	0	0	0	0	0	0	0	0	(32,719)	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**	(172,531)	0	(6,056)	0	0	0	0	0	0	0	0	(178,587)	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)**	(2,367,393)	0	243,215	0	0	0	0	0	0	0	0	(2,124,178)	45

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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 ST ANDREW LIFE CTR # 0044776 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%	99,537	99,537	19
20	V	30	Depreciation	30,709	Presence Health	100.00%	24,653	(6,056)	20
21	V	17	Admin Consulting,Other	340,455	Presence Health	100.00%	490,189	149,734	21
22	V	39	Ancillary Services - Other	188,685	Presence Senior Services Pharmacy	100.00%	188,685		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			$ 559,849			$ 803,064	$ * 243,215	39

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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 ST ANDREW LIFE CTR # 0044776 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 ST ANDREW LIFE CTR # 0044776 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		1	1	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914	4,162,833	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					$ 5,811,130	$ 4,162,833		$ 1	25

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	340,455	$ 99,537	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		30,709	33,525	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		340,455	349,691	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		$ 482,753	25

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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			$	$		$ 188,685	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					$	$		$ 188,685	25

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	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 ST ANDREW LIFE CTR **#** 0044776 **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 ST ANDREW LIFE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044776

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 ST ANDREW LIFE CTR # 0044776 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 155,990 B. General Construction Type: Exterior BRICK Frame MASONARY Number of Stories 6

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	436,304	2000	$ 2,600,000	1
2					2
3	TOTALS	436,304		$ 2,600,000	3

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	55		2000	1951	$ 3,406,552	$ 148,111	23	$ 148,111	$	$ 2,198,690	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2001	90,467	2,653	12	2,653		85,161	9
10	VARIOUS			2002	328,284	17,713	13	17,713		282,044	10
11	VARIOUS			2003	284,446	4,307	15	4,307		252,733	11
12	VARIOUS			2004	576,422	31,061	17	31,061		336,730	12
13	VARIOUS			2005	390,063	29,999	12	29,999		306,648	13
14	VARIOUS			2006	75,302	4,730	12	4,730		60,613	14
15	VARIOUS			2007	6,217,538	318,484	17	318,484		2,559,126	15
16	VARIOUS			2008	161,444	13,863	13	13,863		92,422	16
17	VARIOUS			2009	36,980	2,540	14	2,540		13,199	17
18	VARIOUS			2010	19,513	1,770	11	1,770		8,848	18
19											19
20	NEW MAIN DRAIN LINE & WATER SUPPLY LINES ON -1ST - 5TH F			2011	7,675	307	25	307		1,228	20
21	ACCESS DOOR INSTALLATION ON THE UPPER LEVEL IN CHAPE			2011	2,838	189	15	189		757	21
22	INSTALL NEW DOOR OPERATOR			2011	6,800	453	15	453		1,813	22
23	NEW CHAPEL DOORS			2011	5,863	293	20	293		879	23
24	PAINTING OF 3RD. & 4TH FLOOR COMMON AREAS - HALLWAYS			2011	10,000	2,000	5	2,000		6,000	24
25	INSTALL NEW FLOORING ON 3RD. & 4TH. FLOOR - INCLUDING			2011	1,240	124	10	124		372	25
26	INSTALL NEW FLOORING ON 3RD. & 4TH. FLOOR - INCLUDING			2011	6,070	607	10	607		1,821	26
27	INSTALL NEW FLOORING ON 3RD. & 4TH. FLOOR - INCLUDING			2011	36,405	3,641	10	3,641		10,922	27
28	INSTALL NEW FLOORING ON 3RD. & 4TH. FLOOR - INCLUDING			2011	1,305	130	10	130		391	28
29	INSTALL NEW FLOORING ON 5TH FL. HALLWAYS - 3 DINING RO			2011	36,727	3,673	10	3,673		11,018	29
30	INSTALL NEW FLOORING ON 3RD. & 4TH. FLOOR - INCLUDING			2011	28,064	2,806	10	2,806		8,419	30
31	INSTALL NEW FLOORING ON 5TH FL. HALLWAYS - 3 DINING RO			2011	6,394	639	10	639		1,918	31
32	NEW PROGRAMMER INSTALLED IN BOILER # 3			2011	3,654	365	10	365		1,096	32
33	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIANCE			2011	7,248	290	25	290		870	33
34	PAINTING OF 3RD. & 4TH FLOOR COMMON AREAS - HALLWAYS			2011	10,000	2,000	5	2,000		6,000	34
35	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIANCE			2011	7,248	483	15	483		1,450	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	WATER HEATER FOR LAUNDRY ROOM	2012	$ 4,550	$ 455	10	$ 455	$	$ 1,138	37
38	TREE PRUNING ALONG NORTH & WEST SIDE PROPERTY	2012	2,800	280	10	280		700	38
39	REMOVAL OF 6 DEAD TREES, BRANCHES & DEBRIS	2012	6,800	680	10	680		1,700	39
40	INSTALLATION OF FIRE DOORS ON 5TH LOOR SUN ROOM	2012	1,780	89	20	89		223	40
41	EMERGENCY MASONRY & ROOF REPAIRS	2012	25,549	2,555	10	2,555		6,387	41
42	EMERGENCY MASONRY & ROOF REPAIRS	2012	12,775	1,277	10	1,277		3,194	42
43	5TH. FLOOR NORTH - ROOMS 536-568 REPONDER 4000 AUD	2012	11,489	1,149	10	1,149		2,872	43
44	5TH. FLOOR NORTH - ROOMS 536-568 REPONDER 4000 AUD	2012	13,403	1,340	10	1,340		3,351	44
45	2 GREASE TRAPS	2012	5,980	399	15	399		997	45
46	5TH. FLOOR NORTH - ROOMS 536-568 REPONDER 4000 AUD	2012	13,403	1,340	10	1,340		3,351	46
47	NEW 12 TUBES IN BOILER # 2	2012	4,500	450	10	450		1,125	47
48	4 FLOOR NORTH SHOWER ROOM	2012	5,620	375	15	375		937	48
49	EMERGENCY ROOF REPLACEMENT - SOUTH-EAST SECTI	2012	39,800	3,980	10	3,980		9,950	49
50	EMERGENCY BOILER REPAIRS	2012	26,865	1,791	15	1,791		4,478	50
51									51
52	NEW 4 inch PIPING NEAR FIRE PUMP	2013	3,746	150	25	150		225	52
53	NEW 4 inch PIPING NEAR FIRE PUMP	2013	3,311	132	25	132		199	53
54	SPRINKLER INSTALLATION PROJECT	2013	32,283	1,291	25	1,291		1,937	54
55	SPRINKLER INSTALLATION PROJECT	2013	16,141	646	25	646		968	55
56	INSTALLATION OF FIRE DOORS	2013	12,600	630	20	630		945	56
57	L & M TO INSTALL 14 ELECTRICAL OUTLETS FOR WIREL	2013	2,475	124	20	124		186	57
58	LIFELINE SYSTEM FOR ASSISTED LIVING-PLUS FREIGHT	2013	28,007	2,801	10	2,801		4,201	58
59	LIFELINE SYSTEM FOR ASSISTED LIVING-INSTALL & TRA	2013	11,694	1,169	10	1,169		1,754	59
60	AMERIKOOLER - NEW WALKIN FREEZER -INSTALLATION	2013	4,346	435	10	435		652	60
61	AMERIKOOLER - NEW WALKIN FREEZER	2013	9,224	922	10	922		1,384	61
62	AMERIKOOLER - NEW WALKIN FREEZER -FREIGHT CHG	2013	1,127	113	10	113		169	62
63	UNIT FLOORING FOR FIFTH FLOOR	2013	47,394	4,739	10	4,739		7,109	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,112,204	$ 622,543		$ 622,543	$	$ 6,311,300	70

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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 12A, Carried Forward		$ 12,112,204	$ 622,543		$ 622,543	$	$ 6,311,300	1
2	EJECTOR PUMPS IN BOILER ROOM NEED CLEANING AND	2014	5,960	298	10	596	298	298	2
3	NEW METAL DOORS FOR STAIRWELL	2014	11,302	283	20	565	282	283	3
4	SPRINKLER INSTALLATION PROJECT	2014	16,141	323	25	646	323	323	4
5	WIRING OF FIRE ALARM DEVICES FLOW SWITCHES & TA	2014	7,959	265	15	531	266	265	5
6	INTERNAL VALVE INSPECTION	2014	3,920	131	15	261	130	131	6
7	ASPHALT PATCHING ON PARKING LOT	2014	5,800	363	8	725	362	363	7
8	REPAIR LEAKS IN GAS TRAINS & PIPING	2014	4,185	140	15	279	139	140	8
9	NEW BOILER BLOW DOWN VALVES - BOILER 1 & 2	2014	3,665	122	15	244	122	122	9
10	REPAIR SINK HOLE BY NORTH PARKING LOT NEW STRON	2014	5,200	52	50	104	52	52	10
11	NEW WATERFLOW FOR 1ST. FLOOR BOILER ROOM / REPA	2014	3,604	90	20	180	90	90	11
12									12
13	DEDUCTION OF NON-CARE ASSETS			(145,039)		(145,039)			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)		$ 12,179,940	$ 479,571		$ 481,635	$ 2,064	$ 6,313,367	34

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	$ 981,866	$ 31,122	$ 31,122	$	10	$ 787,129	71
72	Current Year Purchases	46,331	2,317	4,637	2,320	10	2,317	72
73	Fully Depreciated Assets	316,998	2,991	2,991		7	316,998	73
74	Home Office Allocation		33,525	33,525				74
75	TOTALS	$ 1,345,195	$ 69,955	$ 72,275	$ 2,320		$ 1,106,444	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	2013 FORD STARCRAFT	2013	2014	$ 50,355	$ 6,294	$ 12,589	$ 6,295	4	$ 6,294	76
77										77
78										78
79										79
80	TOTALS			$ 50,355	$ 6,294	$ 12,589	$ 6,295		$ 6,294	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,175,490	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 555,820	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 566,499	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,679	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,426,105	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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: $ 12,788 Description: Administration $11,340, Nursing $600, Assisted Living $300, Plant $95, Dietary $453,
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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 ST ANDREW LIFE CTR # 0044776 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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,1	8 hrs	319				8	319	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				188,685		188,685	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			$ 319		$	$ 188,685	8	$ 189,004	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	$ 2,481	$	1
2	Cash-Patient Deposits	5,794		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	813,072		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)**	$ 821,347	$	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)**	$ 821,347	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (29,794)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	767,152		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	(925,291)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (187,933)	$	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)**	$ (187,933)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,009,280	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 821,347	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR **#** 0044776 **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**	$ 958,567	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 958,567	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	50,713	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)**	$ 50,713	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)**	$ 1,009,280	24	*

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	$ 2,716,336	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,716,336	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	(7,629)	13
14	Non-Patient Meals	8,693	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	261,056	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	14,759	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 276,879	23
	D. Non-Operating Revenue		
24	Contributions	24,478	24
25	Interest and Other Investment Income***	5,452	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,930	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc Income	3,893,550	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,893,550	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,916,695	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,089,578	31
32	Health Care	1,840,278	32
33	General Administration	1,755,020	33
	B. Capital Expense		
34	Ownership	875,193	34
	C. Ancillary Expense		
35	Special Cost Centers	188,685	35
36	Provider Participation Fee	117,228	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,865,982	40
41	**Income before Income Taxes (line 30 minus line 40)****	50,713	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 50,713	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,168,985	44
45	Private Pay - Net Inpatient Revenue	1,549,804	45
46	Medicare - Net Inpatient Revenue	(2,453)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,716,336	49

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

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

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

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

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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	1,737	1,943	$ 103,798	$ 53.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,082	11,531	401,745	34.84	3
4	Licensed Practical Nurses	3,947	4,538	125,887	27.74	4
5	CNAs & Orderlies	26,111	29,385	393,757	13.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	1,980	37,730	19.06	9
10	Activity Assistants	4,645	5,372	61,495	11.45	10
11	Social Service Workers	31,364	35,688	630,582	17.67	11
12	Dietician	32	32	764	23.88	12
13	Food Service Supervisor	175	363	11,127	30.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,335	3,869	43,832	11.33	15
16	Dishwashers					16
17	Maintenance Workers	9,074	10,067	206,452	20.51	17
18	Housekeepers	13,941	15,716	186,249	11.85	18
19	Laundry	3,789	4,186	45,240	10.81	19
20	Administrator	1,429	1,846	95,445	51.70	20
21	Assistant Administrator					21
22	Other Administrative	4,716	5,084	91,471	17.99	22
23	Office Manager	728	923	16,930	18.34	23
24	Clerical	167	189	4,571	24.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	103	103	10,815	105.00	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	2,745	3,111	77,364	24.87	32
33	Other(specify) Pastoral Care	2,351	2,519	70,270	27.90	33
34	TOTAL (lines 1 - 33)	121,340	138,445	$ 2,615,524 *	$ 18.89	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	48	2,400	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	$ 2,400		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alpana Patel	Administrator		$ 95,445
Administrative Staff	Office Manager		16,930
Administrative Staff	Department Heads		59,133
Administrative Staff	Receptionists		32,338
Administrative Staff	Medical Director		
Administrative Staff	Admissions		77,364
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 281,210

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 340,455
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 340,455

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 8,825
Gain/Loss on Sale	Various	191,875
Beautician	Various	6,320
Survey & Analytical Tools	Various	5,403
Living Design/Aquarium Maint	Various	3,141
Trust Fund Transfer	Various	6,712
Outsourced Services	Various	1,571
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 223,847

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,609
Unemployment Compensation Insurance	8,031
FICA Taxes	190,675
Employee Health Insurance	347,596
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation/Non Care Adjustment	(182,179)
Dental	8,316
Life Insurance	1,823
Disability Insurance	18,594
Pension	134,615
Tuition Reimbursement	8,393
Other Benefits	3,030
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,503

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 22)	
Patient Background Checks 20	
Dues & Subscription	6,725
Advertising & Public Relations	17,717
Home Office Allocation	
Less: Public Relations Expense	( )
Non-allowable advertising	(17,717)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,725

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,635
Seminar Expense	868
Home Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,503

**See instructions.

Facility Name & ID Number PRESENCE ST ANDREW LIFE CTR # 0044776 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 ST ANDREW LIFE CTR # 0044776 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 $6338**

(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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,557** 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. $ **117,228**
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? **Yes-Assisted Living** 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. $ **8,693**

(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.