

		FOR BHF USE					

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**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)**

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.

<p>I. IDPH License ID Number: <u>0044768</u></p> <p>Facility Name: <u>PRESENCE MARYHAVEN NSG & REH</u></p> <p>Address: <u>1700 EAST LAKE AVE</u> <u>GLENVIEW</u> <u>60025</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>847-729-1300</u> Fax # <u>847-729-9620</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03-01-00</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>GEORGE VIEU</u> Telephone Number: <u>708-478-7943</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/15</u> to <u>12/31/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	135	Skilled (SNF)	135	49,275	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	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,245	14,525	7,083	39,853	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,245	14,525	7,083	39,853	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.88%

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

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

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 Date 03-01-00 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 135 and days of care provided 5,045

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12-31-15 Fiscal Year: 12-31-15

* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		33,971	474,780	508,751	508,751		508,751			1
2	Food Purchase		266,240		266,240	266,240	(11,948)	254,292			2
3	Housekeeping	162,016	6,879	435	169,330	169,330		169,330			3
4	Laundry	114,645	41,304	100	156,049	156,049	(58,510)	97,539			4
5	Heat and Other Utilities			214,260	214,260	214,260	2,219	216,479			5
6	Maintenance	84,844	22,442	123,536	230,822	230,822	3,531	234,353			6
7	Other (specify):* Pastoral	41,810	870	9,035	51,715	51,715		51,715			7
8	TOTAL General Services	403,315	371,706	822,146	1,597,167	1,597,167	(64,708)	1,532,459			8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500	16,500		16,500			9
10	Nursing and Medical Records	3,336,535	166,963	16,811	3,520,309	3,520,309		3,520,309			10
10a	Therapy	296,728		873,585	1,170,313	1,170,313		1,170,313			10a
11	Activities	121,944	2,457	2,844	127,245	127,245	531	127,776			11
12	Social Services	80,505		365	80,870	80,870		80,870			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,835,712	169,420	910,105	4,915,237	4,915,237	531	4,915,768			16
	C. General Administration										
17	Administrative	253,802	7,880	940,020	1,201,702	1,201,702	176,195	1,377,897			17
18	Directors Fees										18
19	Professional Services			1,331	1,331	1,331	39,878	41,209			19
20	Dues, Fees, Subscriptions & Promotions			41,831	41,831	41,831	(2,447)	39,384			20
21	Clerical & General Office Expenses			(18,894)	(18,894)	(18,894)	3,941	(14,953)			21
22	Employee Benefits & Payroll Taxes			1,213,266	1,213,266	1,213,266	46,292	1,259,558			22
23	Inservice Training & Education						1,110	1,110			23
24	Travel and Seminar						1,342	1,342			24
25	Other Admin. Staff Transportation			882	882	882		882			25
26	Insurance-Prop.Liab.Malpractice			329,305	329,305	329,305	43,338	372,643			26
27	Other (specify):*										27
28	TOTAL General Administration	253,802	7,880	2,507,741	2,769,423	2,769,423	309,649	3,079,072			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,492,829	549,006	4,239,992	9,281,827	9,281,827	245,472	9,527,299			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			455,270	455,270		455,270	(48,761)	406,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,755	93,755		93,755	(306)	93,449			32
33	Real Estate Taxes			587,151	587,151		587,151	(587,151)				33
34	Rent-Facility & Grounds							20,748	20,748			34
35	Rent-Equipment & Vehicles			67,365	67,365		67,365	757	68,122			35
36	Other (specify):*											36
37	TOTAL Ownership			1,203,541	1,203,541		1,203,541	(614,713)	588,828			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			676,028	676,028		676,028		676,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,049	267,049		267,049		267,049			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			943,077	943,077		943,077		943,077			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,492,829	549,006	6,386,610	11,428,445		11,428,445	(369,241)	11,059,204			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,389)	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	(58,510)	4		8
9	Non-Straightline Depreciation	2,292	30		9
10	Interest and Other Investment Income	(306)	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	(2,956)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(587,151)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (660,020)		\$	30

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (660,020)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

PRESENCE MARYHAVEN NSG & REH

ID# 0044768

Report Period Beginning: 1/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2	Real Estate Tax	(587,151)	33	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		(587,151)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,389)	1,441	0	0	0	0	0	0	0	0	0	(11,948)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(58,510)	0	0	0	0	0	0	0	0	0	0	(58,510)	4
5	Heat and Other Utilities	0	2,219	0	0	0	0	0	0	0	0	0	2,219	5
6	Maintenance	0	3,531	0	0	0	0	0	0	0	0	0	3,531	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(71,899)	7,191	0	0	0	0	0	0	0	0	0	(64,708)	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	531	0	0	0	0	0	0	0	0	0	531	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	531	0	0	0	0	0	0	0	0	0	531	16
	C. General Administration													
17	Administrative	0	(109,334)	285,529	0	0	0	0	0	0	0	0	176,195	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	39,878	0	0	0	0	0	0	0	0	0	39,878	19
20	Fees, Subscriptions & Promotions	(2,956)	509	0	0	0	0	0	0	0	0	0	(2,447)	20
21	Clerical & General Office Expenses	0	3,941	0	0	0	0	0	0	0	0	0	3,941	21
22	Employee Benefits & Payroll Taxes	0	46,292	0	0	0	0	0	0	0	0	0	46,292	22
23	Inservice Training & Education	0	1,110	0	0	0	0	0	0	0	0	0	1,110	23
24	Travel and Seminar	0	1,342	0	0	0	0	0	0	0	0	0	1,342	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	43,338	0	0	0	0	0	0	0	0	0	43,338	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,956)	27,076	285,529	0	0	0	0	0	0	0	0	309,649	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(74,855)	34,798	285,529	0	0	0	0	0	0	0	0	245,472	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH# 0044768

Report Period Beginning:

1/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	2,292	0	(51,053)	0	0	0	0	0	0	0	0	(48,761)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(306)	0	0	0	0	0	0	0	0	0	0	(306)	32
33	Real Estate Taxes	(587,151)	0	0	0	0	0	0	0	0	0	0	(587,151)	33
34	Rent-Facility & Grounds	0	0	20,748	0	0	0	0	0	0	0	0	20,748	34
35	Rent-Equipment & Vehicles	0	0	757	0	0	0	0	0	0	0	0	757	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(585,165)	0	(29,548)	0	0	0	0	0	0	0	0	(614,713)	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)	(660,020)	34,798	255,981	0	0	0	0	0	0	0	0	(369,241)	45

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	Chicago	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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 1,441	\$ 1,441	1
2	V	5 Utilities		Presence Life Connections	100.00%	2,219	2,219	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	3,531	3,531	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	531	531	4
5	V	17 Admin - Misc. Other	353,618	Presence Life Connections	100.00%	13,317	(340,301)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	230,967	230,967	6
7	V	19 Professional Services		Presence Life Connections	100.00%	39,878	39,878	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	509	509	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	3,941	3,941	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	46,292	46,292	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	1,110	1,110	11
12	V	24 Travel		Presence Life Connections	100.00%	1,342	1,342	12
13	V	26 Insurance		Presence Life Connections	100.00%	43,338	43,338	13
14	Total		\$ 353,618			\$ 388,416	\$ * 34,798	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 4,148	\$ 4,148
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	20,748	20,748
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	757	757
19	V	17 Admin Salaries		Presence Health	100.00%	137,775	137,775
20	V	22 Employee Benefits		Presence Health	100.00%		
21	V	30 Depreciation	96,114	Presence Health	100.00%	40,913	(55,201)
22	V	34 Rent Facility		Presence Health	100.00%		
23	V	17 Admin Consulting,Other	586,402	Presence Health	100.00%	734,156	147,754
24	V	17 Information Systems Salaries		Presence Health	100.00%		
25	V	17 Information Systems - Other		Presence Health	100.00%		
26	V	17 Admin Salaries		Presence Health	100.00%		
27	V	17 Information Systems Salaries		Presence Health	100.00%		
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%		
29	V	17 Admin Consulting,Other		Presence Health	100.00%		
30	V	32 Admin - Interest Expense		Presence Health	100.00%		
31	V	39 Ancillary Services - Other	676,028	Presence Senior Services Pharmacy	100.00%	676,028	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,358,544			\$ 1,614,525	\$ * 255,981

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

Facility Name & ID Number

PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending:

12/31/15

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 Dowd	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	James Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6	Joseph Hugar	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	John Larson	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8	Sr Marie Mason	BOD			Presence St. Vincent	Freeport	Community Living	8
9	Sallie Miller	BOD			Presence Behavioral H	Broadview	Parent	9
10	Phyllis Nichols	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Lawrence Pankau, MD	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Tim Phillippe	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Thomas Smith	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14					Presence Ambulatory	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 Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Est	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/15 Ending: 12/31/15

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	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 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	NA								\$	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 MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 7,761,581	27	\$ 31,634	\$	353,618	\$ 1,441	1
2	5	Utilities	Management Fee Income 7,761,581	27	48,706		353,618	2,219	2
3	6	Maintenance - Other	Management Fee Income 7,761,581	27	77,498		353,618	3,531	3
4	11	Activities-Special Events	Management Fee Income 7,761,581	27	11,644		353,618	531	4
5	17	Admin - Misc. Other	Management Fee Income 7,761,581	27	292,301		353,618	13,317	5
6	17	Administrative Salaries	Management Fee Income 7,761,581	27	5,069,517	5,069,517	353,618	230,967	6
7	19	Professional Services	Management Fee Income 7,761,581	27	875,274		353,618	39,878	7
8	20	Dues,Subscriptions	Management Fee Income 7,761,581	27	11,166		353,618	509	8
9	21	Clerical Supplies	Management Fee Income 7,761,581	27	86,492		353,618	3,941	9
10	22	Employee Benefits	Management Fee Income 7,761,581	27	1,016,065		353,618	46,292	10
11	23	Education/Conference	Management Fee Income 7,761,581	27	24,366		353,618	1,110	11
12	24	Travel	Management Fee Income 7,761,581	27	29,466		353,618	1,342	12
13	26	Insurance	Management Fee Income 7,761,581	27	951,237		353,618	43,338	13
14	30	Depreciation	Management Fee Income 7,761,581	27	91,051		353,618	4,148	14
15	32	Interest	Management Fee Income 7,761,581	27	0		353,618	0	15
16	34	Rent - Facility	Management Fee Income 7,761,581	27	455,407		353,618	20,748	16
17	35	Rent - Equipment	Management Fee Income 7,761,581	27	16,606		353,618	757	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 9,088,430	\$ 5,069,517		\$ 414,069	25

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	6,565,680	6	\$ 1,542,600	\$ 1,542,600	586,402	\$ 137,775	1
2	22	Employee Benefits	Operating Expense							2
3	30	Depreciation	Operating Expense	1,043,631	6	444,245	96,114	40,913		3
4	34	Rent Facility	Operating Expense							4
5	17	Admin Consulting,Other	Operating Expense	6,565,680	6	8,220,016	586,402	734,156		5
6	17	Information Systems Salaries	Operating Expense							6
7	17	Information Systems - Other	Operating Expense							7
8	17	Admin Salaries	Direct Cost							8
9	17	Information Systems Salaries	Direct Cost							9
10	6	Information Systems - Equip Mai	Direct Cost							10
11	17	Admin Consulting,Other	Direct Cost							11
12	32	Admin - Interest Expense	Direct Cost							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					\$ 10,206,861	\$ 1,542,600		\$ 912,844	25

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 NO

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 ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 676,028	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				\$	\$		\$ 676,028	25

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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.)

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.				
1. Real Estate Tax accrual used on 2014 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 2015 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:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE MARYHAVEN NSG & REH COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044768

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 2014 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 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 83,762 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>83,762</u>	<u>2000</u>	<u>\$ 2,935,798</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>83,762</u>		<u>\$ 2,935,798</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	135	2000	1961	\$ 5,932,922	\$ 120,189	40	\$ 120,189		\$ 2,978,280
5									
6									
7									
8									
Improvement Type**									
9	VARIOUS		2000	126,735		18			126,735
10	VARIOUS		2001	251,673	17,071	15	17,071		234,727
11	VARIOUS		2002	1,434,032	59,516	11	59,516		1,366,013
12	VARIOUS		2003	1,428	98	15	98		1,143
13	VARIOUS		2004	1,760	112	15	112		1,406
14	VARIOUS		2005	61,382	624	9	624		58,188
15	VARIOUS		2006	107,161	2,839	11	2,839		96,212
16	VARIOUS		2007	2,310		8			2,310
17	VARIOUS		2008	73,448	3,532	20	3,532		29,332
18	VARIOUS		2012	44,500	7,497	6	7,497		27,205
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,037,352	\$ 211,477		\$ 211,477	\$	\$ 4,921,552	70

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

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	\$ 2,078,657	\$ 86,764	\$ 86,764	\$	13	\$ 1,495,959	71
72	Current Year Purchases	512,029	41,400	43,692	2,292	14	41,400	72
73	Fully Depreciated Assets	650,643	19,515	19,515		7	650,643	73
74	Home Office Allocation		96,114	96,114				74
75	TOTALS	\$ 3,241,329	\$ 243,793	\$ 246,085	\$ 2,292		\$ 2,188,002	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,214,479	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 455,269	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 457,562	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,292	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,109,554	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.

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				20,748			5
6								6
7	TOTAL				\$ 20,748			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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 NO

16. Rental Amount for movable equipment: \$ 68,122 Description: Administration 25239, Dietary 32, Nursing 42093, Home Office

(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 MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/15 Ending: 12/31/15
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a,3	2808	hrs	\$ 110,692	6,030	\$ 363,932	\$	8,838	\$ 474,624	1
2	Licensed Speech and Language Development Therapist	10a,3	875	hrs	38,797	1,649	104,872		2,524	143,669	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,3	2420	hrs	94,194	5,974	361,870		8,394	456,064	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 prescripts				676,028		676,028	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): DIRECTOR		1413		53,045				1,413	53,045	12
13	Other (specify):										13
14	TOTAL				\$ 296,728	13,653	\$ 830,674	\$ 676,028	21,169	\$ 1,803,430	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 MARYHAVEN NSG & REH**

0044768

Report Period Beginning: **1/01/15**

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/15** (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	\$ 15,116,271	\$	1
2	Cash-Patient Deposits	142,276		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	38,985,402		3
4	Supply Inventory (priced at)	1,405,559		4
5	Short-Term Investments	1,530,325		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,822,954		7
8	Accounts Receivable (owners or related parties)	2,119,287		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 61,122,074	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,185,056		12
13	Land	17,252,477		13
14	Buildings, at Historical Cost	235,676,159		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,751,494		16
17	Accumulated Depreciation (book methods)	(179,552,982)		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):	397,300		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,709,504	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 217,831,578	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 13,801,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,484,204		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,921,984		32
33	Accrued Interest Payable	6,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Due from Third Parties	(1,674,742)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 40,542,848	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,286,073		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Conditional Asset Retirement	99,654		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,385,727	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 41,928,575	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 175,903,003	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 217,831,578	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,885,610	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	171,432,175	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 176,317,785	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(881,234)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,437,836	11
12	Expenditures for Specific Purposes	(971,384)	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)	\$ (414,782)	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)	\$ 175,903,003	24 *

* This must agree with page 17, line 47.

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,280,542	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,280,542	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,184,717	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,184,717	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		13
14	Non-Patient Meals	13,389	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	984,498	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	58,510	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,056,397	23
D. Non-Operating Revenue			
24	Contributions	704	24
25	Interest and Other Investment Income***	306	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,010	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	24,545	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,545	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,547,211	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,597,167	31
32	Health Care	4,915,237	32
33	General Administration	2,769,423	33
B. Capital Expense			
34	Ownership	1,203,541	34
C. Ancillary Expense			
35	Special Cost Centers	676,028	35
36	Provider Participation Fee	267,049	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,428,445	40
41	Income before Income Taxes (line 30 minus line 40)**	(881,234)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (881,234)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,989,958	44
45	Private Pay - Net Inpatient Revenue	2,575,315	45
46	Medicare - Net Inpatient Revenue	1,207,762	46
47	Other-(specify) <u>Insurance</u>	507,507	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,280,542	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 MARYHAVEN NSG & REH**

0044768

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	1,432	1,721	\$ 89,901	\$ 52.24	1
2	Assistant Director of Nursing	1,744	1,938	78,644	40.58	2
3	Registered Nurses	54,030	58,143	1,854,472	31.90	3
4	Licensed Practical Nurses	4,549	5,044	120,192	23.83	4
5	CNAs & Orderlies	90,435	99,389	1,144,138	11.51	5
6	CNA Trainees					6
7	Licensed Therapist	7,129	7,516	296,728	39.48	7
8	Rehab/Therapy Aides	2,520	2,818	36,267	12.87	8
9	Activity Director	1,811	2,088	42,480	20.34	9
10	Activity Assistants	7,191	7,718	79,464	10.30	10
11	Social Service Workers	2,549	3,131	80,505	25.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	14,186	16,322	215,000	13.17	17
18	Housekeepers					18
19	Laundry	8,950	12,163	146,505	12.05	19
20	Administrator	1,867	2,080	84,829	40.78	20
21	Assistant Administrator					21
22	Other Administrative		-	-		22
23	Office Manager	1,996	2,099	41,480	19.76	23
24	Clerical	5,001	5,274	59,461	11.27	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	2,080	2,153	36,641	17.02	31
32	Other Health C: Admissions	1,529	1,706	44,313	25.97	32
33	Other(specify) <u>Pastoral</u>	1,432	1,547	41,809	27.03	33
34	TOTAL (lines 1 - 33)	210,431	232,850	\$ 4,492,829 *	\$ 19.29	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	\$		35	
36	Medical Director	Monthly	16,500	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				44
45	Social Service Consultant	26	1,733	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	26	\$ 18,233		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	970	25,009	10,2	52
53	TOTAL (lines 50 - 52)	970	\$ 25,009		53

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	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 MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/15

Ending:

12/31/15

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. LEADING AGE \$8890.64
- (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? 14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,686 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.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 267,049
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. \$ 13,389
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.