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: 0044784

Facility Name: PRESENCE ST BENEDICT N & R

Address: 6930 WEST TOUHY AVE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: 847-647-0003 **Fax #** 847-647-1936

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 BENEDICT N & R # 0044784 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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	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	5,701	15,633	12,556	33,890	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		8,622		8,622	12
13	DD 16 OR LESS					13
14	TOTALS	5,701	24,255	12,556	42,512	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 9,927

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 ST BENEDICT N & R # 0044784 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	49,559	22,981	634,074	706,614		706,614		706,614			1
2	Food Purchase		302,132		302,132		302,132	(71,781)	230,351			2
3	Housekeeping	207,264	1,486	3,782	212,532		212,532	(43,104)	169,428			3
4	Laundry	114,105	55,096		169,201		169,201	(15,044)	154,157			4
5	Heat and Other Utilities			243,819	243,819		243,819	(46,957)	196,862			5
6	Maintenance	130,917	8,606	172,402	311,925		311,925	(62,544)	249,381			6
7	Other (specify):* Pastoral Care	39,266	10,838		50,104		50,104		50,104			7
8	TOTAL General Services	541,111	401,139	1,054,077	1,996,327		1,996,327	(239,430)	1,756,897			8
	B. Health Care and Programs											
9	Medical Director	18,504			18,504		18,504		18,504			9
10	Nursing and Medical Records	2,713,793	109,043	167,868	2,990,704		2,990,704	(40,127)	2,950,577			10
10a	Therapy	813	369	1,301,612	1,302,794		1,302,794		1,302,794			10a
11	Activities	151,084	10,414	250	161,748		161,748	405	162,153			11
12	Social Services	83,799	2,268		86,067		86,067		86,067			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Assisted Living	120,201			120,201		120,201	(120,201)				15
16	TOTAL Health Care and Programs	3,088,194	122,094	1,469,730	4,680,018		4,680,018	(159,923)	4,520,095			16
	C. General Administration											
17	Administrative	247,911	17,871	696,881	962,663		962,663	349,349	1,312,012			17
18	Directors Fees											18
19	Professional Services			28,284	28,284		28,284	18,378	46,662			19
20	Dues, Fees, Subscriptions & Promotions			11,530	11,530		11,530	5,004	16,534			20
21	Clerical & General Office Expenses			2,471	2,471		2,471	1,647	4,118			21
22	Employee Benefits & Payroll Taxes			1,091,884	1,091,884		1,091,884	(10,423)	1,081,461			22
23	Inservice Training & Education							253	253			23
24	Travel and Seminar			700	700		700	1,609	2,309			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,821	90,821		90,821	(239)	90,582			26
27	Other (specify):*											27
28	TOTAL General Administration	247,911	17,871	1,922,571	2,188,353		2,188,353	365,578	2,553,931			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,877,216	541,104	4,446,378	8,864,698		8,864,698	(33,775)	8,830,923			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 BENEDICT N & R #0044784 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			369,324	369,324		369,324	(162,473)	206,851			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,301	76,301		76,301	(6,754)	69,547			32
33	Real Estate Taxes			7,384	7,384		7,384	(7,384)				33
34	Rent-Facility & Grounds							18,795	18,795			34
35	Rent-Equipment & Vehicles			10,690	10,690		10,690	1,129	11,819			35
36	Other (specify):*											36
37	**TOTAL Ownership**			463,699	463,699		463,699	(156,687)	307,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		681,337		681,337		681,337		681,337			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,894	201,894		201,894		201,894			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		681,337	201,894	883,231		883,231		883,231			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,877,216	1,222,441	5,111,971	10,211,628		10,211,628	(190,462)	10,021,166			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 BENEDICT N & R # 0044784 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	(11,103)	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	(15,044)	4		8
9	Non-Straightline Depreciation	10,990	30		9
10	Interest and Other Investment Income	(6,754)	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	(134,496)	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	(1,338)	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	(429,713)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (587,458)		$	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))**	$ (587,458)		37

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

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

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

PRESENCE ST BENEDICT N & R

ID# 0044784

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted/Ind Living - Wages	$ (120,201)	15	1
2	Assisted/Ind Living - Benefits	(44,908)	22	2
3	Assisted/Ind Living - Meals/Supplies	(61,276)	2	3
4	Assisted/Ind Living - Maintenance/OH	(63,263)	6	4
5	Assisted/Ind Living - Utilities	(49,450)	5	5
6	Assisted/Ind Living - Housekeeping	(43,104)	3	6
7				7
8	Labs	(40,127)	10	8
9				9
10	Real Estate Tax	(7,384)	33	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**	(429,713)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(72,379)	598	0	0	0	0	0	0	0	0	0	(71,781)	2
3	Housekeeping	(43,104)	0	0	0	0	0	0	0	0	0	0	(43,104)	3
4	Laundry	(15,044)	0	0	0	0	0	0	0	0	0	0	(15,044)	4
5	Heat and Other Utilities	(49,450)	2,493	0	0	0	0	0	0	0	0	0	(46,957)	5
6	Maintenance	(63,263)	719	0	0	0	0	0	0	0	0	0	(62,544)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(243,240)	3,810	0	0	0	0	0	0	0	0	0	(239,430)	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	(40,127)	0	0	0	0	0	0	0	0	0	0	(40,127)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	405	0	0	0	0	0	0	0	0	0	405	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):*	(120,201)	0	0	0	0	0	0	0	0	0	0	(120,201)	15
16	TOTAL Health Care and Programs	(160,328)	405	0	0	0	0	0	0	0	0	0	(159,923)	16
	C. General Administration													
17	Administrative	0	(14,204)	363,553	0	0	0	0	0	0	0	0	349,349	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18,378	0	0	0	0	0	0	0	0	0	18,378	19
20	Fees, Subscriptions & Promotions	(1,338)	6,342	0	0	0	0	0	0	0	0	0	5,004	20
21	Clerical & General Office Expenses	0	1,647	0	0	0	0	0	0	0	0	0	1,647	21
22	Employee Benefits & Payroll Taxes	(44,908)	34,485	0	0	0	0	0	0	0	0	0	(10,423)	22
23	Inservice Training & Education	0	253	0	0	0	0	0	0	0	0	0	253	23
24	Travel and Seminar	0	1,609	0	0	0	0	0	0	0	0	0	1,609	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	(239)	0	0	0	0	0	0	0	0	0	(239)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(46,246)	48,271	363,553	0	0	0	0	0	0	0	0	365,578	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(449,814)	52,486	363,553	0	0	0	0	0	0	0	0	(33,775)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 **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	(123,506)	0	(38,967)	0	0	0	0	0	0	0	0	(162,473)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,754)	0	0	0	0	0	0	0	0	0	0	(6,754)	32
33	Real Estate Taxes	(7,384)	0	0	0	0	0	0	0	0	0	0	(7,384)	33
34	Rent-Facility & Grounds	0	0	18,795	0	0	0	0	0	0	0	0	18,795	34
35	Rent-Equipment & Vehicles	0	0	1,129	0	0	0	0	0	0	0	0	1,129	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(137,644)	0	(19,043)	0	0	0	0	0	0	0	0	(156,687)	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)**	(587,458)	52,486	344,510	0	0	0	0	0	0	0	0	(190,462)	45

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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%	$ 598	$ 598	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,493	2,493	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	719	719	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	405	405	4
5	V	17	Admin - Misc. Other	200,339	Presence Life Connections	100.00%	9,818	(190,521)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	176,317	176,317	6
7	V	19	Professional Services		Presence Life Connections	100.00%	18,378	18,378	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	6,342	6,342	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,647	1,647	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	34,485	34,485	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	253	253	11
12	V	24	Travel		Presence Life Connections	100.00%	1,609	1,609	12
13	V	26	Insurance			100.00%	(239)	(239)	13
14	Total			$ 200,339			$ 252,825	$ * 52,486	14

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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%	$ (26,618)	$ (26,618)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	18,795	18,795	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,129	1,129	18
19	V	17	Admin Salaries		Presence Health	100.00%	145,171	145,171	19
20	V	30	Depreciation	62,619	Presence Health	100.00%	50,270	(12,349)	20
21	V	17	Admin Consulting,Other	496,542	Presence Health	100.00%	714,924	218,382	21
22	V	39	Ancillary Services - Other	681,337	Presence Senior Services Pharmacy	100.00%	681,337		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			$ 1,240,498			$ 1,585,008	$ * 344,510	39

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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 BENEDICT N & R # 0044784 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 BENEDICT N & R # 0044784 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	$	200,339	$ 598	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		200,339	2,493	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		200,339	719	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		200,339	405	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		200,339	9,818	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	200,339	176,317	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		200,339	18,378	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		200,339	6,342	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		200,339	1,647	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		200,339	34,485	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		200,339	253	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		200,339	1,609	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		200,339	(239)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		200,339	(26,618)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		200,339	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		200,339	18,795	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		200,339	1,129	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,130	$ 4,162,833		$ 246,131	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	496,542	$ 145,171	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		62,619	68,361	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		496,542	510,012	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		$ 723,544	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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			$	$		$ 681,337	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					$	$		$ 681,337	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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 BENEDICT N & R # 0044784 **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 BENEDICT N & R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

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 BENEDICT N & R # 0044784 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior BRICK Frame METAL Number of Stories 2

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

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

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

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

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

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

1. Total Amount Incurred: 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	56,961	2000	$ 2,910,262	1
2					2
3	TOTALS	56,961		$ 2,910,262	3

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	99		2000	1991	$ 5,342,488	$ 123,854	39	$ 123,854	$	$ 2,235,806	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	30,917		9			30,917	9
10	VARIOUS			2001	286,598	17,680	14	17,680		243,610	10
11	VARIOUS			2002	34,410	1,884	15	1,884		29,366	11
12	VARIOUS			2003	3,328	166	20	166		1,997	12
13	VARIOUS			2004	23,972	1,288	14	1,288		16,462	13
14	VARIOUS			2005	172,249	10,157	10	10,157		127,367	14
15	VARIOUS			2006	135,090	8,665	10	8,665		101,946	15
16											16
17	VARIOUS			2008	1,284	64	20	64		450	17
18											18
19	REMOVAL OF RADIATOR FOR NEW PATIO ENTRANCE			2011	4,229	282	15	282		846	19
20	NEW FLOORING OF BACK HALLWAY - DOCK VINYL			2011	8,817	882	10	882		2,645	20
21	INSTALL WOOD HANDRAILS & BASE TO MATCH EXISTING IN NI			2011	4,761	317	15	317		952	21
22	EMERGENCY SECURITY DOOR SYSTEM REPAIRS			2011	2,016	202	10	202		605	22
23	NEW CARPET IN COMMON AREAS 1ST. & 2ND. FLOORS - INCLUI			2011	27,131	5,426	5	5,426		16,278	23
24	NEW CARPET IN COMMON AREAS 1ST. & 2ND. FLOORS - INCLUI			2011	9,423	1,885	5	1,885		5,654	24
25	NEW CARPET IN COMMON AREAS 1ST. & 2ND. FLOORS - INCLUI			2011	11,267	2,253	5	2,253		6,760	25
26	NEW CARPET IN COMMON AREAS 1ST. & 2ND. FLOORS - INCLUI			2011	22,143	4,429	5	4,429		13,286	26
27	INSTALL SHREDDED HARDWOODMULCH TO ALL PLANTING BE			2011	3,400	1,133	3	1,133		3,400	27
28	EMERGENCY REPAIR TO MAIN KITCHEN REFRIGERATOR			2011	4,542	908	5	908		2,725	28
29	INSTALL BELBIEN ON ELEVATOR PANELS IN 2 CABS			2011	6,244	624	10	624		1,873	29
30	10 GALLON CLIPPER DUO			2011	2,999	600	5	600		1,799	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	NEW CARPETING IN OFFICES	2012	$ 1,776	$ 355	5	$ 355	$	$ 888	37
38	NEW CARPETING IN OFFICES	2012	3,891	778	5	778		1,946	38
39	FURNISH & INSTALL A FOLDING DOOR	2012	7,725	773	10	773		1,931	39
40	EXTERIOR LIGHTING & RUN NEW LINE FOR WATER FOU	2012	2,260	113	20	113		283	40
41	L & M TO INSTALL SOLID OAK DOUBLE FRENCH DOORS	2012	5,360	357	15	357		893	41
42	L & M TO INSTALL SOLID OAK CORE DOOR	2012	1,780	119	15	119		297	42
43	L & M TO INSTALL OAK FIRE RATED DOOR	2012	2,260	151	15	151		377	43
44	SECURITY SYSTEMS FOR FRONT & REAR ACCESS	2012	10,776	1,078	10	1,078		2,694	44
45	INSTALL WOOD HANDRAILS & BASE TO MATCH EXISTIN	2012	3,581	239	15	239		597	45
46	CARPET FOR DINING ROOMS	2012	5,677	1,135	5	1,135		2,838	46
47	EMERGENCY REPAIR TO WATER MAIN	2012	4,868	243	20	243		608	47
48	ADD SECURITY CAMERA TO DOCK ENTRANCE & SECURE	2012	3,605	361	10	361		901	48
49	NEW 5 inch CHILLES WATER SUPPLY BUTTERFLY VALVE	2012	5,161	344	15	344		860	49
50	NEW 6 inch FIRE SYSTEM RPZ AND MIXING VALVES	2012	11,600	773	15	773		1,933	50
51	ADD SPRINKLER SYSTEM TO EXTERIOR CANOPY & ELEV	2012	10,656	426	25	426		1,066	51
52	INSTALL 3 MAGNETIC HOLD DEVICES & WIRE TO FIRE SY	2012	5,202	347	15	347		867	52
53	RHC - RNRC FSES - 2011	2012	1,656	110	15	110		276	53
54									54
55	WATER FILTER SYSTEM	2013	280	28	10	28		42	55
56	INSTALLING 100 FOOT LONG CURB CONCRETE RETAININ	2013	6,900	345	20	345		518	56
57	INSTALLATION OF BOILER - BURNHAM BOILER	2013	10,920	546	20	546		819	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,243,242	$ 191,320		$ 191,320	$	$ 2,865,378	70

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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		$ 6,243,242	$ 191,320		$ 191,320	$	$ 2,865,378	1
2	FINISH STAIRWELLS TO CREATE FIRE BARRIER PER IDPI	2014	7,425	248	15	495	247	248	2
3	REMOVING TOP 2 inch OF ASPHALT & PAVING WITH NEW	2014	50,900	3,181	8	6,363	3,182	3,181	3
4	BACK FILLING CONCRETE TRENCH IN THE KITCHEN	2014	2,800	28	50	56	28	28	4
5	MESH ON ALL STAIRWELL RAILINGS	2014	5,143	171	15	343	172	171	5
6	KITCHEN GRADE TILES AND LEVELING WITH GROUT	2014	2,354	78	15	157	79	78	6
7	OVAL GAZEBO 9 FT. WHITE	2014	6,899	172	20	345	173	172	7
8	NEW SIDEWALK AND PATIO FOR NEW GAZEBO	2014	4,500	150	15	300	150	150	8
9	DEMOLISH AND CONSTRUCT WALLS IN RESIDENT RMS	2014	50,400	1,260	20	2,520	1,260	1,260	9
10	REPAIRS TO DAMAGED ELECTRICAL LINES ON 2ND FLR	2014	3,647	91	20	182	91	91	10
11	NEW PLANT MATERIAL AROUND NEW GAZEBO	2014	7,000	350	10	700	350	350	11
12	DEMOLISH AND CONSTRUCT WALLS IN RESIDENT RMS	2014	177	4	20	9	5	4	12
13	65 inch CAST IRON SEWER LINES IN KITCHEN & EJECTOR	2014	35,665	446	40	892	446	446	13
14	REPAIRS TO DRYWALL AND PILLARS IN ACTIVITY ROOM	2014	4,472	56	40	112	56	56	14
15	DEMOLISH AND CONSTRUCT WALLS IN RESIDENT RMS	2014	2,496	62	20	125	63	62	15
16									16
17	DEDUCTIONS FOR NON-CARE ASSETS			(134,496)		(134,496)			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)		$ 6,427,120	$ 63,121		$ 69,422	$ 6,301	$ 2,871,675	34

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	$ 1,787,358	$ 88,619	$ 88,620	$ 1	11	$ 1,290,966	71
72	Current Year Purchases	161,406	4,688	9,376	4,688	13	4,688	72
73	Fully Depreciated Assets	325,625	15,781	15,781		6	325,625	73
74	Home Office Allocation		41,743	23,652	(18,091)			74
75	TOTALS	$ 2,274,389	$ 150,831	$ 137,429	$ (13,402)		$ 1,621,279	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,611,771	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 213,952	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 206,851	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,101)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,492,954	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 BENEDICT N & R # 0044784 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				18,795			5
6								6
7	TOTAL				$ 18,795 **			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: $ 11,819 Description: Administration $10690, Home Office $1129
    (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 BENEDICT N & R # 0044784 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 BENEDICT N & R # 0044784 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units		Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3		hrs	$	9,452	$	561,478	$	9,452	$ 561,478	1
2	Licensed Speech and Language Development Therapist	10a,3	20	hrs	813	2,189		133,960		2,209	134,773	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10a,3		hrs		10,205		606,174		10,205	606,174	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					681,337		681,337	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				$ 813	21,846	$	1,301,612	$ 681,337	21,866	$ 1,983,762	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 BENEDICT N & R # 0044784 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	$ 635,371	$	1
2	Cash-Patient Deposits	11,107		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,438,701		3
4	Supply Inventory (priced at)	22,956		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)**	$ 3,108,135	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,910,262		13
14	Buildings, at Historical Cost	5,992,321		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,709,189		16
17	Accumulated Depreciation (book methods)	(4,492,956)		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)**	$ 7,118,816	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,226,951	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 353,634	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	648,067		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	(16,011,653)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (15,009,952)	$	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)**	$ (15,009,952)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 25,236,903	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,226,951	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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**	$ 23,513,191	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 23,513,191	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,705,313	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	18,399	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)**	$ 1,723,712	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)**	$ 25,236,903	24	*

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	$ 8,079,234	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,079,234	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,866,923	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,866,923	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	(15,778)	13
14	Non-Patient Meals	11,103	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	866,347	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,127	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	15,044	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 916,843	23
	D. Non-Operating Revenue		
24	Contributions	2,293	24
25	Interest and Other Investment Income***	6,754	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,047	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Misc Income	44,894	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,894	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,916,941	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,996,327	31
32	Health Care	4,680,018	32
33	General Administration	2,188,353	33
	B. Capital Expense		
34	Ownership	463,699	34
	C. Ancillary Expense		
35	Special Cost Centers	681,337	35
36	Provider Participation Fee	201,894	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,211,628	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,705,313	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,705,313	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 938,260	44
45	Private Pay - Net Inpatient Revenue	4,046,782	45
46	Medicare - Net Inpatient Revenue	2,533,903	46
47	Other-(specify) Insurance	560,289	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,079,234	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 BENEDICT N & R # 0044784 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	1,405	1,702	$ 74,944	$ 44.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,402	36,632	1,329,735	36.30	3
4	Licensed Practical Nurses	7,211	8,100	211,920	26.16	4
5	CNAs & Orderlies	67,045	74,471	1,025,382	13.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,810	2,107	59,851	28.41	9
10	Activity Assistants	6,398	7,182	91,744	12.77	10
11	Social Service Workers	11,855	13,422	199,640	14.87	11
12	Dietician	119	278	9,179	33.02	12
13	Food Service Supervisor	130	291	8,822	30.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,688	4,900	58,209	11.88	15
16	Dishwashers					16
17	Maintenance Workers	4,682	5,371	129,674	24.14	17
18	Housekeepers	14,342	16,382	208,952	12.75	18
19	Laundry	9,310	10,330	113,941	11.03	19
20	Administrator	1,807	2,086	104,795	50.24	20
21	Assistant Administrator					21
22	Other Administrative	4,941	5,263	66,284	12.59	22
23	Office Manager	775	833	15,107	18.14	23
24	Clerical	1,783	2,124	51,443	24.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	120	120	18,504	154.20	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	1,810	2,073	61,725	29.78	32
33	Other(specify) Pastoral Care	1,503	1,589	37,365	23.51	33
34	TOTAL (lines 1 - 33)	172,136	195,256	$ 3,877,216 *	$ 19.86	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	40	2,200	12,2	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	$ 2,200		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 BENEDICT N & R # 0044784 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bernie Ladra	Administrator		$ 104,795
Admnistrative Staff	Office Manager		15,107
Admnistrative Staff	Department Heads		7,380
Admnistrative Staff	Receptionists		58,904
Admnistrative Staff	Medical Director		
Admnistrative Staff	Admissions		61,725
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 247,911

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 696,881
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 696,881

C. Professional Services

Vendor/Payee	Type	Amount
Cielo - recruiter	Various	$ 13,250
Joint Commission		7,108
Illinois State Police		1,192
HR Plus		1,515
Illinois Business Comm		1,246
Survey & Analytical Tools		894
Outsourced Services		3,079
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 28,284

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,941
Unemployment Compensation Insurance	9,553
FICA Taxes	281,502
Employee Health Insurance	495,587
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation/Non Care Adjustment	(10,423)
Dental	11,729
Life Insurance	2,720
Disability Insurance	25,487
Pension	185,928
Tuition Reimbursement	11,508
Other Benefits	3,929
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,081,461

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 28)	
Patient Background Checks 275	
Dues & Subscription	10,192
Advertising & Public Relations	1,338
Home Office Allocation	6,342
Less: Public Relations Expense	( )
Non-allowable advertising	(1,338)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	26
Seminar Expense	674
Home Office Allocation	1,609
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,309

**See instructions.

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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 BENEDICT N & R # 0044784 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 $9600**

(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? **13 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,911** 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. $ **201,894**
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. $ **11,103**

(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.