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.

I. IDPH License ID Number: 0041871

Facility Name: PRESENCE ST JOSEPH CENTER

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

County: STEPHENSON

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

HFS ID Number:

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

Type of Ownership:

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 ST JOSEPH CENTER # 0041871 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	124	Skilled (SNF)	124	45,260	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	124	TOTALS	124	45,260	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	19,556	9,790	8,025	37,371	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,556	9,790	8,025	37,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.57%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07-01-96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07-01-096 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 5,608

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 ST JOSEPH CENTER # 0041871 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		15,927	598,790	614,717		614,717		614,717			1
2	Food Purchase		267,775		267,775		267,775	(41,601)	226,174			2
3	Housekeeping	120,136	22,804	125	143,065		143,065		143,065			3
4	Laundry		3,527	105,593	109,120		109,120		109,120			4
5	Heat and Other Utilities			206,798	206,798		206,798	1,875	208,673			5
6	Maintenance	134,374	40,392	128,918	303,684		303,684	26,259	329,943			6
7	Other (specify):* PASTORAL	49,925	2,089	459	52,473		52,473		52,473			7
8	TOTAL General Services	304,435	352,514	1,040,683	1,697,632		1,697,632	(13,467)	1,684,165			8
	B. Health Care and Programs											
9	Medical Director			14,000	14,000		14,000		14,000			9
10	Nursing and Medical Records	2,474,985	90,841	110,475	2,676,301		2,676,301		2,676,301			10
10a	Therapy	151,729	1,400	446,002	599,131		599,131		599,131			10a
11	Activities	81,302	1,539	4,719	87,560		87,560	448	88,008			11
12	Social Services	56,589		660	57,249		57,249		57,249			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,764,605	93,780	575,856	3,434,241		3,434,241	448	3,434,689			16
	C. General Administration											
17	Administrative	314,695	37,461	773,802	1,125,958		1,125,958	217,473	1,343,431			17
18	Directors Fees											18
19	Professional Services			20,081	20,081		20,081	33,686	53,767			19
20	Dues, Fees, Subscriptions & Promotions			47,300	47,300		47,300	(2,265)	45,035			20
21	Clerical & General Office Expenses			20,496	20,496		20,496	(21,785)	(1,289)			21
22	Employee Benefits & Payroll Taxes			1,051,437	1,051,437		1,051,437	105,403	1,156,840			22
23	Inservice Training & Education			251	251		251	938	1,189			23
24	Travel and Seminar			(3,886)	(3,886)		(3,886)	1,134	(2,752)			24
25	Other Admin. Staff Transportation			1,617	1,617		1,617		1,617			25
26	Insurance-Prop.Liab.Malpractice			164,631	164,631		164,631	36,609	201,240			26
27	Other (specify):*											27
28	TOTAL General Administration	314,695	37,461	2,075,729	2,427,885		2,427,885	371,193	2,799,078			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,383,735	483,755	3,692,268	7,559,758		7,559,758	358,174	7,917,932			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER #0041871 **Report Period Beginning:** 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			540,532	540,532		540,532	(84,977)	455,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,316	192,316		192,316	89,124	281,440			32
33	Real Estate Taxes			125,310	125,310		125,310		125,310			33
34	Rent-Facility & Grounds							36,951	36,951			34
35	Rent-Equipment & Vehicles			15,872	15,872		15,872	639	16,511			35
36	Other (specify):*											36
37	**TOTAL Ownership**			874,030	874,030		874,030	41,737	915,767			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			238,206	238,206		238,206		238,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,258	265,258		265,258		265,258			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			503,464	503,464		503,464		503,464			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,383,735	483,755	5,069,762	8,937,252		8,937,252	399,911	9,337,163			45

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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	(42,818)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,717	30		9
10	Interest and Other Investment Income	(5,714)	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	(20,223)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,695)	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	(25,114)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,847)		$	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))**	$ (88,847)		37

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

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

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

PRESENCE ST JOSEPH CENTER

ID# 0041871

Report Period Beginning: 1/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (25,114)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(25,114)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **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	(42,818)	1,217	0	0	0	0	0	0	0	0	0	(41,601)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,875	0	0	0	0	0	0	0	0	0	1,875	5
6	Maintenance	0	2,983	23,276	0	0	0	0	0	0	0	0	26,259	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(42,818)	6,075	23,276	0	0	0	0	0	0	0	0	(13,467)	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	448	0	0	0	0	0	0	0	0	0	448	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	448	0	0	0	0	0	0	0	0	0	448	16
	C. General Administration													
17	Administrative	0	(92,357)	309,830	0	0	0	0	0	0	0	0	217,473	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	33,686	0	0	0	0	0	0	0	0	0	33,686	19
20	Fees, Subscriptions & Promotions	(2,695)	430	0	0	0	0	0	0	0	0	0	(2,265)	20
21	Clerical & General Office Expenses	(25,114)	3,329	0	0	0	0	0	0	0	0	0	(21,785)	21
22	Employee Benefits & Payroll Taxes	0	39,104	66,299	0	0	0	0	0	0	0	0	105,403	22
23	Inservice Training & Education	0	938	0	0	0	0	0	0	0	0	0	938	23
24	Travel and Seminar	0	1,134	0	0	0	0	0	0	0	0	0	1,134	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	36,609	0	0	0	0	0	0	0	0	0	36,609	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,809)	22,873	376,129	0	0	0	0	0	0	0	0	371,193	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,627)	29,396	399,405	0	0	0	0	0	0	0	0	358,174	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **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	(12,506)	0	(72,471)	0	0	0	0	0	0	0	0	(84,977)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,714)	0	94,838	0	0	0	0	0	0	0	0	89,124	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	36,951	0	0	0	0	0	0	0	0	36,951	34
35	Rent-Equipment & Vehicles	0	0	639	0	0	0	0	0	0	0	0	639	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(18,220)	0	59,957	0	0	0	0	0	0	0	0	41,737	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)	(88,847)	29,396	459,362	0	0	0	0	0	0	0	0	399,911	45

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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%	$ 1,217	$ 1,217	1
2	V	5	Utilities		Presence Life Connections	100.00%	1,875	1,875	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,983	2,983	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	448	448	4
5	V	17	Admin - Misc. Other	298,713	Presence Life Connections	100.00%	11,250	(287,463)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	195,106	195,106	6
7	V	19	Professional Services		Presence Life Connections	100.00%	33,686	33,686	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	430	430	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,329	3,329	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	39,104	39,104	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	938	938	11
12	V	24	Travel		Presence Life Connections	100.00%	1,134	1,134	12
13	V	26	Insurance		Presence Life Connections	100.00%	36,609	36,609	13
14	Total			$ 298,713			$ 328,109	$ * 29,396	14

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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%	$ 3,504	$ 3,504	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	17,527	17,527	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	639	639	18
19	V	17	Admin Salaries		Presence Health	100.00%	109,310	109,310	19
20	V	22	Employee Benefits		Presence Health	100.00%	66,299	66,299	20
21	V	30	Depreciation	152,006	Presence Health	100.00%	76,031	(75,975)	21
22	V	34	Rent Facility		Presence Health	100.00%	19,424	19,424	22
23	V	17	Admin Consulting,Other	475,089	Presence Health	100.00%	403,302	(71,787)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	38,761	38,761	24
25	V	17	Information Systems - Other		Presence Health	100.00%	138,492	138,492	25
26	V	17	Admin Salaries		Presence Health	100.00%	32,036	32,036	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	44,172	44,172	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	23,276	23,276	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	18,846	18,846	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	94,838	94,838	30
31	V	39	Ancillary Services - Other	238,206	Presence Senior Services Pharmacy	100.00%	238,206		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 865,301			$ 1,324,663	$ * 459,362	39

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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 ST JOSEPH CENTER # 0041871 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 ST JOSEPH CENTER # 0041871 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	$	298,713	$ 1,217	1
2	5	Utilities	Management Fee Income	7,761,581	27	48,706		298,713	1,875	2
3	6	Maintenance - Other	Management Fee Income	7,761,581	27	77,498		298,713	2,983	3
4	11	Activities-Special Events	Management Fee Income	7,761,581	27	11,644		298,713	448	4
5	17	Admin - Misc. Other	Management Fee Income	7,761,581	27	292,301		298,713	11,250	5
6	17	Administrative Salaries	Management Fee Income	7,761,581	27	5,069,517	5,069,517	298,713	195,106	6
7	19	Professional Services	Management Fee Income	7,761,581	27	875,274		298,713	33,686	7
8	20	Dues,Subscriptions	Management Fee Income	7,761,581	27	11,166		298,713	430	8
9	21	Clerical Supplies	Management Fee Income	7,761,581	27	86,492		298,713	3,329	9
10	22	Employee Benefits	Management Fee Income	7,761,581	27	1,016,065		298,713	39,104	10
11	23	Education/Conference	Management Fee Income	7,761,581	27	24,366		298,713	938	11
12	24	Travel	Management Fee Income	7,761,581	27	29,466		298,713	1,134	12
13	26	Insurance	Management Fee Income	7,761,581	27	951,237		298,713	36,609	13
14	30	Depreciation	Management Fee Income	7,761,581	27	91,051		298,713	3,504	14
15	32	Interest	Management Fee Income	7,761,581	27	0		298,713	0	15
16	34	Rent - Facility	Management Fee Income	7,761,581	27	455,407		298,713	17,527	16
17	35	Rent - Equipment	Management Fee Income	7,761,581	27	16,606		298,713	639	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,088,430	$ 5,069,517		$ 349,779	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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	5,977,354	17	$ 1,375,283	$ 1,375,283	475,089	$ 109,310	1
2	22	Employee Benefits	Operating Expense	5,977,354	17	834,149		475,089	66,299	2
3	30	Depreciation	Operating Expense	1,607,196	17	803,889		152,006	76,031	3
4	34	Rent Facility	Operating Expense	5,977,354	17	244,378		475,089	19,424	4
5	17	Admin Consulting,Other	Operating Expense	5,977,354	17	5,074,164		475,089	403,302	5
6	17	Information Systems Salaries	Operating Expense	5,977,354	17	487,675	487,675	475,089	38,761	6
7	17	Information Systems - Other	Operating Expense	5,977,354	17	1,742,443		475,089	138,492	7
8	17	Admin Salaries	Direct Cost	5,977,354	17	403,064	403,064	475,089	32,036	8
9	17	Information Systems Salaries	Direct Cost	5,977,354	17	555,758	555,758	475,089	44,172	9
10	6	Information Systems - Equip Mai	Direct Cost	5,977,354	17	292,852		475,089	23,276	10
11	17	Admin Consulting,Other	Direct Cost	5,977,354	17	237,106		475,089	18,846	11
12	32	Admin - Interest Expense	Direct Cost	5,977,354	17	1,193,207		475,089	94,838	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 13,243,968	$ 2,821,780		$ 1,064,787	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60614
Phone Number: (815-936-3644
Fax Number: (815-936-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 238,206	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					$	$		$ 238,206	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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						$	$			$ 94,838	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 94,838	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 94,838	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 ST JOSEPH CENTER **#** 0041871 **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.)		$ 125,310	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.		$ 125,310	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 ST JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT GEORGE VIEU

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

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

Enter the tax index number and real estate tax assessed for 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.	To be Determined		$ 125,310.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 125,310.00	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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	120		1996	1996	$ 2,500,000	$ 39,593	53	$ 39,593	$	$ 1,170,346	4
5	10		2013	2013	3,002,792	77,291	35	77,291		193,293	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698	2,134	13	2,134		70,873	11
12	VARIOUS			2001	19,599	255	10	255		18,154	12
13	VARIOUS			2002	28,056	691	13	691		26,372	13
14	VARIOUS			2003	77,639	1,190	11	1,190		74,961	14
15	VARIOUS			2004	16,330	101	10	101		15,934	15
16	VARIOUS			2005	93,561	2,433	12	2,433		70,099	16
17	VARIOUS			2006	47,671	4,538	10	4,538		39,248	17
18	VARIOUS			2007	163,794	10,561	13	10,561		89,604	18
19	VARIOUS			2008	197,106	15,940	14	15,940		141,174	19
20	VARIOUS			2009	153,368	11,998	12	11,998		84,532	20
21	VARIOUS			2010	128,973	11,403	10	11,403		79,866	21
22	VARIOUS			2011	39,476	4,064	10	4,064		19,741	22
23											23
24	B WING COMPRESSOR			2012	4,976	332	15	332		1,165	24
25	COVER TO EDGE OF THIRD STORY			2012	4,268	427	10	427		1,909	25
26											26
27	A WING COMPRESSOR			2013	2,754	230	12	230		574	27
28	ARCHITECTURAL SERVICES 12 ROOM			2013	422,752	10,569	40	10,569		26,389	28
29	CLF FLOORING			2013	149,568	14,957	10	14,957		37,188	29
30	CLF INSTALL NEW VINYL PLANKING			2013	3,478	348	10	348		875	30
31	DESIGN BUILD TABERNACLE FOR CH			2013	4,599	307	15	307		766	31
32	LANDSCAPPING			2013	1,500	150	10	150		373	32
33	LIGHTING 16 PORT DKT INTERFACE			2013	3,297	330	10	330		820	33
34	PARKING LOT SEALED GRINDING JO			2013	9,350	4,675	2	4,675		9,350	34
35	RESHAPE EXISTING STONE ASPHALT			2013	25,973	3,247	8	3,247		8,058	35
36	ROLLER SHADES			2013	2,051	410	5	410		1,008	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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	WALL MOUNT DISPENSER DOUBLE RO	2013	$ 1,029	$ 147	7	$ 147	$	$ 364	37
38	WANDER SYSTEM FOR DINING ROOM	2013	4,240	424	10	424		1,053	38
39									39
40	ADD CELL PHONE CAPABILITY	2014	2,972	297	10	297		737	40
41	CEILING TILES FOR OCEANVIEW	2014	2,846	285	10	285		706	41
42	CLF FLOORING IN DINING AREA KI	2014	22,170	4,434	5	4,434		6,831	42
43	COMPRESSOR FOR CARRIER CONDENS	2014	5,090	424	12	424		636	43
44	CONTRACT LABOR MATERIAL AND EQ	2014	9,251	1,156	8	1,156		1,712	44
45	DESIGN BUILD INSTALL HIGH ALTA	2014	3,774	252	15	252		378	45
46	DOOR ENTRANCE STORM	2014	6,855	457	15	457		1,137	46
47	FIRE ALARM SYSTEM MODIFICATION	2014	2,735	109	25	109		273	47
48	FIRE DOORS	2014	2,828	141	20	141		352	48
49	GENERATOR	2014	4,700	392	12	392		585	49
50	NEW BOILER	2014	22,230	1,112	20	1,112		1,671	50
51	PARKING LOT	2014	9,750	1,950	5	1,950		2,873	51
52	NORTH ROOF OF ONEILL H	2014	11,850	1,185	10	1,185		1,760	52
53	TUCKPOINTING ADC CHAPEL	2014	9,700	139	70	139		208	53
54									54
55	AIR COND. CONDENSING UNIT FOR SUNSHINE COURT	2015	26,832	894	10	2,683	1,789	894	55
56	DOOR ALARMS WEST UNIT	2015	2,740	183	10	274	91	183	56
57	CIRCUIT BREAKER AND WIRING NODES FOR BUILDING	2015	10,514	44	20	526	482	44	57
58	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOMS	2015	2,674	80	25	107	27	80	58
59	LIGHTING EQUIP. FOR RESIDENT ROOMS AND HALLWAY	2015	11,017	673	15	734	61	673	59
60	COUNTERTOP/SINKS/TOILETS/STALLS FOR MENS ROOM	2015	13,691	628	20	685	57	628	60
61	ROOF REPAIR ADC BLDG	2015	71,175	2,966	10	7,118	4,152	2,966	61
62	ROOFTOP HEATING AC UNIT	2015	3,746	160	35	107	(53)	160	62
63	WALK-IN TUB, TILE AND MIRROR FOR BATHROOM IN CL	2015	10,337	771	20	517	(254)	771	63
64	WINDOW REPLACEMENT CLF	2015	3,380	155	20	169	14	155	64
65	YORK ROOF TOP	2015	11,140	928	10	1,114	186	928	65
66									66
67	DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(484)	-15	(484)		(2,173)	67
68	DEDUCTION FOR NON-CARE ASSETS	2013	(153,046)	(15,305)	-10	(15,305)		(38,063)	68
69	DEDUCTION FOR NON-CARE ASSETS	2014	(22,170)	(4,434)	-5	(4,434)		(6,831)	69
70	TOTAL (lines 4 thru 69)		$ 7,293,175	$ 218,334		$ 224,885	$ 6,552	$ 2,169,119	70

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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	$ 1,320,015	$ 123,359	$ 123,359	$	12	$ 708,202	71
72	Current Year Purchases	53,489	3,168	4,333	1,165	12	3,168	72
73	Fully Depreciated Assets	767,588	2,342	2,342		6	767,588	73
74	Home Office Allocation		152,006	152,006				74
75	TOTALS	$ 2,141,092	$ 280,875	$ 282,040	$ 1,165		$ 1,478,958	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TOTAL			$ 229,693	$ 21,100	$ 21,100	$		$ 204,264	76
77	SEE VEHICLE ATTACHMENT									77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 229,693	$ 21,100	$ 21,100	$		$ 204,264	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)	$ 11,063,960	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 520,309	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 528,026	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,717	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,852,341	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5
76	PLANT ENGINEERING	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$ 0
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123	0
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275	0
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649	0
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155	0
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232	14,558
79C	PLANT ENGINEERING	2014 BUICK ENCORE 4WD	2014	26,169	6,542
80	TOTALS			$ 229,693	$ 21,100

Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
$ 0	$ 0	5	$ 24,090	76
0	0	3	23,123	77
0	0	4	34,275	78
0	0	4	15,649	79
0	0	4	48,155	79
14,558	0	4	49,335	79
6,542	0	4	9,637	
$ 21,100	$ 0		$ 204,264	80

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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				36,951			5
6								6
7	TOTAL				$ 36,951 **			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: $ 16,511 Description: Nursing 8855, Administration 7017, 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 ST JOSEPH CENTER # 0041871 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 ST JOSEPH CENTER # 0041871 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	1772	hrs	$ 37,059	3,036	$ 181,935	$	4,808	$ 218,994	1
2	Licensed Speech and Language Development Therapist	10a,1&3	443	hrs		368	23,407		811	23,407	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,1&3	2341	hrs	80,376	3,450	209,568		5,791	289,944	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				238,206		238,206	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): DIRECTOR		301		34,294				301	34,294	12
13	Other (specify):										13
14	TOTAL				$ 151,729	6,854	$ 414,910	$ 238,206	11,711	$ 804,845	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 ST JOSEPH CENTER # 0041871 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 ST JOSEPH CENTER # 0041871 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**	$ 73,167,735	1
2	Restatements (describe):		2
3			3
4	**Adj. to reconcile consolidated equity & consolidated income**	103,239,097	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 176,406,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(970,281)	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)**	$ (503,829)	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 ST JOSEPH CENTER # 0041871 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	$ 6,169,136	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,169,136	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,217,515	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,217,515	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	42,818	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	502,590	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 545,408	23
	D. Non-Operating Revenue		
24	Contributions	29,198	24
25	Interest and Other Investment Income***	5,714	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,912	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,966,971	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,697,632	31
32	Health Care	3,434,241	32
33	General Administration	2,427,885	33
	B. Capital Expense		
34	Ownership	874,030	34
	C. Ancillary Expense		
35	Special Cost Centers	238,206	35
36	Provider Participation Fee	265,258	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,937,252	40
41	**Income before Income Taxes (line 30 minus line 40)****	(970,281)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (970,281)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,786,500	44
45	Private Pay - Net Inpatient Revenue	1,642,236	45
46	Medicare - Net Inpatient Revenue	1,184,422	46
47	Other-(specify) Insurance	555,978	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,169,136	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

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

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 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	1,886	2,099	$ 77,249	$ 36.80	1
2	Assistant Director of Nursing	1,935	2,099	69,395	33.06	2
3	Registered Nurses	29,048	30,895	657,573	21.28	3
4	Licensed Practical Nurses	29,398	32,008	637,990	19.93	4
5	CNAs & Orderlies	87,977	94,248	943,003	10.01	5
6	CNA Trainees					6
7	Licensed Therapist	4,840	4,857	151,729	31.24	7
8	Rehab/Therapy Aides	3,342	3,871	53,809	13.90	8
9	Activity Director	1,933	2,088	38,186	18.29	9
10	Activity Assistants	3,921	4,250	43,117	10.15	10
11	Social Service Workers	2,656	2,955	42,233	14.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	19,855	22,180	254,510	11.47	17
18	Housekeepers	2,926	3,085	66,367	21.51	18
19	Laundry					19
20	Administrator	1,670	2,098	93,195	44.42	20
21	Assistant Administrator	15	15	444	29.60	21
22	Other Administrative	1,133	1,808	42,443	23.48	22
23	Office Manager	1,681	1,891	37,036	19.59	23
24	Clerical	9,960	10,836	125,533	11.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Admissions					32
33	Other(specify) Pastoral	1,832	2,031	49,923	24.58	33
34	TOTAL (lines 1 - 33)	206,008	223,314	$ 3,383,735 *	$ 15.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,000	9,3	36
37	Medical Records Consultant	32	2,304	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	2	99	11,3	44
45	Social Service Consultant	14	941	12,3	45
46	Other(specify)				46
47	MDS Coordinator	180	20,369	10,3	47
48					48
49	TOTAL (lines 35 - 48)	228	$ 37,713		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	122	$ 5,371	10,2	50
51	Licensed Practical Nurses	265	10,429	10,2	51
52	Certified Nurse Assistants/Aides	579	14,389	10,2	52
53	TOTAL (lines 50 - 52)	966	$ 30,189		53

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 93,195
Admnistrative Staff	Receptionist		46,427
Admnistrative Staff	Office Manager		37,036
Admnistrative Staff	Admin Assistant		444
Admnistrative Staff	Admissions		86,255
Admnistrative Staff	Other Admin		51,338
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 314,695

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 773,802
TOTAL (agree to Schedule V, line 17, col. 3)	$ 773,802
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 10,473
Survey & Analytical Tools	Various	2,985
Shredding/Storage	Various	1,096
Living Design	Various	1,303
Outsourced Services	Various	2,043
Collection Fee	Various	64
Courier Service	Various	2,117
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,081

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,209
Unemployment Compensation Insurance	14,826
FICA Taxes	232,206
Employee Health Insurance	454,349
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	105,403
Dental	16,680
Life Insurance	2,571
Disability Insurance	20,837
Pension	196,720
Tuition Reimbursement	12,180
Other Benefits	30,859
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,156,840

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 37)	
Patient Background Checks 241	
Employee Recruitement	22,890
Dues & Subscription	21,715
Advertising & Public Relations	2,695
Home Office Allocation	430
Less: Public Relations Expense	( )
Non-allowable advertising	(2,695)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,035

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	(3,886)
Seminar Expense	
Home Office Allocation	1,134
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ (2,752)

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 ST JOSEPH CENTER # 0041871 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 $5851.14**

(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? **12 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,472** 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. $ **265,258**
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. $ **42,818**

(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.