		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: 0041871

Facility Name: PRESENCE ST JOSEPH CENTER

Address: 659 E JEFFERSON ST (Number) FREEPORT (City) 61032 (Zip Code)

County: STEPHENSON

Telephone Number: 815-232-6181 **Fax #** 815-232-6143

HFS ID Number:

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[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 JOSEPH CENTER # 0041871 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	130	Skilled (SNF)	124	46,508	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	124	46,508	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,062	10,347	7,623	37,032	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,062	10,347	7,623	37,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.63%

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 07/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 4,813

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 JOSEPH CENTER # 0041871 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	97,874	15,735	516,080	629,689		629,689		629,689			1
2	Food Purchase		250,001		250,001		250,001	(49,313)	200,688			2
3	Housekeeping	110,826	22,488		133,314		133,314		133,314			3
4	Laundry		4,170	117,144	121,314		121,314		121,314			4
5	Heat and Other Utilities			228,424	228,424		228,424	2,270	230,694			5
6	Maintenance	129,085	27,059	88,638	244,782		244,782	33,400	278,182			6
7	Other (specify):* Pastoral Care	50,334	1,633	1,100	53,067		53,067		53,067			7
8	TOTAL General Services	388,119	321,086	951,386	1,660,591		1,660,591	(13,643)	1,646,948			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,413,153	170,879	23,098	2,607,130		2,607,130		2,607,130			10
10a	Therapy			548,629	548,629		548,629		548,629			10a
11	Activities	67,467	1,093	4,676	73,236		73,236	369	73,605			11
12	Social Services	44,329		399	44,728		44,728		44,728			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,524,949	171,972	589,802	3,286,723		3,286,723	369	3,287,092			16
	C. General Administration											
17	Administrative	305,303	10,136	615,480	930,919		930,919	(116,283)	814,636			17
18	Directors Fees											18
19	Professional Services			12,825	12,825		12,825	16,734	29,559			19
20	Dues, Fees, Subscriptions & Promotions			28,274	28,274		28,274	5,153	33,427			20
21	Clerical & General Office Expenses			28,946	28,946		28,946	(19,733)	9,213			21
22	Employee Benefits & Payroll Taxes			993,887	993,887		993,887	105,608	1,099,495			22
23	Inservice Training & Education							230	230			23
24	Travel and Seminar			2,526	2,526		2,526	1,465	3,991			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			220,998	220,998		220,998	(217)	220,781			26
27	Other (specify):*											27
28	TOTAL General Administration	305,303	10,136	1,902,936	2,218,375		2,218,375	(7,043)	2,211,332			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,218,371	503,194	3,444,124	7,165,689		7,165,689	(20,317)	7,145,372			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 JOSEPH CENTER #0041871 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			559,194	559,194		559,194	(144,012)	415,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,408	162,408		162,408	81,667	244,075			32
33	Real Estate Taxes			120,660	120,660		120,660		120,660			33
34	Rent-Facility & Grounds							39,874	39,874			34
35	Rent-Equipment & Vehicles			8,565	8,565		8,565	1,028	9,593			35
36	Other (specify):*											36
37	TOTAL Ownership			850,827	850,827		850,827	(21,443)	829,384			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			619,384	619,384		619,384	(343,343)	276,041			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			259,795	259,795		259,795		259,795			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			879,179	879,179		879,179	(343,343)	535,836			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,218,371	503,194	5,174,130	8,895,695		8,895,695	(385,103)	8,510,592			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 JOSEPH CENTER # 0041871 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	(49,857)	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				8
9	Non-Straightline Depreciation	14,064	30		9
10	Interest and Other Investment Income	(37,140)	32		10
11	Discounts, Allowances, Rebates & Refunds	(343,343)	39		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	(18,006)	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	(622)	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	(21,232)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (456,136)		$	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))**	$ (456,136)		37

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

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

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

STATE OF ILLINOIS

PRESENCE ST JOSEPH CENTER

ID# 0041871

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (21,232)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(21,232)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(49,857)	544	0	0	0	0	0	0	0	0	0	(49,313)	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	2,270	0	0	0	0	0	0	0	0	0	2,270	5
6	Maintenance	0	654	32,746	0	0	0	0	0	0	0	0	33,400	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(49,857)	3,468	32,746	0	0	0	0	0	0	0	0	(13,643)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	369	0	0	0	0	0	0	0	0	0	369	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**	0	369	0	0	0	0	0	0	0	0	0	369	16
	C. General Administration													
17	Administrative	0	(12,933)	(103,350)	0	0	0	0	0	0	0	0	(116,283)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,734	0	0	0	0	0	0	0	0	0	16,734	19
20	Fees, Subscriptions & Promotions	(622)	5,775	0	0	0	0	0	0	0	0	0	5,153	20
21	Clerical & General Office Expenses	(21,232)	1,499	0	0	0	0	0	0	0	0	0	(19,733)	21
22	Employee Benefits & Payroll Taxes	0	31,399	74,209	0	0	0	0	0	0	0	0	105,608	22
23	Inservice Training & Education	0	230	0	0	0	0	0	0	0	0	0	230	23
24	Travel and Seminar	0	1,465	0	0	0	0	0	0	0	0	0	1,465	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	(217)	0	0	0	0	0	0	0	0	0	(217)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,854)	43,952	(29,141)	0	0	0	0	0	0	0	0	(7,043)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,711)	47,789	3,605	0	0	0	0	0	0	0	0	(20,317)	29

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	(3,942)	0	(140,070)	0	0	0	0	0	0	0	0	(144,012)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,140)	0	118,807	0	0	0	0	0	0	0	0	81,667	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	39,874	0	0	0	0	0	0	0	0	39,874	34
35	Rent-Equipment & Vehicles	0	0	1,028	0	0	0	0	0	0	0	0	1,028	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(41,082)	0	19,639	0	0	0	0	0	0	0	0	(21,443)	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	(343,343)	0	0	0	0	0	0	0	0	0	0	(343,343)	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**	(343,343)	0	0	0	0	0	0	0	0	0	0	(343,343)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(456,136)	47,789	23,244	0	0	0	0	0	0	0	0	(385,103)	45

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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%	$ 544	$ 544	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,270	2,270	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	654	654	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	369	369	4
5	V	17	Admin - Misc. Other	182,408	Presence Life Connections	100.00%	8,939	(173,469)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	160,536	160,536	6
7	V	19	Professional Services		Presence Life Connections	100.00%	16,734	16,734	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	5,775	5,775	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,499	1,499	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	31,399	31,399	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	230	230	11
12	V	24	Travel		Presence Life Connections	100.00%	1,465	1,465	12
13	V	26	Insurance		Presence Life Connections	100.00%	(217)	(217)	13
14	Total			$ 182,408			$ 230,197	$ * 47,789	14

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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%	$ (24,235)	$ (24,235)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	17,112	17,112	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,028	1,028	18
19	V	17	Admin Salaries		Presence Health	100.00%	90,936	90,936	19
20	V	22	Employee Benefits		Presence Health	100.00%	74,209	74,209	20
21	V	30	Depreciation	162,935	Presence Health	100.00%	47,100	(115,835)	21
22	V	34	Rent Facility		Presence Health	100.00%	22,762	22,762	22
23	V	17	Admin Consulting,Other	433,072	Presence Health	100.00%	40,283	(392,789)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	27,253	27,253	24
25	V	17	Information Systems - Other		Presence Health	100.00%	107,034	107,034	25
26	V	17	Admin Salaries		Presence Health	100.00%	25,571	25,571	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	38,392	38,392	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	32,746	32,746	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	253	253	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	118,807	118,807	30
31	V	39	Ancillary Services - Other	619,384	Presence Senior Services Pharmacy	100.00%	619,384		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,215,391			$ 1,238,635	$ * 23,244	39

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 Ad	Freeport	Adult Day Care	6
7	Joseph G. Hugar	BOD	Presence St Andrew Life Center	Niles	Presence Heritage Day	Kankakee	Adult Day Care	7
8	John Larson	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9	Sr. Marie Mason	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral H	Broadview	Parent	9
10	Sallie Miller	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Phyllis Nichols	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Lawrence R. Pankau	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Tim Phillippe	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14	Thomas E. Smith	BOD			Presence Ambulatory	Various	Parent	14
15					Resurrection Developn	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 Pl	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Esta	Kankakee	Independent Living	30

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 JOSEPH CENTER # 0041871 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	$	182,408	$ 544	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		182,408	2,270	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		182,408	654	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		182,408	369	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		182,408	8,939	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	182,408	160,536	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		182,408	16,734	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		182,408	5,775	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		182,408	1,499	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		182,408	31,399	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		182,408	230	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		182,408	1,465	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		182,408	(217)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		182,408	(24,235)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		182,408	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		182,408	17,112	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		182,408	1,028	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,130	$ 4,162,833		$ 224,102	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 [ ]

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: ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

	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	433,072	$ 117,535	1
2	22	Employee Benefits	Operating Expense	5,067,405	17	834,149		433,072	71,288	2
3	30	Depreciation	Operating Expense	1,479,052	17	803,889		162,935	88,558	3
4	34	Rent Facility	Operating Expense	5,067,405	17	244,378		433,072	20,885	4
5	17	Admin Consulting,Other	Operating Expense	5,067,405	17	5,074,164		433,072	433,650	5
6	17	Information Systems Salaries	Operating Expense	5,067,405	17	487,675	487,675	433,072	41,678	6
7	17	Information Systems - Other	Operating Expense	5,067,405	17	1,742,443		433,072	148,913	7
8	17	Admin Salaries	Direct Cost	5,067,405	17	403,064	403,064	433,072	34,447	8
9	17	Information Systems Salaries	Direct Cost	5,067,405	17	555,758	555,758	433,072	47,496	9
10	6	Information Systems - Equip Mai	Direct Cost	5,067,405	17	292,852		433,072	25,028	10
11	17	Admin Consulting,Other	Direct Cost	5,067,405	17	237,106		433,072	20,264	11
12	32	Admin - Interest Expense	Direct Cost	5,067,405	17	1,193,207		433,072	101,974	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		$ 1,151,716	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 [ ]

Name of Related Organization: Presence Senior Services Pharmacy
Street Address: 670 North Convent Street
City / State / Zip Code: Bourbonnais, IL 60914
Phone Number: (815-936-3644
Fax Number: (815-936-3238

B. Show the allocation of costs below. If necessary, please attach worksheets.

	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			$	$		$ 619,384	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					$	$		$ 619,384	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Home Office Allocation						$	$			$ 101,974	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 101,974	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 101,974	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 JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description		Amount	Line
1	1. Real Estate Tax accrual used on 2013 report.	$		1
2	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	3. Under or (over) accrual (line 2 minus line 1).	$		3
4	4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,660	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	120,660	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
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 JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT George Vieu

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

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	To be Determined		$ 120,660.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 120,660.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? __________ YES __________ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,080 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		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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		1996	1996	$ 2,500,000	$ 36,938	53	$ 36,938	$	$ 1,130,688	4
5	10		2013	2013	3,002,792	77,291	35	77,291		115,937	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698	2,227	13	2,227		68,677	11
12	VARIOUS			2001	19,599	262	10	262		17,894	12
13	VARIOUS			2002	28,187	722	13	722		25,771	13
14	VARIOUS			2003	77,509	1,405	11	1,405		73,567	14
15	VARIOUS			2004	16,330	370	10	370		15,826	15
16	VARIOUS			2005	93,561	6,651	12	6,651		65,590	16
17	VARIOUS			2006	34,761	2,093	10	2,093		26,416	17
18	VARIOUS			2007	154,464	11,454	12	11,454		90,670	18
19	VARIOUS			2008	219,347	18,468	14	18,468		121,384	19
20	VARIOUS			2009	170,973	14,783	12	14,783		81,709	20
21	VARIOUS			2010	111,369	12,690	10	12,690		57,104	21
22											22
23	FIRE CODE SAFETY DOORS SYSTEM			2011	4,214	281	15	281		983	23
24	FIRE ALARM & SMOKE DETECTOR WIRING			2011	13,175	1,318	10	1,318		4,611	24
25	SECURITY SYSTEM			2011	6,350	635	10	635		2,222	25
26	CARPET			2011	5,303	1,061	5	1,061		3,712	26
27	PAINTING			2011	3,174	635	5	635		2,222	27
28	CLF - 4 FIRE DOORS			2011	7,260	484	15	484		1,694	28
29	COVER TO EDGE OF THIRD STORY			2011	4,268	427	10	427		1,494	29
30	B WING COMPRESSOR			2011	4,976	332	15	332		829	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 JOSEPH CENTER # 0041871 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	CLF - INSTALL NEW VINYL PLANKING FLO	2013	$ 3,478	$ 348	10	$ 348	$	$ 522	37
38	"A" WING COMPRESSOR	2013	2,754	230	12	230		344	38
39	DESIGN & BUILD TABERNACLE FOR CHAPEL	2013	4,599	307	15	307		459	39
40	LANDSCAPPING	2013	1,499	150	10	150		225	40
41	ARCHITECTURAL SERVICES 12 ROOM RENO	2013	422,752	10,159	40	10,159		15,441	41
42	CLF - FLOORING	2013	149,568	14,957	10	14,957		22,435	42
43	LIGHTING & 16 PORT DKT INTERFACE	2013	3,297	330	10	330		495	43
44	NEW STONE & ASPHALT	2013	25,973	3,247	8	3,247		4,870	44
45	ROLLER SHADES	2013	2,051	410	5	410		615	45
46	WANDER SYSTEM FOR DINING ROOM	2013	4,240	424	10	424		636	46
47	WALL MOUNT DISPENSER DOUBLE ROLL	2013	1,029	147	7	147		221	47
48	CEILING TILES FOR OCEANVIEW	2013	2,846	285	10	285		427	48
49	ADD CELL PHONE CAPABILITY	2013	2,972	297	10	297		446	49
50	DOOR ENTRANCE & STORM	2013	6,855	457	15	457		686	50
51	FIRE DOORS	2013	2,828	141	20	141		212	51
52	FIRE ALARM SYSTEM MODIFICATION	2013	2,735	109	25	109		164	52
53	PARKING LOT SEALED & GRINDING JOINTS	2013	9,350	4,675	2	4,675		7,013	53
54									54
55	CLF - FLOORING IN DINING AREA & KITC	2014	22,170	2,217	5	4,434	2,217	2,217	55
56	DESIGN, BUILD & INSTALL HIGH ALTAR F	2014	3,774	126	15	252	126	126	56
57	NEW BOILER	2014	22,230	556	20	1,112	556	556	57
58	COMPRESSOR FOR CARRIER CONDENSING UN	2014	5,090	212	12	424	212	212	58
59	GENERATOR	2014	4,700	196	12	392	196	196	59
60	TUCKPOINTING ADC & CHAPEL	2014	9,700	69	70	139	70	69	60
61	PARKING LOT	2014	9,750	975	5	1,950	975	975	61
62	NORTH ROOF OF ONEILL HALL	2014	11,850	593	10	1,185	592	593	62
63	NEW LAYER OF ASPHALT FOR PARKING LOT	2014	9,251	578	8	1,156	578	578	63
64	ROOFTOP HEATING/AC UNIT	2014	3,746	54	35	107	53	54	64
65	WALK IN TUB FOR CLF	2014	10,337	258	20	517	259	258	65
66	DEDUCTION FOR NON-CARE ASSETS	2014	(22,170)	(2,217)	-5	(4,434)	(2,217)	(2,217)	66
67	DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(484)	-15	(484)		(1,694)	67
68	DEDUCTION FOR NON-CARE ASSETS	2013	(3,478)	(348)	-10	(348)		(522)	68
69	DEDUCTION FOR NON-CARE ASSETS	2013	(149,568)	(14,957)	-10	(14,957)		(22,435)	69
70	TOTAL (lines 4 thru 69)		$ 7,140,013	$ 215,028		$ 218,645	$ 3,617	$ 1,947,932	70

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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	$ 1,351,699	$ 126,277	$ 126,271	$ (6)	11	$ 704,805	71
72	Current Year Purchases	124,517	7,182	14,364	7,182	10	7,182	72
73	Fully Depreciated Assets	632,621	5,918	5,918		6	632,621	73
74	Home Office Allocation		22,865	22,865				74
75	TOTALS	$ 2,108,837	$ 162,242	$ 169,418	$ 7,176		$ 1,344,608	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	TOTAL			$ 229,693	$ 20,577	$ 20,577	$		$ 184,958	76
77	8SEE VEHICLE ATTACHMENT				3,271	6,542	3,271			77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 229,693	$ 23,848	$ 27,119	$ 3,271		$ 184,958	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)	$ 10,878,543	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 401,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,182	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,064	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,477,498	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.

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5
76	PLANT ENGINEERING	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$ 0
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123	0
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275	0
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649	0
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155	6,019
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232	14,558
79C	PLANT ENGINEERING	2014 BUICK ENCORE 4WD	2014	26,169	3,271
80	TOTALS			$ 229,693	$ 23,848

Straight Line Depreciation 6	Adjustments 7	Life in Years 8	Accumulated Depreciation 9	
$ 0	$ 0	5	$ 24,090	76
0	0	3	23,123	77
0	0	4	34,275	78
0	0	4	15,649	79
6,019	0	4	48,155	79
14,558	0	4	36,395	79
6,542	3,271	4	3,271	
$ 20,577	$ 0		$ 184,958	80

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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				17,112			5
6								6
7	TOTAL				$ 17,112 **			7

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	$

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: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 9,593 Description: Administration $7020, Nursing $1545, Home Office $1028
    (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 JOSEPH CENTER # 0041871 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	3,944	$ 234,483	$	3,944	$ 234,483	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		586	35,922		586	35,922	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		4,685	278,224		4,685	278,224	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				619,384		619,384	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			$	9,215	$ 548,629	$ 619,384	9,215	$ 1,168,013	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 JOSEPH CENTER # 0041871 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.)

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	(1,125,884)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,569,995	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(680,734)	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)**	$ (402,260)	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 JOSEPH CENTER # 0041871 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	$ 6,098,781	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,098,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	727,815	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 727,815	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	1,085	13
14	Non-Patient Meals	49,857	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	918,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 969,586	23
	D. Non-Operating Revenue		
24	Contributions	36,352	24
25	Interest and Other Investment Income***	37,140	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,492	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Purchase Rebates	343,343	28
28a	Other Misc Income	1,944	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 345,287	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,214,961	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,660,591	31
32	Health Care	3,286,723	32
33	General Administration	2,218,375	33
	B. Capital Expense		
34	Ownership	850,827	34
	C. Ancillary Expense		
35	Special Cost Centers	619,384	35
36	Provider Participation Fee	259,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,895,695	40
41	**Income before Income Taxes (line 30 minus line 40)****	(680,734)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (680,734)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,621,644	44
45	Private Pay - Net Inpatient Revenue	1,955,727	45
46	Medicare - Net Inpatient Revenue	962,618	46
47	Other-(specify) Insurance	558,793	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,098,782	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 JOSEPH CENTER # 0041871 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,086	$ 78,385	$ 37.58	1
2	Assistant Director of Nursing	1,845	2,082	67,311	32.33	2
3	Registered Nurses	18,692	19,866	517,555	26.05	3
4	Licensed Practical Nurses	28,181	30,762	687,835	22.36	4
5	CNAs & Orderlies	71,771	79,406	914,922	11.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,442	3,949	55,343	14.01	8
9	Activity Director	1,095	1,282	19,134	14.93	9
10	Activity Assistants	4,063	4,390	47,849	10.90	10
11	Social Service Workers	3,050	3,299	43,481	13.18	11
12	Dietician	48	73	1,887	25.85	12
13	Food Service Supervisor	577	785	17,712	22.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,928	9,273	88,904	9.59	15
16	Dishwashers					16
17	Maintenance Workers	7,976	8,902	130,566	14.67	17
18	Housekeepers	10,862	11,893	110,534	9.29	18
19	Laundry					19
20	Administrator	1,799	2,086	86,196	41.32	20
21	Assistant Administrator					21
22	Other Administrative	6,037	6,686	95,009	14.21	22
23	Office Manager	1,849	2,086	40,085	19.22	23
24	Clerical	5,725	6,431	80,818	12.57	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					31
32	Other Health C: Admissions	3,889	4,374	84,013	19.21	32
33	Other(specify) Pastoral Care	1,936	2,087	50,832	24.36	33
34	TOTAL (lines 1 - 33)	182,645	201,798	$ 3,218,371 *	$ 15.95	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	32	$ 2,436	1,3	35
36	Medical Director	Monthly	13,000	9,3	36
37	Medical Records Consultant	33	2,361	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	3	187	11,3	44
45	Social Service Consultant	6	382	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	74	$ 18,366		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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 JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 86,196
Admnistrative Staff	Bookkeeper		
Admnistrative Staff	Human Resource		46,448
Admnistrative Staff	Receptionist		48,561
Admnistrative Staff	Office Manager		40,085
Admnistrative Staff	Admin Assistant		
	Admissions		84,013
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 305,303

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 615,480
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 615,480

C. Professional Services

Vendor/Payee	Type	Amount
Legal		$ 7,125
Survey & Analytical Tools		2,970
Shredding/Storage		835
Living Design		734
Outsourced Services		1,071
Collection Fee		90
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 12,825

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,224
Unemployment Compensation Insurance	10,857
FICA Taxes	232,129
Employee Health Insurance	516,027
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	105,608
Dental	12,339
Life Insurance	2,851
Disability Insurance	26,885
Pension	104,314
Tuition Reimbursement	12,119
Other Benefits	12,142
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,099,495

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 22)	
Patient Background Checks 329	
Employee Recruitement	11,389
Dues & Subscription	16,181
Advertising & Public Relations	704
Home Office Allocation	5,775
Less: Public Relations Expense	( )
Non-allowable advertising	(622)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,427

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,926
Seminar Expense	600
Home Office Allocation	1,465
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,991

**See instructions.

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		$		$	$	$	$	$	$	$	$	$

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 $5982**

(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. $ **28,713** 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. $ **259,795**
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. $ **49,857**

(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 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.