FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0044784

Facility Name: PRESENCE SAINT BENEDICT N&R

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
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 1/01/15 to 12/31/15 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 OF 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 SAINT BENEDICT N&R # 0044784 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,037	18,830	10,574	34,441	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		8,228		8,228	12
13	DD 16 OR LESS					13
14	TOTALS	5,037	27,058	10,574	42,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.33%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 8,760

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

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

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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		28,378	654,650	683,028		683,028		683,028			1
2	Food Purchase		302,353		302,353		302,353	(62,426)	239,927			2
3	Housekeeping	194,786	26,386	2,244	223,416		223,416	(44,683)	178,733			3
4	Laundry	103,693	36,236	9	139,938		139,938	(25,742)	114,196			4
5	Heat and Other Utilities			220,441	220,441		220,441	(41,908)	178,533			5
6	Maintenance	117,248	23,160	142,230	282,638		282,638	(53,060)	229,578			6
7	Other (specify):* PASTORAL	38,331	7,727		46,058		46,058		46,058			7
8	TOTAL General Services	454,058	424,240	1,019,574	1,897,872		1,897,872	(227,819)	1,670,053			8
	B. Health Care and Programs											
9	Medical Director	22,698			22,698		22,698		22,698			9
10	Nursing and Medical Records	2,709,621	119,442	256,608	3,085,671		3,085,671		3,085,671			10
10a	Therapy	314,543		945,374	1,259,917		1,259,917		1,259,917			10a
11	Activities	158,422	13,765	928	173,115		173,115	521	173,636			11
12	Social Services	71,009	2,558		73,567		73,567		73,567			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Assisted Living	125,003			125,003		125,003	(125,003)				15
16	TOTAL Health Care and Programs	3,401,296	135,765	1,202,910	4,739,971		4,739,971	(124,482)	4,615,489			16
	C. General Administration											
17	Administrative	303,993	5,717	929,721	1,239,431		1,239,431	176,161	1,415,592			17
18	Directors Fees											18
19	Professional Services			8,977	8,977		8,977	36,972	45,949			19
20	Dues, Fees, Subscriptions & Promotions			42,444	42,444		42,444	(849)	41,595			20
21	Clerical & General Office Expenses			(9,558)	(9,558)		(9,558)	3,871	(5,687)			21
22	Employee Benefits & Payroll Taxes			1,154,926	1,154,926		1,154,926	(724)	1,154,202			22
23	Inservice Training & Education			875	875		875	1,090	1,965			23
24	Travel and Seminar							1,319	1,319			24
25	Other Admin. Staff Transportation			311	311		311		311			25
26	Insurance-Prop.Liab.Malpractice			328,159	328,159		328,159	42,572	370,731			26
27	Other (specify):*											27
28	TOTAL General Administration	303,993	5,717	2,455,855	2,765,565		2,765,565	260,412	3,025,977			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,159,347	565,722	4,678,339	9,403,408		9,403,408	(91,889)	9,311,519			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 SAINT BENEDICT N&R #0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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			409,705	409,705		409,705	(47,902)	361,803			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,799	76,799		76,799	(827)	75,972			32
33	Real Estate Taxes			9,244	9,244		9,244	(9,244)				33
34	Rent-Facility & Grounds							20,381	20,381			34
35	Rent-Equipment & Vehicles			11,191	11,191		11,191	743	11,934			35
36	Other (specify):*											36
37	TOTAL Ownership			506,939	506,939		506,939	(36,849)	470,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			695,803	695,803		695,803		695,803			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,022	210,022		210,022		210,022			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			905,825	905,825		905,825		905,825			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,159,347	565,722	6,091,103	10,816,172		10,816,172	(128,738)	10,687,434			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 SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	(3,371)	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	(25,742)	4		8
9	Non-Straightline Depreciation	10,841	30		9
10	Interest and Other Investment Income	(827)	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	(2,200)	19		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,349)	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	(386,214)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (408,862)		$	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))**	$ (408,862)		37

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

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

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

STATE OF ILLINOIS

PRESENCE SAINT BENEDICT N&R

ID# 0044784

Report Period Beginning: 1/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted/Ind Living - Wages	$ (125,003)	15	1
2	Assisted/Ind Living - Benefits	(46,197)	22	2
3	Assisted/Ind Living - Meals/Supplies	(60,471)	2	3
4	Assisted/Ind Living - Maintenance/OH	(56,528)	6	4
5	Assisted/Ind Living - Utilities	(44,088)	5	5
6	Assisted/Ind Living - Housekeeping	(44,683)	3	6
7				7
8				8
9				9
10	Real Estate Tax	(9,244)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(386,214)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 **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 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	(63,842)	1,416	0	0	0	0	0	0	0	0	0	(62,426)	2
3	Housekeeping	(44,683)	0	0	0	0	0	0	0	0	0	0	(44,683)	3
4	Laundry	(25,742)	0	0	0	0	0	0	0	0	0	0	(25,742)	4
5	Heat and Other Utilities	(44,088)	2,180	0	0	0	0	0	0	0	0	0	(41,908)	5
6	Maintenance	(56,528)	3,468	0	0	0	0	0	0	0	0	0	(53,060)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(234,883)	7,064	0	0	0	0	0	0	0	0	0	(227,819)	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	521	0	0	0	0	0	0	0	0	0	521	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):*	(125,003)	0	0	0	0	0	0	0	0	0	0	(125,003)	15
16	**TOTAL Health Care and Programs**	(125,003)	521	0	0	0	0	0	0	0	0	0	(124,482)	16
	C. General Administration													
17	Administrative	0	(107,399)	283,560	0	0	0	0	0	0	0	0	176,161	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,200)	39,172	0	0	0	0	0	0	0	0	0	36,972	19
20	Fees, Subscriptions & Promotions	(1,349)	500	0	0	0	0	0	0	0	0	0	(849)	20
21	Clerical & General Office Expenses	0	3,871	0	0	0	0	0	0	0	0	0	3,871	21
22	Employee Benefits & Payroll Taxes	(46,197)	45,473	0	0	0	0	0	0	0	0	0	(724)	22
23	Inservice Training & Education	0	1,090	0	0	0	0	0	0	0	0	0	1,090	23
24	Travel and Seminar	0	1,319	0	0	0	0	0	0	0	0	0	1,319	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	42,572	0	0	0	0	0	0	0	0	0	42,572	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,746)	26,598	283,560	0	0	0	0	0	0	0	0	260,412	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(409,632)	34,183	283,560	0	0	0	0	0	0	0	0	(91,889)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 **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	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	10,841	0	(58,743)	0	0	0	0	0	0	0	0	(47,902)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(827)	0	0	0	0	0	0	0	0	0	0	(827)	32
33	Real Estate Taxes	(9,244)	0	0	0	0	0	0	0	0	0	0	(9,244)	33
34	Rent-Facility & Grounds	0	0	20,381	0	0	0	0	0	0	0	0	20,381	34
35	Rent-Equipment & Vehicles	0	0	743	0	0	0	0	0	0	0	0	743	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	770	0	(37,619)	0	0	0	0	0	0	0	0	(36,849)	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)	(408,862)	34,183	245,941	0	0	0	0	0	0	0	0	(128,738)	45

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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. [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%	$ 1,416	$ 1,416	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,180	2,180	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	3,468	3,468	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	521	521	4
5	V	17	Admin - Misc. Other	347,362	Presence Life Connections	100.00%	13,082	(334,280)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	226,881	226,881	6
7	V	19	Professional Services		Presence Life Connections	100.00%	39,172	39,172	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	500	500	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,871	3,871	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	45,473	45,473	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,090	1,090	11
12	V	24	Travel		Presence Life Connections	100.00%	1,319	1,319	12
13	V	26	Insurance		Presence Life Connections	100.00%	42,572	42,572	13
14	Total			$ 347,362			$ 381,545	$ * 34,183	14

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

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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%	$ 4,075	$ 4,075	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	20,381	20,381	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	743	743	18
19	V	17	Admin Salaries		Presence Health	100.00%	136,825	136,825	19
20	V	22	Employee Benefits		Presence Health	100.00%			20
21	V	30	Depreciation	109,376	Presence Health	100.00%	46,558	(62,818)	21
22	V	34	Rent Facility		Presence Health	100.00%			22
23	V	17	Admin Consulting,Other	582,359	Presence Health	100.00%	729,094	146,735	23
24	V	17	Information Systems Salaries		Presence Health	100.00%			24
25	V	17	Information Systems - Other		Presence Health	100.00%			25
26	V	17	Admin Salaries		Presence Health	100.00%			26
27	V	17	Information Systems Salaries		Presence Health	100.00%			27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%			28
29	V	17	Admin Consulting,Other		Presence Health	100.00%			29
30	V	32	Admin - Interest Expense		Presence Health	100.00%			30
31	V	39	Ancillary Services - Other	695,803	Presence Senior Services Pharmacy	100.00%	695,803		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,387,538			$ 1,633,479	$ * 245,941	39

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

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 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		BOD			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 Esta	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 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	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	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 SAINT BENEDICT N&R # 0044784 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 [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	7,761,581	27	$ 31,634	$	347,362	$ 1,416	1
2	5	Utilities	Management Fee Income	7,761,581	27	48,706		347,362	2,180	2
3	6	Maintenance - Other	Management Fee Income	7,761,581	27	77,498		347,362	3,468	3
4	11	Activities-Special Events	Management Fee Income	7,761,581	27	11,644		347,362	521	4
5	17	Admin - Misc. Other	Management Fee Income	7,761,581	27	292,301		347,362	13,082	5
6	17	Administrative Salaries	Management Fee Income	7,761,581	27	5,069,517	5,069,517	347,362	226,881	6
7	19	Professional Services	Management Fee Income	7,761,581	27	875,274		347,362	39,172	7
8	20	Dues,Subscriptions	Management Fee Income	7,761,581	27	11,166		347,362	500	8
9	21	Clerical Supplies	Management Fee Income	7,761,581	27	86,492		347,362	3,871	9
10	22	Employee Benefits	Management Fee Income	7,761,581	27	1,016,065		347,362	45,473	10
11	23	Education/Conference	Management Fee Income	7,761,581	27	24,366		347,362	1,090	11
12	24	Travel	Management Fee Income	7,761,581	27	29,466		347,362	1,319	12
13	26	Insurance	Management Fee Income	7,761,581	27	951,237		347,362	42,572	13
14	30	Depreciation	Management Fee Income	7,761,581	27	91,051		347,362	4,075	14
15	32	Interest	Management Fee Income	7,761,581	27	0		347,362	0	15
16	34	Rent - Facility	Management Fee Income	7,761,581	27	455,407		347,362	20,381	16
17	35	Rent - Equipment	Management Fee Income	7,761,581	27	16,606		347,362	743	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,088,430	$ 5,069,517		$ 406,744	25

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 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 [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	6,565,680	6	$ 1,542,600	$ 1,542,600	582,359	$ 136,825	1
2	22	Employee Benefits	Operating Expense							2
3	30	Depreciation	Operating Expense	1,043,631	6	444,245		109,376	46,558	3
4	34	Rent Facility	Operating Expense							4
5	17	Admin Consulting,Other	Operating Expense	6,565,680	6	8,220,016		582,359	729,094	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		$ 912,477	25

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 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 [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			$	$		$ 695,803	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					$	$		$ 695,803	25

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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. **$** N/A **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 SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 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
2011		9
2012		10
2013		11
2014		12

	FOR BHF USE ONLY		
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 SAINT BENEDICT N&R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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) 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 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.

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	56,961	2000	$ 2,910,262	1
2					2
3	TOTALS	56,961		$ 2,910,262	3

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000	1991	$ 5,342,488	$ 123,433	39	$ 123,433	$	$ 2,359,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	92,057		7			92,057	9
10	VARIOUS			2001	273,061	20,499	12	20,499		254,542	10
11	VARIOUS			2002	29,538	1,603	16	1,603		26,285	11
12	VARIOUS			2003	8,200	156	15	156		7,031	12
13	VARIOUS			2004	12,982	639	15	639		8,737	13
14	VARIOUS			2005	191,740	8,390	10	8,390		155,363	14
15	VARIOUS			2006	86,586	3,684	10	3,684		74,392	15
16	VARIOUS			2008	1,284	64	20	64		514	16
17	ADD SPRINKLER SYSTEM TO EXTERI			2012	10,656	426	25	426		1,491	17
18	EMERGENCY REPAIR TO WATER MAIN			2012	4,868	243	20	243		851	18
19											19
20	REMOVING TOP 2 inch OF ASPHALT			2014	50,900	6,363	8	6,363		9,493	20
21	RENOVATIONS FOR CONVERSION OF			2014	50,400	2,520	20	2,520		3,762	21
22	REPLACE AIR COOLED CHILLER MOD			2014	125,000	6,250	20	6,250		9,339	22
23											23
24	: DEPOSIT TO INSTALL NEW LIGHT			2015	6,477	81	20	324	243	81	24
25	BARIATRIC BED, ELECTRONIC, WID			2015	6,918	32	18	384	352	32	25
26	BARIATRIC POWERED ALTERNATING			2015	1,770	8	18	98	90	8	26
27	LIGHTING FIXTURES INDEP LIVING			2015	6,884	115	15	459	344	115	27
28	MATRESS LOW AIR/ALT PRESS, DIG			2015	2,067	10	18	115	105	10	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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			$	$		$	$	$	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)		$ 6,303,876	$ 174,516		$ 175,650	$ 1,134	$ 3,003,623	70

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

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	$ 2,026,339	$ 227,160	$ 227,160	$	13	$ 1,454,302	71
72	Current Year Purchases	187,445	8,029	17,736	9,707	13	8,029	72
73	Fully Depreciated Assets	327,332				6	327,332	73
74								74
75	TOTALS	$ 2,541,116	$ 235,189	$ 244,896	$ 9,707		$ 1,789,663	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,755,254	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 409,705	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 420,546	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,841	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,793,286	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 SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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				20,381			5
6								6
7	TOTAL				$ 20,381 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 11,934 Description: Administration 10778, Activities 35, Nursing 378, 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 SAINT BENEDICT N&R # 0044784 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.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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,1&3	3383	hrs	$ 138,556	6,356	$ 408,917	$	9,739	$ 547,473	1
2	Licensed Speech and Language Development Therapist	10a,1&3	758	hrs	32,026	1,380	87,771		2,138	119,797	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,1&3	3413	hrs	134,496	7,503	449,778		10,916	584,274	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,3		# of prescrpts				695,803		695,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): DIRECTOR		199		9,466				199	9,466	12
13	Other (specify):										13
14	TOTAL				$ 314,544	15,239	$ 946,466	$ 695,803	22,992	$ 1,956,813	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.

STATE OF ILLINOIS

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 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 to 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.)**

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 25,236,903	1
2	Restatements (describe):		2
3			3
4	**Adj. to reconcile consolidated equity & consolidated income**	148,498,257	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 173,735,160	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,701,391	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)**	$ 2,167,843	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.**

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,735,399	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,735,399	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,586,652	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,586,652	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	3,371	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,120,721	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	25,742	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,149,834	23
	D. Non-Operating Revenue		
24	Contributions	1,682	24
25	Interest and Other Investment Income***	827	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,509	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	43,169	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,169	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,517,563	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,897,872	31
32	Health Care	4,739,971	32
33	General Administration	2,765,565	33
	B. Capital Expense		
34	Ownership	506,939	34
	C. Ancillary Expense		
35	Special Cost Centers	695,803	35
36	Provider Participation Fee	210,022	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,816,172	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,701,391	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,701,391	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 849,998	44
45	Private Pay - Net Inpatient Revenue	5,403,629	45
46	Medicare - Net Inpatient Revenue	2,326,777	46
47	Other-(specify) Insurance	154,995	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,735,399	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 SAINT BENEDICT N&R # 0044784 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,086	$ 92,049	$ 44.13	1
2	Assistant Director of Nursing	-	-	-		2
3	Registered Nurses	39,980	43,179	1,386,315	32.11	3
4	Licensed Practical Nurses	8,831	9,470	215,712	22.78	4
5	CNAs & Orderlies	76,888	84,234	985,498	11.70	5
6	CNA Trainees					6
7	Licensed Therapist	7,453	7,753	314,544	40.57	7
8	Rehab/Therapy Aides	10,631	11,947	125,995	10.55	8
9	Activity Director	3,648	4,138	97,508	23.56	9
10	Activity Assistants	5,520	6,068	60,914	10.04	10
11	Social Service Workers	3,831	4,037	84,021	20.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	19,695	22,164	312,580	14.10	17
18	Housekeepers					18
19	Laundry	9,701	10,680	104,087	9.75	19
20	Administrator	1,795	2,100	107,897	51.38	20
21	Assistant Administrator					21
22	Other Administrative	30	30	771	25.70	22
23	Office Manager	143	143	2,428	16.98	23
24	Clerical	5,527	5,788	57,932	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	154	154	22,698	147.39	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,840	2,085	49,976	23.97	31
32	Other Health C: Admissions	3,264	3,727	100,090	26.86	32
33	Other(specify) Pastoral	1,425	1,601	38,332	23.94	33
34	TOTAL (lines 1 - 33)	202,340	221,384	$ 4,159,347 *	$ 18.79	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	2,420	12,2	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	32	$ 2,420		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	7,575	194,455	10,2&3	52
53	TOTAL (lines 50 - 52)	7,575	$ 194,455		53

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bernie Ladra	Administrator		$ 107,897
Admnistrative Staff	Office Manager		2,428
Admnistrative Staff	Admissions		100,090
Admnistrative Staff	Receptionists		57,932
Admnistrative Staff	Other Administrative		35,646
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 303,993

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 929,721
TOTAL (agree to Schedule V, line 17, col. 3)	$ 929,721
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cielo - recruiter	Various	$
Joint Commission	Various	2,300
Brinks	Various	1,015
HR Plus	Various	
IDPH	Various	2,200
Survey & Analytical Tools	Various	
Outsourced Services	Various	3,462
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,977

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,129
Unemployment Compensation Insurance	14,639
FICA Taxes	294,941
Employee Health Insurance	400,647
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation/Non Care Adjustment	(724)
Dental	11,470
Life Insurance	2,396
Disability Insurance	20,584
Pension	250,018
Tuition Reimbursement	13,128
Other Benefits	31,777
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,108,005

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 30)	
Patient Background Checks 213	
Employee Recruitement	20,780
Dues & Subscription	20,315
Advertising & Public Relations	1,349
Home Office Allocation	500
Less: Public Relations Expense	( )
Non-allowable advertising	(1,349)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,595

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	
Home Office Allocation	1,319
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,319

**See instructions.

Facility Name & ID Number PRESENCE SAINT BENEDICT N&R # 0044784 Report Period Beginning: 1/01/15 Ending: 12/31/15

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 SAINT BENEDICT N&R # 0044784 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 $10787.44**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **13 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,119** 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. $ **210,022**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES-ASSISTED LIVI** 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. $ **3,371**

(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.