FOR BHF USE

LL1

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: 0044792

Facility Name: PRESENCE VILLA SCALABRNI N&R

Address: 480 NORTH WOLF ROAD (Number) NORTHLAKE (City) 60164 (Zip Code)

County: COOK

Telephone Number: 708-562-0040 **Fax #** 708-562-5180

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
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 VILLA SCALABRNI N&R # 0044792 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	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,345	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	28,077	8,027	17,039	53,143	8
9	SNF/PED					9
10	ICF	13,464	7,395		20,859	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,541	15,422	17,039	74,002	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.14%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 14,361

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 VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	60,863	145,910	894,740	1,101,513		1,101,513		1,101,513			1
2	Food Purchase		526,531		526,531		526,531	(8,611)	517,920			2
3	Housekeeping	286,729	109,047	1,476	397,252		397,252		397,252			3
4	Laundry	165,280	87,891	4,501	257,672		257,672	(37,709)	219,963			4
5	Heat and Other Utilities			454,959	454,959		454,959	4,722	459,681			5
6	Maintenance	181,612	28,252	536,772	746,636		746,636	1,362	747,998			6
7	Other (specify):* Pastoral Care	159,096	11,523	231	170,850		170,850		170,850			7
8	TOTAL General Services	853,580	909,154	1,892,679	3,655,413		3,655,413	(40,236)	3,615,177			8
	B. Health Care and Programs											
9	Medical Director			82,700	82,700		82,700		82,700			9
10	Nursing and Medical Records	6,054,932	266,529	163,577	6,485,038		6,485,038		6,485,038			10
10a	Therapy	1,345	16,502	2,179,965	2,197,812		2,197,812		2,197,812			10a
11	Activities	176,378	33,024	4,689	214,091		214,091	767	214,858			11
12	Social Services	152,277	507	233	153,017		153,017		153,017			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,384,932	316,562	2,431,164	9,132,658		9,132,658	767	9,133,425			16
	C. General Administration											
17	Administrative	431,691	22,611	1,326,346	1,780,648		1,780,648	666,315	2,446,963			17
18	Directors Fees											18
19	Professional Services			42,005	42,005		42,005	34,818	76,823			19
20	Dues, Fees, Subscriptions & Promotions			22,215	22,215		22,215	7,750	29,965			20
21	Clerical & General Office Expenses			6,794	6,794		6,794	3,120	9,914			21
22	Employee Benefits & Payroll Taxes			2,100,428	2,100,428		2,100,428	65,331	2,165,759			22
23	Inservice Training & Education							479	479			23
24	Travel and Seminar			3,928	3,928		3,928	3,048	6,976			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,058	100,058		100,058	(452)	99,606			26
27	Other (specify):*											27
28	TOTAL General Administration	431,691	22,611	3,601,774	4,056,076		4,056,076	780,409	4,836,485			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,670,203	1,248,327	7,925,617	16,844,147		16,844,147	740,940	17,585,087			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 VILLA SCALABRNI N&R #0044792 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			642,612	642,612		642,612	(29,401)	613,211			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,829	133,829		133,829	(49,446)	84,383			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							35,606	35,606			34
35	Rent-Equipment & Vehicles			116,882	116,882		116,882	2,139	119,021			35
36	Other (specify):*											36
37	TOTAL Ownership			893,323	893,323		893,323	(41,102)	852,221			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,855,498		1,855,498		1,855,498		1,855,498			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			504,982	504,982		504,982		504,982			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,855,498	504,982	2,360,480		2,360,480		2,360,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,670,203	3,103,825	9,323,922	20,097,950		20,097,950	699,838	20,797,788			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 VILLA SCALABRNI N&R # 0044792 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	(9,743)	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	(37,709)	4		8
9	Non-Straightline Depreciation	41,960	30		9
10	Interest and Other Investment Income	(49,446)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,266)	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
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,204)		$	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))**	$ (59,204)		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 VILLA SCALABRNI N&R

ID# 0044792

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 **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	(9,743)	1,132	0	0	0	0	0	0	0	0	0	(8,611)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(37,709)	0	0	0	0	0	0	0	0	0	0	(37,709)	4
5	Heat and Other Utilities	0	4,722	0	0	0	0	0	0	0	0	0	4,722	5
6	Maintenance	0	1,362	0	0	0	0	0	0	0	0	0	1,362	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(47,452)	7,216	0	0	0	0	0	0	0	0	0	(40,236)	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	767	0	0	0	0	0	0	0	0	0	767	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	767	0	0	0	0	0	0	0	0	0	767	16
	C. General Administration													
17	Administrative	0	(26,909)	693,224	0	0	0	0	0	0	0	0	666,315	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	34,818	0	0	0	0	0	0	0	0	0	34,818	19
20	Fees, Subscriptions & Promotions	(4,266)	12,016	0	0	0	0	0	0	0	0	0	7,750	20
21	Clerical & General Office Expenses	0	3,120	0	0	0	0	0	0	0	0	0	3,120	21
22	Employee Benefits & Payroll Taxes	0	65,331	0	0	0	0	0	0	0	0	0	65,331	22
23	Inservice Training & Education	0	479	0	0	0	0	0	0	0	0	0	479	23
24	Travel and Seminar	0	3,048	0	0	0	0	0	0	0	0	0	3,048	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	(452)	0	0	0	0	0	0	0	0	0	(452)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,266)	91,451	693,224	0	0	0	0	0	0	0	0	780,409	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,718)	99,434	693,224	0	0	0	0	0	0	0	0	740,940	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 **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	41,960	0	(71,361)	0	0	0	0	0	0	0	0	(29,401)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,446)	0	0	0	0	0	0	0	0	0	0	(49,446)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	35,606	0	0	0	0	0	0	0	0	35,606	34
35	Rent-Equipment & Vehicles	0	0	2,139	0	0	0	0	0	0	0	0	2,139	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,486)	0	(33,616)	0	0	0	0	0	0	0	0	(41,102)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(59,204)	99,434	659,608	0	0	0	0	0	0	0	0	699,838	45

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 1,132	$ 1,132	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,722	4,722	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,362	1,362	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	767	767	4
5	V	17	Admin - Misc. Other	379,538	Presence Life Connections	100.00%	18,600	(360,938)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	334,029	334,029	6
7	V	19	Professional Services		Presence Life Connections	100.00%	34,818	34,818	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	12,016	12,016	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,120	3,120	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	65,331	65,331	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	479	479	11
12	V	24	Travel		Presence Life Connections	100.00%	3,048	3,048	12
13	V	26	Insurance				(452)	(452)	13
14	Total			$ 379,538			$ 478,972	$ * 99,434	14

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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%	$ (50,427)	$ (50,427)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	35,606	35,606	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	2,139	2,139	18
19	V	17	Admin Salaries		Presence Health	100.00%	276,813	276,813	19
20	V	30	Depreciation	106,150	Presence Health	100.00%	85,216	(20,934)	20
21	V	17	Admin Consulting,Other	946,808	Presence Health	100.00%	1,363,219	416,411	21
22	V	39	Ancillary Services - Other	1,855,498	Presence Senior Services Pharmacy	100.00%	1,855,498		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,908,456			$ 3,568,064	$ * 659,608	39

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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 VILLA SCALABRNI N&R # 0044792 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 VILLA SCALABRNI N&R # 0044792 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	$	379,538	$ 1,132	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		379,538	4,722	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		379,538	1,362	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		379,538	767	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		379,538	18,600	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	379,538	334,029	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		379,538	34,818	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		379,538	12,016	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		379,538	3,120	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		379,538	65,331	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		379,538	479	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		379,538	3,048	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		379,538	(452)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		379,538	(50,427)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		379,538	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		379,538	35,606	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		379,538	2,139	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,130	$ 4,162,833		$ 466,290	25

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Presence Health
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (815-806-2327
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	5,276,287	8	$ 1,542,600	$ 1,542,600	946,808	$ 276,813	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		106,150	115,883	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		946,808	972,492	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,566,137	$ 1,542,600		$ 1,365,188	25

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Presence Senior Services Pharmacy
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847-410-4900
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,855,498	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					$	$		$ 1,855,498	25

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NA **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R **#** 0044792 **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 VILLA SCALABRNI N&R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044792

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 VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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 [ ] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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	253		2000		$ 7,510,695	$ 153,120	24	$ 153,120	$	$ 3,618,891	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2001	22,045		10			22,045	9
10	VARIOUS			2002	7,030	180	15	180		6,536	10
11	VARIOUS			2003	60,584	1,323	10	1,323		56,614	11
12	VARIOUS			2004	104,281	1,867	14	1,867		88,729	12
13	VARIOUS			2005	125,857	8,201	10	8,201		108,431	13
14	VARIOUS			2006	2,030,638	95,537	16	95,537		919,539	14
15	VARIOUS			2007	114,355	5,997	17	5,997		51,558	15
16	VARIOUS			2008	112,297	6,246	15	6,246		51,800	16
17	VARIOUS			2009	232,410	15,092	9	15,092		178,395	17
18	VARIOUS			2010	117,737	13,279	10	13,279		63,251	18
19											19
20	NEW SIDE ENTRY TUB FOR UNIT			2011	15,577	1,558	10	1,558		6,349	20
21	NEW HEAT EXCHANGER IN BOILER ROOM - INSTALL 6 inch BYP			2011	7,115	356	20	356		1,423	21
22	ADDITIONAL WORK NEEDED - NEW HEAT EXCHANGER IN BOIL			2011	8,136	407	20	407		1,627	22
23	ADD SPRINKLERS TO COMMON AREA RESTROOMS @ BUILDING			2011	2,500	100	25	100		400	23
24	EMEGENCY REPAIRS IN KITCHEN PLUMBING AREA			2011	3,085	154	20	154		617	24
25	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS			2011	2,400	240	10	240		960	25
26	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS			2011	6,550	655	10	655		2,620	26
27	REPAIR DOORS INSTALL NEW HARDWARE & NEW CLOSER FOR			2011	5,380	538	10	538		2,152	27
28	INSTALL MAGNETIC DOOR HOLDERS ON MULTIPLE DOORS			2011	15,250	1,525	10	1,525		6,100	28
29	INSTALL FIRE PUMPS ALARM SIGNAL			2011	7,265	727	10	727		2,906	29
30	NEW FLOOR IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT			2011	9,483	948	10	948		2,845	30
31	NEW FLOOR IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT			2011	4,832	483	10	483		1,449	31
32	NEW FLOOR IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT			2011	10,670	1,067	10	1,067		3,201	32
33	NEW FLOOR IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT			2011	10,643	1,064	10	1,064		3,193	33
34	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIANCE			2011	19,580	783	25	783		2,350	34
35	ARCHITECTURAL SERVICE FOR LOWER LEVEL PT ROOMS			2011	23,445	1,563	15	1,563		4,689	35
36	REMOVE TILE & BASEBOARD IN HALLWAY & CLEAN UP										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 VILLA SCALABRNI N&R # 0044792 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	REMOVE TILE & BASEBOARD IN HALLWAY & CLEAN UP	2011	$ 9,500	$ 633	15	$ 633	$	$ 1,900	37
38	INSTALL DRYWALL FOR NEW WALLS & PAINT WALLS &	2011	14,500	967	15	967		2,900	38
39	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIAN	2011	19,581	1,305	15	1,305		3,916	39
40	OPTION # 1 - BOILER REPAIR NEW BURNER & INNER DOO	2011	16,450	1,097	15	1,097		3,290	40
41	INSTALLED 4 NEW CONDENSER FAN MOTOS BLADES & RA	2011	4,901	327	15	327		980	41
42	EM ICE MACHINE REPAIR	2011	2,360	472	5	472		1,416	42
43	INTERIOR OF 4 ELEVATORS	2011	15,772	1,577	10	1,577		4,732	43
44	INSTALL FLOORING IN COMMON AREAS HALLS WITH VI	2011	24,012	2,401	10	2,401		7,204	44
45	ADDITIONAL FLOOR PREP FOR HALLWAY FLOOR PROJE	2011	5,377	538	10	538		1,613	45
46	EMERGENCY REPAIRS OF HEATING SYSTEM	2011	2,265	227	10	227		680	46
47	EMERGENCY REPAIR OF FIRE ALRAM SYSTEM	2011	2,642	264	10	264		793	47
48									48
49	NEW FLOOR FINISHING IN UNITS C & G	2012	2,751	550	5	550		1,376	49
50	# 3 BOILER REPAIRS - INSTALL BURNER HEAD & BURNER	2012	9,475	948	10	948		2,369	50
51	INSTALLED CONDENSING UNIT-ADDED LINE DRIER & SU	2012	2,265	151	15	151		378	51
52	SIGMA SPECTRUM NON-WIRELESS PUMP	2012	12,800	1,280	10	1,280		3,200	52
53	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	30,000	2,000	15	2,000		5,000	53
54	PHYSICAL THERAPY ROOM PERMITS & FEES	2012	8,500	567	15	567		1,417	54
55	6 MECHO V MANUAL SHADES IN HALLWAY BY STATUES	2012	2,621	262	10	262		655	55
56	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	45,000	3,000	15	3,000		7,500	56
57	ARCHITECTURAL SERVICE FOR LOWER LEVEL PT ROOM	2012	5,471	365	15	365		912	57
58	WINDOW TREATMENTS & CUBICLE CURTAINS FOR NEW	2012	18,740	1,874	10	1,874		4,685	58
59	INSTALLATION OF 80 GALLON ELECTRICAL WATER HEA	2012	6,500	650	10	650		1,625	59
60	INSTALLATION OF 9 STANDARD DROPS & RELOCATE 3 EX	2012	6,675	445	15	445		1,112	60
61	NEW SPRINKLER SYSTEM THERAPY ROOM	2012	7,500	300	25	300		750	61
62	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	24,283	1,619	15	1,619		4,047	62
63	TRI W G MOTORIZED BARIATRIC HI-LO MAT TABLE - CO	2012	9,095	606	15	606		1,516	63
64	TRI W-G 6 MOTORIZED BAIATRIC HI-LO PARALLEL BARS	2012	12,185	812	15	812		2,031	64
65	TOTAL BODY CYCLE	2012	4,262	284	15	284		710	65
66	UNWEIGHTING SYSTEM	2012	7,150	477	15	477		1,192	66
67	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE & EXTRA	2012	1,595	106	15	106		266	67
68	LANDICE REHABILITATION TREADMILL	2012	5,290	353	15	353		882	68
69	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE & EXTRA	2012	518	35	15	35		86	69
70	TOTAL (lines 4 thru 69)		$ 10,929,876	$ 339,502		$ 339,502	$	$ 5,279,803	70

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,929,876	$ 339,502		$ 339,502	$	$ 5,279,803	1
2	2 MOTOR CONTROL PANELS & CIRCUIT BREAKER PANEL	2012	17,200	1,147	15	1,147		2,867	2
3	NEW KITCHEN FLOORING - PORTION/DISHWASHING SOU	2012	31,500	1,575	20	1,575		3,938	3
4	SPRINKLER INSTALLATION PROJECT	2012	30,000	1,200	25	1,200		3,000	4
5	CONSTRUCTION OF PHYSICAL THERAPY ROOM	2012	28,078	1,872	15	1,872		4,680	5
6	KITCHEN PANEL BOARD	2012	3,165	211	15	211		528	6
7	NEW FLOORING FOR PT ROOM & SURROUNDING HALLW	2012	1,545	155	10	155		386	7
8									8
9	SPRINKLER INSTALLATION PROJECT	2013	57,000	2,280	25	2,280		3,420	9
10	SPRINKLER INSTALLATION PROJECT	2013	166,239	6,650	25	6,650		9,974	10
11	8 RESIDENT ROOM FLOORING, FURNITURE & LIGHTING,	2013	25,932	1,729	15	1,729		2,593	11
12	INSTALLATION OF DOORS IN CONFERENCE ROOM, G SOU	2013	9,180	612	15	612		918	12
13	SPRINKLER INSTALLATION PROJECT	2013	77,699	3,108	25	3,108		4,662	13
14	SPRINKLER INSTALLATION PROJECT	2013	100,000	4,000	25	4,000		6,000	14
15	SPRINKLER INSTALLATION PROJECT	2013	75,000	3,000	25	3,000		4,500	15
16	L & M TO REMOVE OLD CARPET AND INSTALL NEW FLOO	2013	16,800	1,680	10	1,680		2,520	16
17	A-BUILDING A/C COMPRESSOR	2013	10,785	719	15	719		1,079	17
18	60 RUSKIN FIRE DAMPERS CEILING MOUNT	2013	14,100	940	15	940		1,410	18
19	SPRINKLER INSTALLATION PROJECT - FINAL PAYMENT	2013	262,193	10,488	25	10,488		15,732	19
20	RELOCATE NURSE CALL SYSTEM PULL BOX & REWIRE T	2013	4,300	430	10	430		645	20
21	RELOCATION OF NURSE CALL LIGHT DUE TO INSTALL O	2013	7,604	760	10	760		1,141	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,196	$ 382,058		$ 382,058	$	$ 5,349,796	34

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,868,196	$ 382,058		$ 382,058	$	$ 5,349,796	1
2	NEEDED TO CONCEAL SPRINKLER PIPING ADDED DROP C	2014	10,550	352	15	703	351	352	2
3	FURNISH & INSTALL 4 DOOR RESTRICTORS	2014	5,960	298	10	596	298	298	3
4	CONVERSIONS OF QUAD UNITS INTO 15 PRIVATE ROOMS	2014	101,261	3,375	15	6,751	3,376	3,375	4
5	NEEDED TO CONCEAL SPRINKLER PIPING ADDED DROP C	2014	3,100	155	10	310	155	155	5
6	OPEN & CLOSE HOLES IN HALLWAY CEILING / PAINT HA	2014	5,950	595	5	1,190	595	595	6
7	POWER UNIT TANK PUMP & MOTOR FOR ELEVATOR	2014	8,450	282	15	563	281	282	7
8	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	100,000	3,333	15	6,667	3,334	3,333	8
9	INSTALL NEW FLOOR IN WALK IN FREEZER	2014	9,050	453	10	905	452	453	9
10	OPTION # 2 - NEW PIPING FROM FEED WATER	2014	3,355	67	25	134	67	67	10
11	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	36,500	1,217	15	2,433	1,216	1,217	11
12	SIDEWALK ADDED FROM THERAPY ROOM TO DRIVEWAY	2014	8,000	267	15	533	266	267	12
13	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	3,500	117	15	233	116	117	13
14	33 NEW SMOKE DETECTORS, 4 PULL STATIONS 1 BEAM DI	2014	5,762	288	10	576	288	288	14
15	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	120,000	4,000	15	8,000	4,000	4,000	15
16	DOORS IN SEVERAL AREAS - 21 TOTAL	2014	17,175	573	15	1,145	572	573	16
17	ARCHITECTURAL SERVICE	2014	46,000	1,533	15	3,067	1,534	1,533	17
18	INSTALLATION OF REMOTE GENERATOR ANNUNCIATOR	2014	3,880	194	10	388	194	194	18
19	NURSE CALL AUDIBLE-VISUAL SYSTEM	2014	21,200	1,060	10	2,120	1,060	1,060	19
20	TRANSFER SWITCH FOR THE EMERGENCY GENERATOR	2014	15,720	524	15	1,048	524	524	20
21	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	150,000	5,000	15	10,000	5,000	5,000	21
22	NEWCOMPRESSOR ON THE MCQUAY CHILLER	2014	10,573	352	15	705	353	352	22
23	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	100,000	3,333	15	6,667	3,334	3,333	23
24	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	90,000	2,250	20	4,500	2,250	2,250	24
25	SIDEWALK REPAIRS	2014	2,500	83	15	167	84	83	25
26	EMERGENCY SEWER REPAIRS	2014	27,500	275	50	550	275	275	26
27	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	21,000	525	20	1,050	525	525	27
28	CONVERSION OF QUAD UNITS INTO 15 PRIVATE ROOMS /	2014	17,000	425	20	850	425	425	28
29	CONVERSIONS OF QUAD UNITS INTO 15 PRIVATE ROOMS	2014	67,507	1,688	20	3,375	1,687	1,688	29
30	UNIT C NEW CORNELL NURSE CALL SYSTEM	2014	25,612	1,281	10	2,561	1,280	1,281	30
31	KITCHEN FIRE SUPPRESSION SYSTEM REPAIRED	2014	3,844	96	20	192	96	96	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,909,145	$ 416,049		$ 450,038	$ 33,989	$ 5,383,787	34

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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	$ 3,076,725	$ 95,058	$ 95,058	$	11	$ 2,487,858	71
72	Current Year Purchases	175,534	7,971	15,942	7,971	10	7,971	72
73	Fully Depreciated Assets	516,953	15,348	15,348		7	516,953	73
74	Hone Office Allocation		65,456	65,456				74
75	TOTALS	$ 3,769,212	$ 183,833	$ 191,804	$ 7,971		$ 3,012,782	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENCE CARE	2004 CARGO VAN	2004	$ 20,358	$ 2,036	$ 2,036	$	10	$ 20,358	76
77										77
78										78
79										79
80	TOTALS			$ 20,358	$ 2,036	$ 2,036	$		$ 20,358	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)	$	18,198,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	601,918	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	643,878	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	41,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	8,416,927	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 VILLA SCALABRNI N&R # 0044792 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				35,606			5
6								6
7	TOTAL				$ 35,606 **			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: $ 119,021 Description: Administration $23883, Nursing $84342, Rehab $4907, Plant Eng $164, Dietary $3586, Home Office $ 2139
    (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 VILLA SCALABRNI N&R # 0044792 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	$	15,537	$ 922,917	$	15,537	$ 922,917	1
2	Licensed Speech and Language Development Therapist	10a, 1 & 3	34 hrs	1,345	3,193	195,401		3,227	196,746	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		17,873	1,061,648		17,873	1,061,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				1,855,498		1,855,498	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 1,345	36,603	$ 2,179,966	$ 1,855,498	36,637	$ 4,036,809	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 VILLA SCALABRNI N&R # 0044792 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	$ 1,273,459	$	1
2	Cash-Patient Deposits	32,503		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,734,578		3
4	Supply Inventory (priced at)	25,645		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,066,185	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	9,862,615		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,866,880		16
17	Accumulated Depreciation (book methods)	(8,416,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,812,573	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,878,758	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 830,958	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,215,572		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	(1,608,816)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 437,714	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 437,714	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 15,441,044	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,878,758	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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**	$ 14,948,464	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,948,464	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,048	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	308,532	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 492,580	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)**	$ 15,441,044	24 *

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,892,606	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,892,606	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,742,270	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,742,270	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	72,754	13
14	Non-Patient Meals	9,743	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,391,110	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,360	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	37,709	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,546,676	23
	D. Non-Operating Revenue		
24	Contributions	1,025	24
25	Interest and Other Investment Income***	49,446	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50,471	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Misc Income	49,976	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49,976	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,281,999	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,655,413	31
32	Health Care	9,132,658	32
33	General Administration	4,056,076	33
	B. Capital Expense		
34	Ownership	893,323	34
	C. Ancillary Expense		
35	Special Cost Centers	1,855,498	35
36	Provider Participation Fee	504,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,097,950	40
41	**Income before Income Taxes (line 30 minus line 40)****	184,049	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 184,049	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,548,319	44
45	Private Pay - Net Inpatient Revenue	2,465,208	45
46	Medicare - Net Inpatient Revenue	3,475,692	46
47	Other-(specify)	403,387	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,892,606	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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	1,807	2,086	$ 105,472	$ 50.56	1
2	Assistant Director of Nursing	1,895	2,078	95,763	46.08	2
3	Registered Nurses	87,896	99,162	3,488,852	35.18	3
4	Licensed Practical Nurses	5,033	5,903	166,018	28.12	4
5	CNAs & Orderlies	143,096	158,197	2,154,455	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,919	2,086	46,860	22.46	9
10	Activity Assistants	10,787	11,762	127,062	10.80	10
11	Social Service Workers	6,877	7,733	151,784	19.63	11
12	Dietician	419	615	12,662	20.59	12
13	Food Service Supervisor	215	296	7,967	26.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,480	5,551	64,547	11.63	15
16	Dishwashers					16
17	Maintenance Workers	7,579	8,637	182,912	21.18	17
18	Housekeepers	20,938	23,772	286,003	12.03	18
19	Laundry	11,769	13,627	143,743	10.55	19
20	Administrator	1,789	2,087	130,377	62.47	20
21	Assistant Administrator					21
22	Other Administrative	8,429	9,267	172,687	18.63	22
23	Office Manager	1,935	2,094	42,491	20.29	23
24	Clerical	8,638	9,373	141,820	15.13	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	3,376	3,580	86,136	24.06	32
33	Other(specify) Pastoral Care	2,003	2,171	62,592	28.83	33
34	TOTAL (lines 1 - 33)	329,880	370,077	$ 7,670,203 *	$ 20.73	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	82,700	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,271	11,3	44
45	Social Service Consultant	4	232	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	25	$ 84,203		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 VILLA SCALABRNI N&R # 0044792 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator		$ 130,377
Administrative Staff	Office Manager		42,491
Administrative Staff	Department Heads		44,601
Administrative Staff	Receptionists		74,641
Administrative Staff	Administrative Asst		53,445
Administrative Staff	Admissions		86,136
Administrative Staff			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 431,691

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,326,346
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,326,346

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 1,269
Cielo- recruiter	Various	24,950
Illinois Council on Long Term Care	Various	12,744
IPMG Risk Management	Various	1,200
Outsourced Services	Various	1,842
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 42,005

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 120,814
Unemployment Compensation Insurance	17,869
FICA Taxes	553,924
Employee Health Insurance	943,233
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocatiion	65,331
Dental	22,065
Life Insurance	5,116
Disability Insurance	47,906
Pension	360,493
Tuition Reimbursement	21,630
Other Benefits	7,378
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,165,759

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 42)	
Patient Background Checks 320	
Dues & Subscription	17,949
Advertising & Public Relations	4,266
Home Office Allocation	12,016
Less: Public Relations Expense	( )
Non-allowable advertising	(4,266)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,965

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,509
Seminar Expense	1,419
Home Office Allocation	3,048
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,976

**See instructions.

Facility Name & ID Number PRESENCE VILLA SCALABRNI N&R # 0044792 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 VILLA SCALABRNI N&R # 0044792 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 $16560**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **110,426** 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. $ **504,982**
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. $ **9,743**

(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.