FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0041731

Facility Name: PRESENCE ST ANNE CENTER

Address: 4405 HIGHCREST ROAD (Number) ROCKFORD (City) 61107 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-229-1999 **Fax #** 815-229-1560

HFS ID Number:

Date of Initial License for Current Owners: 10/06/86

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: GEORGE VIEU **Telephone Number:** 708-478-7943
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	21,535	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	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	12,613	6,727	21,265	40,605	8
9	SNF/PED					9
10	ICF	6,213	3,313		9,526	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,826	10,040	21,265	50,131	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.73%

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 10/06/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/06/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 14,792

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 ANNE CENTER # 0041731 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	125,538	49,603	616,739	791,880		791,880		791,880			1
2	Food Purchase		454,405		454,405		454,405	974	455,379			2
3	Housekeeping	113,758	15,244		129,002		129,002		129,002			3
4	Laundry	7,007	28,202	138,746	173,955		173,955		173,955			4
5	Heat and Other Utilities			323,214	323,214		323,214	4,060	327,274			5
6	Maintenance	157,567	44,674	82,231	284,472		284,472	59,790	344,262			6
7	Other (specify):* Pastoral Care	53,944	1,182	12,261	67,387		67,387		67,387			7
8	**TOTAL General Services**	457,814	593,310	1,173,191	2,224,315		2,224,315	64,824	2,289,139			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	4,219,522	420,959	15,401	4,655,882		4,655,882	(25,436)	4,630,446			10
10a	Therapy			1,914,698	1,914,698		1,914,698		1,914,698			10a
11	Activities	111,673	4,138	8,672	124,483		124,483	660	125,143			11
12	Social Services	106,648		569	107,217		107,217		107,217			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,437,843	425,097	1,960,340	6,823,280		6,823,280	(24,776)	6,798,504			16
	C. General Administration											
17	Administrative	559,626	22,972	1,101,562	1,684,160		1,684,160	(208,142)	1,476,018			17
18	Directors Fees											18
19	Professional Services			17,154	17,154		17,154	29,936	47,090			19
20	Dues, Fees, Subscriptions & Promotions			36,758	36,758		36,758	1,619	38,377			20
21	Clerical & General Office Expenses			23,677	23,677		23,677	(2,263)	21,414			21
22	Employee Benefits & Payroll Taxes			1,459,894	1,459,894		1,459,894	189,013	1,648,907			22
23	Inservice Training & Education							412	412			23
24	Travel and Seminar			9,769	9,769		9,769	2,620	12,389			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			393,386	393,386		393,386	(389)	392,997			26
27	Other (specify):*											27
28	**TOTAL General Administration**	559,626	22,972	3,042,200	3,624,798		3,624,798	12,806	3,637,604			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,455,283	1,041,379	6,175,731	12,672,393		12,672,393	52,854	12,725,247			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 ANNE CENTER #0041731 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			568,435	568,435		568,435	(160,961)	407,474			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			290,541	290,541		290,541	159,438	449,979			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							71,360	71,360			34
35	Rent-Equipment & Vehicles			154,994	154,994		154,994	1,839	156,833			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,013,970	1,013,970		1,013,970	71,676	1,085,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,678,704	1,678,704		1,678,704	(783,644)	895,060			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops							(97,532)	(97,532)			41
42	Provider Participation Fee			312,451	312,451		312,451		312,451			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,991,155	1,991,155		1,991,155	(881,176)	1,109,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,455,283	1,041,379	9,180,856	15,677,518		15,677,518	(756,646)	14,920,872			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 ANNE CENTER # 0041731 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	(97,532)	41		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	34,544	30		9
10	Interest and Other Investment Income	(53,238)	32		10
11	Discounts, Allowances, Rebates & Refunds	(783,644)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(924)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,712)	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	(29,457)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (938,963)		$	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))**	$ (938,963)		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 ANNE CENTER

ID# 0041731

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (4,021)	21	1
2	Radiology and Xray	(25,436)	10	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(29,457)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST ANNE CENTER **#** 0041731 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	974	0	0	0	0	0	0	0	0	0	974	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,060	0	0	0	0	0	0	0	0	0	4,060	5
6	Maintenance	0	1,171	58,619	0	0	0	0	0	0	0	0	59,790	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	6,205	58,619	0	0	0	0	0	0	0	0	64,824	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	(25,436)	0	0	0	0	0	0	0	0	0	0	(25,436)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	660	0	0	0	0	0	0	0	0	0	660	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(25,436)	660	0	0	0	0	0	0	0	0	0	(24,776)	16
	C. General Administration													
17	Administrative	0	(23,136)	(185,006)	0	0	0	0	0	0	0	0	(208,142)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	29,936	0	0	0	0	0	0	0	0	0	29,936	19
20	Fees, Subscriptions & Promotions	(8,712)	10,331	0	0	0	0	0	0	0	0	0	1,619	20
21	Clerical & General Office Expenses	(4,945)	2,682	0	0	0	0	0	0	0	0	0	(2,263)	21
22	Employee Benefits & Payroll Taxes	0	56,171	132,842	0	0	0	0	0	0	0	0	189,013	22
23	Inservice Training & Education	0	412	0	0	0	0	0	0	0	0	0	412	23
24	Travel and Seminar	0	2,620	0	0	0	0	0	0	0	0	0	2,620	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	(389)	0	0	0	0	0	0	0	0	0	(389)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,657)	78,627	(52,164)	0	0	0	0	0	0	0	0	12,806	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,093)	85,492	6,455	0	0	0	0	0	0	0	0	52,854	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	34,544	0	(195,505)	0	0	0	0	0	0	0	0	(160,961)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(53,238)	0	212,676	0	0	0	0	0	0	0	0	159,438	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	71,360	0	0	0	0	0	0	0	0	71,360	34
35	Rent-Equipment & Vehicles	0	0	1,839	0	0	0	0	0	0	0	0	1,839	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(18,694)	0	90,370	0	0	0	0	0	0	0	0	71,676	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	(783,644)	0	0	0	0	0	0	0	0	0	0	(783,644)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(97,532)	0	0	0	0	0	0	0	0	0	0	(97,532)	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	(881,176)	0	0	0	0	0	0	0	0	0	0	(881,176)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(938,963)	85,492	96,825	0	0	0	0	0	0	0	0	(756,646)	45

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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%	$ 974	$ 974	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,060	4,060	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,171	1,171	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	660	660	4
5	V	17	Admin - Misc. Other	326,322	Presence Life Connections	100.00%	15,992	(310,330)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	287,194	287,194	6
7	V	19	Professional Services		Presence Life Connections	100.00%	29,936	29,936	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	10,331	10,331	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	2,682	2,682	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	56,171	56,171	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	412	412	11
12	V	24	Travel		Presence Life Connections	100.00%	2,620	2,620	12
13	V	26	Insurance		Presence Life Connections	100.00%	(389)	(389)	13
14	Total			$ 326,322			$ 411,814	$ * 85,492	14

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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%	$ (43,356)	$ (43,356)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	30,613	30,613	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,839	1,839	18
19	V	17	Admin Salaries		Presence Health	100.00%	162,784	162,784	19
20	V	22	Employee Benefits		Presence Health	100.00%	132,842	132,842	20
21	V	30	Depreciation	214,014	Presence Health	100.00%	61,865	(152,149)	21
22	V	34	Rent Facility		Presence Health	100.00%	40,747	40,747	22
23	V	17	Admin Consulting,Other	775,240	Presence Health	100.00%	72,110	(703,130)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	48,785	48,785	24
25	V	17	Information Systems - Other		Presence Health	100.00%	191,601	191,601	25
26	V	17	Admin Salaries		Presence Health	100.00%	45,775	45,775	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	68,726	68,726	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	58,619	58,619	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	453	453	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	212,676	212,676	30
31	V	39	Ancillary Services - Other	1,678,704	Presence Senior Services Pharmacy	100.00%	1,678,704		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,667,958			$ 2,764,783	$ * 96,825	39

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 ANNE CENTER # 0041731 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 ANNE CENTER # 0041731 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	$	326,322	$ 974	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		326,322	4,060	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		326,322	1,171	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		326,322	660	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		326,322	15,992	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	326,322	287,194	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		326,322	29,936	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		326,322	10,331	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		326,322	2,682	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		326,322	56,171	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		326,322	412	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		326,322	2,620	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		326,322	(389)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		326,322	(43,356)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		326,322	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		326,322	30,613	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		326,322	1,839	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,130	$ 4,162,833		$ 400,910	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	5,067,405	17	$ 1,375,283	$ 1,375,283	775,240	$ 210,398	1
2	22	Employee Benefits	Operating Expense	5,067,405	17	834,149		775,240	127,613	2
3	30	Depreciation	Operating Expense	1,479,052	17	803,889		214,014	116,320	3
4	34	Rent Facility	Operating Expense	5,067,405	17	244,378		775,240	37,386	4
5	17	Admin Consulting,Other	Operating Expense	5,067,405	17	5,074,164		775,240	776,274	5
6	17	Information Systems Salaries	Operating Expense	5,067,405	17	487,675	487,675	775,240	74,607	6
7	17	Information Systems - Other	Operating Expense	5,067,405	17	1,742,443		775,240	266,569	7
8	17	Admin Salaries	Direct Cost	5,067,405	17	403,064	403,064	775,240	61,663	8
9	17	Information Systems Salaries	Direct Cost	5,067,405	17	555,758	555,758	775,240	85,023	9
10	6	Information Systems - Equip Mai	Direct Cost	5,067,405	17	292,852		775,240	44,802	10
11	17	Admin Consulting,Other	Direct Cost	5,067,405	17	237,106		775,240	36,274	11
12	32	Admin - Interest Expense	Direct Cost	5,067,405	17	1,193,207		775,240	182,543	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					$ 13,243,968	$ 2,821,780		$ 2,019,472	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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: 670 North Convent Street
City / State / Zip Code: Bourbonnais, IL 60914
Phone Number: (815936-3644
Fax Number: (815-936-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,678,704	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,678,704	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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						$	$			$ 182,543	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 182,543	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 182,543	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 ANNE CENTER **#** 0041731 **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 ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

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 ANNE CENTER # 0041731 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

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

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

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

1. Total Amount Incurred: 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		1984	$ 639,976	1
2					2
3	TOTALS			$ 639,976	3

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	120		1986	1986	$ 3,516,907	$ 10,360	63	$ 10,360	$	$ 2,852,023	4
5	59		1993	1993	2,722,251	17,417	56	17,417		1,869,313	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	34,784	1,122	31	1,122		27,491	9
10	VARIOUS			1994	5,000		10			5,000	10
11	VARIOUS			1995	40,225	1,271	18	1,271		32,174	11
12	VARIOUS			1996	28,449		12			28,449	12
13	VARIOUS			1997	20,255		5			20,255	13
14	VARIOUS			1998	23,000		5			23,000	14
15	VARIOUS			1999	6,269		5			6,269	15
16	VARIOUS			2000	23,160		5			23,160	16
17	VARIOUS			2001	279,756	6,328	6	6,328		238,624	17
18	VARIOUS			2002	13,716	456	10	456		12,692	18
19	VARIOUS			2003	26,366		9			26,366	19
20	VARIOUS			2004	38,378	1,551	8	1,551		37,718	20
21	VARIOUS			2005	26,107	1,866	9	1,866		24,369	21
22	VARIOUS			2006	95,650	6,801	12	6,801		67,549	22
23	VARIOUS			2007	171,521	14,791	12	14,791		122,267	23
24	VARIOUS			2008	168,183	16,055	12	16,055		105,758	24
25	VARIOUS			2009	39,927	4,504	11	4,504		24,773	25
26	VARIOUS			2010	83,355	7,570	10	7,570		34,066	26
27											27
28	WATER HEATER SOUTH BASEMENT			2011	5,512	551	10	551		1,929	28
29	ROOFTOP CONDENSING UNIT			2011	32,862	2,191	15	2,191		7,668	29
30	PTAC UNITS QTY 10			2011	5,835	583	10	583		2,042	30
31	NEW BATHROOM			2011	3,989	199	20	199		698	31
32	NEW SPRINKLER HEADS			2011	2,940	588	5	588		2,058	32
33	AIR HANDLER SOUTH BASEMENT			2011	19,000	950	20	950		3,325	33
34	TILE FOR ADMIN OFFICE			2011	13,853	1,385	10	1,385		4,849	34
35	PARKING LOT			2011	25,885	3,236	8	3,236		11,325	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 ANNE CENTER # 0041731 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	BRANCH LINES&32 SPRINKLER HEADS. REP	2012	$ 60,212	$ 2,409	25	$ 2,409	$	$ 6,021	37
38	CARPET IN SOUTHWEST F-WING & UNIT #5	2012	2,935	587	5	587		1,468	38
39	HVAC WORK FOR LIBRARY & SOUTH UNIT	2012	14,642	2,928	5	2,928		6,901	39
40									40
41	WATER HEATER	2013	16,087	1,609	10	1,609		2,413	41
42	FURNACE	2013	4,746	316	15	316		475	42
43	GENERATOR	2013	34,537	6,907	5	6,907		10,040	43
44	STEAM TABLE	2013	4,411	441	10	441		662	44
45	NEW FIRE SPRINKLER IN OFFICE AR	2013	8,574	343	25	343		514	45
46	STERLING 100,000 BTU - 100 DUCT FURN	2013	2,578	258	10	258		387	46
47	NEW FLOORING	2013	326,360	32,636	10	32,636		48,954	47
48	INTEGRATED ANTENNAS & LED TVS LOUNGE	2013	10,737	2,147	5	2,147		2,982	48
49	NEW WALLPAPER, FRAMING DRYWALL, R	2013	22,000	2,200	10	2,200		3,300	49
50	WEST LOUNGE ROOF TOP HVAC	2013	6,081	608	10	608		912	50
51	CANOPY	2013	73,700	4,913	15	4,913		7,370	51
52	CANOPY FIRE SPRINKLER	2013	3,980	159	25	159		239	52
53	WALL PAINT FOR F-HALL	2013	853	171	5	171		256	53
54	DESK TOP WATER PANEL	2013	2,788	558	5	558		654	54
55									55
56									56
57	ROOF	2014	260,500	13,025	10	26,050	13,025	13,025	57
58	INSTALLATION OF FIRESTOP SYSTEMS THROUGH BLDG	2014	5,540	277	10	554	277	277	58
59	SEAL COAT AND PATCH PARKING LOT	2014	49,995	3,571	7	7,142	3,571	3,571	59
60	OUTER DOOR ALARM	2014	2,740	137	10	274	137	137	60
61	KITCHEN DINING ROOM DOORS	2014	2,570	51	25	103	52	51	61
62	WATER SOFTENER	2014	12,000	600	10	1,200	600	600	62
63	TILE AND HARDWARE IN BATHROOMS - ST PAUL UNIT	2014	31,000	775	20	1,550	775	775	63
64	WATER HEATER	2014	7,750	388	10	775	387	388	64
65	LIGHTING &FIXTURES FOR COMMON AREA/HALLWAYS	2014	14,020	467	15	935	468	467	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,454,471	$ 178,256		$ 197,548	$ 19,292	$ 5,728,049	70

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 1,593,699	$ 147,539	$ 147,530	$ (9)	11	$ 796,043	71
72	Current Year Purchases	184,500	10,767	21,534	10,767	9	10,767	72
73	Fully Depreciated Assets	596,846	13,365	13,365		6	596,846	73
74	Home Offic Allocation		18,509	18,509				74
75	TOTALS	$ 2,375,045	$ 190,180	$ 200,938	$ 10,758		$ 1,403,656	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	PLANT ENGINEERING	MINI VAN	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOV	1999	23,172				3	23,172	77
78	PLANT ENGINEERING	FORD F-250	2014	35,951	4,494	8,988	4,494	3	4,494	78
79								4		79
80	TOTALS			$ 102,623	$ 4,494	$ 8,988	$ 4,494		$ 71,166	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)	$ 11,572,115	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 372,930	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 407,474	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,544	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,202,871	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 ANNE CENTER # 0041731 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				30,613			5
6								6
7	TOTAL				$ 30,613 **			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: $ 156,833 Description: Administration $15996, Nursing $136694, Plant $2304, Home Office $1839
    (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 ANNE CENTER # 0041731 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	13,652	$ 811,759	$	13,652	$ 811,759	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,456	89,168		1,456	89,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		17,070	1,013,771		17,070	1,013,771	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,3	# of prescrpts				1,678,704		1,678,704	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			$	32,178	$ 1,914,698	$ 1,678,704	32,178	$ 3,593,402	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 ANNE CENTER # 0041731 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	$ 17,950,359	$	1
2	Cash-Patient Deposits	72,337		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	19,407,606		3
4	Supply Inventory (priced at)	1,093,010		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,333,260		7
8	Accounts Receivable (owners or related parties)	164,572		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 40,021,144	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,430,526		12
13	Land	4,046,124		13
14	Buildings, at Historical Cost	102,077,391		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,435,524		16
17	Accumulated Depreciation (book methods)	(71,565,717)		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):	178,882		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 71,602,730	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 111,623,874	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,937,682	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,520,349		28
29	Short-Term Notes Payable	80,363		29
30	Accrued Salaries Payable	3,587,416		30
31	Accrued Taxes Payable (excluding real estate taxes)	165,802		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,802,942		32
33	Accrued Interest Payable	6,892		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	20,821,819		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 36,923,265	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	813,772		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	246,530		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44	Deferred Lease Payable	33,828		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,532,874	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 38,456,139	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 73,167,735	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 111,623,874	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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**	$ 74,695,879	1	
2	Restatements (describe):		2	
3			3	
4	**Adj to reconcile consolidated equity & consolidated income**	(2,486,051)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 72,209,828	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	679,433	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	389,214	11	
12	Expenditures for Specific Purposes	(110,740)	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)**	$ 957,907	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)**	$ 73,167,735	24	*

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 9,872,904	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,872,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,853,973	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,853,973	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	4,483	13
14	Non-Patient Meals	97,532	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,570,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	25,436	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,697,989	23
	D. Non-Operating Revenue		
24	Contributions	50,586	24
25	Interest and Other Investment Income***	53,238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 103,824	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	783,644	28
28a	Other Misc Income	44,617	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 828,261	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,356,951	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,224,315	31
32	Health Care	6,823,280	32
33	General Administration	3,624,798	33
	B. Capital Expense		
34	Ownership	1,013,970	34
	C. Ancillary Expense		
35	Special Cost Centers	1,678,704	35
36	Provider Participation Fee	312,451	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,677,518	40
41	**Income before Income Taxes (line 30 minus line 40)****	679,433	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 679,433	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,785,151	44
45	Private Pay - Net Inpatient Revenue	2,020,049	45
46	Medicare - Net Inpatient Revenue	3,462,057	46
47	Other-(specify) Insurance	1,605,648	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,872,905	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 ANNE CENTER # 0041731 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	1,901	2,084	$ 96,717	$ 46.41	1
2	Assistant Director of Nursing	1,909	2,086	64,332	30.84	2
3	Registered Nurses	52,994	57,937	1,615,703	27.89	3
4	Licensed Practical Nurses	36,085	40,502	1,019,462	25.17	4
5	CNAs & Orderlies	90,103	99,930	1,245,905	12.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,821	8,523	107,173	12.57	8
9	Activity Director	1,872	2,086	34,548	16.56	9
10	Activity Assistants	6,169	6,541	77,373	11.83	10
11	Social Service Workers	5,554	6,100	107,591	17.64	11
12	Dietician	649	836	17,790	21.28	12
13	Food Service Supervisor	353	383	8,176	21.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,426	10,738	111,116	10.35	15
16	Dishwashers					16
17	Maintenance Workers	8,945	10,172	158,691	15.60	17
18	Housekeepers	10,335	11,107	112,681	10.15	18
19	Laundry	811	819	7,003	8.55	19
20	Administrator	1,764	2,086	129,281	61.98	20
21	Assistant Administrator	1,769	2,086	62,718	30.07	21
22	Other Administrative	7,294	8,221	138,270	16.82	22
23	Office Manager	1,834	2,091	48,252	23.08	23
24	Clerical	2,573	3,302	53,612	16.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	227	241	3,832	15.90	31
32	Other Health C: Admissions	5,678	6,219	181,105	29.12	32
33	Other(specify) Pastoral Care	2,319	2,516	53,952	21.44	33
34	TOTAL (lines 1 - 33)	258,385	286,606	$ 5,455,283 *	$ 19.03	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	89	$ 5,438	1.3	35
36	Medical Director	Monthly	21,000	9,3	36
37	Medical Records Consultant	33	2,322	10,3	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	48	2,592	11,3	44
45	Social Service Consultant	9	569	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	179	$ 31,921		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 ANNE CENTER # 0041731 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Administrator		$ 129,281
Admnistrative Staff	Office Manager		48,252
Betty Hillier	Asst Administrator		66,912
Admnistrative Staff	Receptionists		58,129
Admnistrative Staff	Human Resource		34,144
Admnistrative Staff	Admin Assistant		41,803
	Admissions		181,105
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 559,626

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,101,562
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,101,562
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 402
Survey & Analytical Tools	Various	2,970
Shredding	Various	2,536
Security	Various	9,288
Collection Fee	Various	335
Outsourced Services	Various	326
Beautician	Various	1,297
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 17,154

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,473
Unemployment Compensation Insurance	15,535
FICA Taxes	395,139
Employee Health Insurance	720,623
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	189,013
Dental	17,201
Life Insurance	3,974
Disability Insurance	36,693
Pension	140,119
Tuition Reimbursement	16,893
Other Benefits	24,244
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,648,907

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 49)	
Patient Background Checks 440	
Employee Recruitment	13,875
Dues & Subscription	13,570
Advertising & Public Relations	9,313
Home Office Allocation	10,331
Less: Public Relations Expense	( )
Non-allowable advertising	(8,712)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,377

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,731
Seminar Expense	1,038
Home Office Allocation	2,620
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,389

**See instructions.

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 ANNE CENTER # 0041731 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 $9148**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,266** 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. $ **312,451**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **97,532**

(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.