		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0041046

Facility Name: PRESENCE COR MARIAE CENTER

Address: 3330 MARIA LINDEN DR (Number) ROCKFORD (City) 61114 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-877-7416 **Fax #** 815-877-4299

HFS ID Number:

Date of Initial License for Current Owners: 06/01/95

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 1/01/16 to 12/31/16 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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	73	Skilled (SNF)	73	26,718	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	89	Sheltered Care (SC)	89	32,574	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,292	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	6,462	5,500	8,452	20,414	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		14,399		14,399	12
13	DD 16 OR LESS					13
14	TOTALS	6,462	19,899	8,452	34,813	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.71%

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 06-05-95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06-05-95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 73 and days of care provided 6,039

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: 12-31-16 Fiscal Year: 12-31-16

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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		11,488	756,921	768,409		768,409		768,409			1
2	Food Purchase		303,415		303,415		303,415	(5,672)	297,743			2
3	Housekeeping	118,026	47,597	3,501	169,124		169,124		169,124			3
4	Laundry	23,488	29,325	29,733	82,546		82,546		82,546			4
5	Heat and Other Utilities			311,430	311,430		311,430	2,789	314,219			5
6	Maintenance	141,336	26,684	209,940	377,960		377,960	11,594	389,554			6
7	Other (specify):* Pastoral	38,537	1,316	10,378	50,231		50,231		50,231			7
8	TOTAL General Services	321,387	419,825	1,321,903	2,063,115		2,063,115	8,711	2,071,826			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,625,768	161,221	420,893	2,207,882		2,207,882		2,207,882			10
10a	Therapy	676,234	10,469	58,687	745,390		745,390		745,390			10a
11	Activities	135,338	1,134	5,515	141,987		141,987	135	142,122			11
12	Social Services	76,279		2,133	78,412		78,412		78,412			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Supportive/Shelter	530,645	795	592	532,032		532,032	(109,236)	422,796			15
16	TOTAL Health Care and Programs	3,044,264	173,619	508,820	3,726,703		3,726,703	(109,101)	3,617,602			16
	C. General Administration											
17	Administrative	382,210	20,330	1,006,638	1,409,178		1,409,178	(35,750)	1,373,428			17
18	Directors Fees											18
19	Professional Services			33,098	33,098		33,098	28,946	62,044			19
20	Dues, Fees, Subscriptions & Promotions			41,094	41,094		41,094	2,039	43,133			20
21	Clerical & General Office Expenses			11,440	11,440		11,440	1,715	13,155			21
22	Employee Benefits & Payroll Taxes			1,022,490	1,022,490		1,022,490	52,570	1,075,060			22
23	Inservice Training & Education							647	647			23
24	Travel and Seminar			241	241		241	4,820	5,061			24
25	Other Admin. Staff Transportation			8,477	8,477		8,477	(76)	8,401			25
26	Insurance-Prop.Liab.Malpractice			177,503	177,503		177,503	1,018	178,521			26
27	Other (specify):*											27
28	TOTAL General Administration	382,210	20,330	2,300,981	2,703,521		2,703,521	55,929	2,759,450			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,747,861	613,774	4,131,704	8,493,339		8,493,339	(44,461)	8,448,878			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 COR MARIAE CENTER #0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			529,386	529,386		529,386	18,023	547,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,701	146,701		146,701	(9,862)	136,839			32
33	Real Estate Taxes			1,406	1,406		1,406	(1,406)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,386	18,386		18,386	19,797	38,183			35
36	Other (specify):*											36
37	**TOTAL Ownership**			695,879	695,879		695,879	26,552	722,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			574,250	574,250		574,250		574,250			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,850	130,850		130,850		130,850			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			705,100	705,100		705,100		705,100			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,747,861	613,774	5,532,683	9,894,318		9,894,318	(17,909)	9,876,409			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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	(7,042)	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		4		8
9	Non-Straightline Depreciation	12,090	30		9
10	Interest and Other Investment Income	(9,862)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(925)	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	(146,706)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (152,445)		$	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)	134,536		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 134,536		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (17,909)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESENCE COR MARIAE CENTER

ID# 0041046

Report Period Beginning: 1/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Supportive Living - Salaries	$ (107,849)	15	1
2	Supportive Living - Benefits	(35,988)	22	2
3	Supportive Living - Supplies	(795)	15	3
4	Supportive Living - Other	(592)	15	4
5	Supportive Living - Mileage	(76)	25	5
6				6
7	Real Estate Taxes	(1,406)	33	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**	(146,706)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	(7,042)	1,370	0	0	0	0	0	0	0	0	0	(5,672)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,789	0	0	0	0	0	0	0	0	0	2,789	5
6	Maintenance	0	9,384	2,210	0	0	0	0	0	0	0	0	11,594	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,042)	13,543	2,210	0	0	0	0	0	0	0	0	8,711	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	135	0	0	0	0	0	0	0	0	0	135	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):*	(109,236)	0	0	0	0	0	0	0	0	0	0	(109,236)	15
16	**TOTAL Health Care and Programs**	(109,236)	135	0	0	0	0	0	0	0	0	0	(109,101)	16
	C. General Administration													
17	Administrative	0	(144,769)	109,019	0	0	0	0	0	0	0	0	(35,750)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,946	0	0	0	0	0	0	0	0	0	28,946	19
20	Fees, Subscriptions & Promotions	(925)	2,964	0	0	0	0	0	0	0	0	0	2,039	20
21	Clerical & General Office Expenses	0	1,715	0	0	0	0	0	0	0	0	0	1,715	21
22	Employee Benefits & Payroll Taxes	(35,988)	75,351	13,207	0	0	0	0	0	0	0	0	52,570	22
23	Inservice Training & Education	0	647	0	0	0	0	0	0	0	0	0	647	23
24	Travel and Seminar	0	4,820	0	0	0	0	0	0	0	0	0	4,820	24
25	Other Admin. Staff Transportation	(76)	0	0	0	0	0	0	0	0	0	0	(76)	25
26	Insurance-Prop.Liab.Malpractice	0	1,018	0	0	0	0	0	0	0	0	0	1,018	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,989)	(29,308)	122,226	0	0	0	0	0	0	0	0	55,929	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,267)	(15,630)	124,436	0	0	0	0	0	0	0	0	(44,461)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 **Report Period Beginning:** 1/01/16 **Ending:** 12/31/16

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	12,090	0	5,933	0	0	0	0	0	0	0	0	18,023	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,862)	0	0	0	0	0	0	0	0	0	0	(9,862)	32
33	Real Estate Taxes	(1,406)	0	0	0	0	0	0	0	0	0	0	(1,406)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	19,797	0	0	0	0	0	0	0	0	19,797	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	822	0	25,730	0	0	0	0	0	0	0	0	26,552	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)**	(152,445)	(15,630)	150,166	0	0	0	0	0	0	0	0	(17,909)	45

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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 Commu
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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

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

1 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%	$ 1,370	$ 1,370	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,789	2,789	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	9,384	9,384	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	135	135	4
5	V	17	Admin - Misc. Other	435,396	Presence Life Connections	100.00%	4,762	(430,634)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	285,865	285,865	6
7	V	19	Professional Services		Presence Life Connections	100.00%	28,946	28,946	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,964	2,964	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,715	1,715	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	75,351	75,351	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	647	647	11
12	V	24	Travel		Presence Life Connections	100.00%	4,820	4,820	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,018	1,018	13
14	Total			$ 435,396			$ 419,766	$ * (15,630)	14

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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%	$ 5,933	$ 5,933	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	0		17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	19,797	19,797	18
19	V	17	Admin Salaries		Presence Health	100.00%	0		19
20	V	22	Employee Benefits		Presence Health	100.00%	13,207	13,207	20
21	V	30	Depreciation	157,459	Presence Health	100.00%	157,459		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	569,043	Presence Health	100.00%	509,055	(59,988)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	0		24
25	V	17	Information Systems - Other		Presence Health	100.00%	121,586	121,586	25
26	V	17	Admin Salaries		Presence Health	100.00%	0		26
27	V	17	Information Systems Salaries		Presence Health	100.00%	37,327	37,327	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	2,210	2,210	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	10,094	10,094	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	0		30
31	V	39	Ancillary Services - Other	574,250	Presence Senior Services Pharmacy	100.00%	574,250		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,300,752			$ 1,450,918	$ * 150,166	39

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Michael Gordon	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Susan Enright	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connecti	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral H	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Ca	Northlake	Independent Living	13
14					Presence Ambulatory	Various	Parent	14
15					Resurrection Developn	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection 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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	9,455,191	33	$ 29,753	$	435,396	$ 1,370	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575		435,396	2,789	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785		435,396	9,384	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934		435,396	135	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412		435,396	4,762	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	435,396	285,865	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607		435,396	28,946	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374		435,396	2,964	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236		435,396	1,715	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354		435,396	75,351	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049		435,396	647	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676		435,396	4,820	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118		435,396	1,018	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835		435,396	5,933	14
15	32	Interest	Management Fee Income	9,455,191	33	0		435,396	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0		435,396	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912		435,396	19,797	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,674,560	$ 6,207,940		$ 445,496	25

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	6,841,683	23	$	$	569,043	$	1
2	22	Employee Benefits	Operating Expense	6,841,683	23	158,790		569,043	13,207	2
3	30	Depreciation	Operating Expense	1,848,371	23	1,848,371		157,459	157,459	3
4	34	Rent Facility	Operating Expense	6,841,683	23			569,043		4
5	17	Admin Consulting,Other	Operating Expense	6,841,683	23	6,120,437		569,043	509,055	5
6	17	Information Systems Salaries	Operating Expense	6,841,683	23			569,043		6
7	17	Information Systems - Other	Operating Expense	6,841,683	23	1,461,845		569,043	121,586	7
8	17	Admin Salaries	Direct Cost	6,841,683	23			569,043		8
9	17	Information Systems Salaries	Direct Cost	6,841,683	23	448,784	448,784	569,043	37,327	9
10	6	Information Systems - Equip Mair	Direct Cost	6,841,683	23	26,573		569,043	2,210	10
11	17	Admin Consulting,Other	Direct Cost	6,841,683	23	121,366		569,043	10,094	11
12	32	Admin - Interest Expense	Direct Cost	6,841,683	23			569,043		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					$ 10,186,166	$ 448,784		$ 850,938	25

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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			$	$		$ 574,250	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					$	$		$ 574,250	25

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Home Office Allocation						$	$			$ 10,094	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 10,094	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 10,094	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	2,341	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.)	$	1,377	2
3. Under or (over) accrual (line 2 minus line 1).	$	(964)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	2,370	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.	$	1,406	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	1,324	8
2012	1,308	9
2013	1,339	10
2014	1,348	11
2015	1,377	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE COR MARIAE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041046

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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	153B004C12-09-104-035	COMM SE COR LT IMPERIAL	$ 1,376.52	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,376.52	$

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 X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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		1995	$ 925,000	1
2					2
3	TOTALS			$ 925,000	3

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	89		1995	1997	$ 1,000,000	$ 10,868	54	$ 18,519	$ 7,650	$ 646,789	4
5	63		1997	1997	2,508,246	41,623	52	48,236	6,613	1,141,638	5
6	10		2005	2005	944,355	18,739	35	22,540	3,800	373,621	6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1995	35,000		10			35,000	9
10	VARIOUS			1996	261,495	1,284	15	(626)	(1,910)	263,405	10
11	VARIOUS			1997	528,604	22,381	16	19,093	(3,288)	523,554	11
12	VARIOUS			1998	174,397	5,415	13	5,239	(176)	114,381	12
13	VARIOUS			1999	10,976		6			10,976	13
14	VARIOUS			2000	35,515		6			35,515	14
15	VARIOUS			2001	52,800	871	9	835	(36)	49,091	15
16	VARIOUS			2002	116,065	3,830	10	3,944	114	112,889	16
17	VARIOUS			2003	126,562	171	9	158	(13)	126,263	17
18	VARIOUS			2004	103,927	942	9	902	(39)	101,724	18
19	VARIOUS			2005	68,501	728	14	716	(12)	62,668	19
20	VARIOUS			2006	115,365	7,381	12	7,346	(36)	100,812	20
21	VARIOUS			2007	48,526	2,941	12	2,930	(11)	33,018	21
22	VARIOUS			2008	201,896	4,792	13	5,370	578	108,178	22
23	VARIOUS			2009	282,197	16,654	11	16,839	185	143,939	23
24	VARIOUS			2010	113,780	10,200	11	10,091	(109)	66,591	24
25	VARIOUS			2011	526,824	24,676	15	24,832	156	135,776	25
26	VARIOUS			2012	64,411	5,421	13	5,265	(156)	23,901	26
27											27
28											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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	CEMENT PAD, WALKING PATH, GAZEBO	2013	$ 6,200	$ 607	10	$ 620	$ 13	$ 2,153	37
38	FURNISH AND INSTALL HANDSOFT PHONE	2013	3,127	159	20	156	(3)	551	38
39	RELOCATE CALL LIGHT & 4 JACKS TO MED	2013	2,009	277	7	287	10	992	39
40	NEW WATER MAIN BREAK	2013	15,716	1,623	10	1,572	(52)	5,570	40
41	SKILLED NURSING/FAMILY ROOM FURNISH	2013	19,462	1,595	12	1,622	27	5,640	41
42									42
43	CENTER AREA STONE VENEER ON WALLS	2014	22,191	3,362	7	3,170	(192)	8,182	43
44	DIALYSIS DEN CONSTRUCTION	2014	1,938	126	15	129	3	319	44
45	EXERCISE ROOM FLOOR	2014	3,500	233	15	233	1	513	45
46	FIRE PANEL ON SHELTERED CARE	2014	3,039	313	10	304	(9)	772	46
47	FURNISHING/DÉCOR FOR FAMILY AND LIVING	2014	19,411	1,302	15	1,294	(8)	3,246	47
48	MAIN BUILDING WATER HEATER	2014	3,296	333	10	330	(3)	828	48
49	WALK IN SHOWER FOR BISHOP	2014	5,701	587	10	570	(17)	1,447	49
50									50
51	BACKFLOW VALVE	2015	2,982	199	15	199		315	51
52	BEDSPREADS CUBICLE CURTAINS	2015	2,436	609	4	609	0	1,167	52
53	FLOORING FOR REHAB UNIT	2015	41,000	1,640	25	1,640		2,187	53
54	HVAC SOFTWARE	2015	17,445	1,745	10	1,745		3,198	54
55	INSTALLATION OF LIGHTING EQUIP	2015	4,277	285	15	285	0	546	55
56	LIGHTING EQUIPMENT	2015	1,288	86	15	86	(0)	165	56
57	PLUMBING DIALYSIS BUILD OUT	2015	13,770	275	50	275		367	57
58	ROOF & GARAGE RAMP	2015	2,950	279	10	295	16	716	58
59	TRANSPORT RECLINERS	2015	7,547	369	20	377	9	910	59
60	DIALYSIS DEN CONSTRUCTION	2015	4,400	367	15	293	(73)	367	60
61									61
62	Emergency transfer switch	2016	34,508	431	20	288	(144)	431	62
63	FURNISH/INSTALL TEKNOFLOR - 1st Floor & Bathrooms	2016	24,425	1,221	20	1,221		1,221	63
64	OPTIMA WHITE FLUSH DOOR - 1st Floor	2016	7,565	378	20	378		378	64
65	REPAIR CONCRETE - Loading Dock	2016	13,575	679	20	679	(0)	679	65
66									66
67									67
68	DEDUCTION FOR NON-CARE ASSETS	2009	(12,466)		-5			(12,466)	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,590,731	$ 197,996		$ 210,887	$ 12,890	$ 4,240,123	70

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	$ 1,199,806	$ 159,154	$ 160,023	$ 869	11	$ 804,474	71
72	Current Year Purchases	1,320	264	264		5	264	72
73	Fully Depreciated Assets	1,365,415	3,161	3,161		10	1,365,416	73
74	Home Office Allocation		163,392	163,392				74
75	TOTALS	$ 2,566,541	$ 325,971	$ 326,840	$ 869		$ 2,170,154	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	PLANT ENGINEERING	1991 CHEVROLET FLEETSIDE	1995	$ 14,000	$	$	$	5	$ 14,000	76
77	PLANT ENGINEERING	2000 FORD ELDORADO CAP	2000	42,500				10	42,500	77
78	PLANT ENGINEERING	2013 CHEVROLET SILVER RA	2014	38,730	11,352	9,683	(1,669)	4	26,432	78
79										79
80	TOTALS			$ 95,230	$ 11,352	$ 9,683	$ (1,669)		$ 82,932	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)	$ 11,177,502	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 535,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 547,409	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,090	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,493,209	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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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				0			5
6								6
7	TOTAL				$ **			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 ☒ X 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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 38,183 Description: Nursing 8,449; Admin 9,477; Activities 460; Home Office 19,797
(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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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 COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	6787	hrs	$ 245,040		$	$	6,787	$ 245,040	1
2	Licensed Speech and Language Development Therapist	10a, 1	428	hrs	18,063				428	18,063	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	8568	hrs	318,681				8,568	318,681	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				574,250		574,250	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Director	10a, 1	1946		94,450				1,946	94,450	12
13	Other (specify):										13
14	TOTAL				$ 676,234		$	$ 574,250	17,729	$ 1,250,484	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE COR MARIAE CENTER **#** 0041046 **Report Period Beginning:** 1/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 13,093,635	$	1
2	Cash-Patient Deposits	136,639		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	39,798,115		3
4	Supply Inventory (priced at)	1,624,833		4
5	Short-Term Investments	1,515,071		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,808,186		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 58,976,479	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,314,676		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	236,115,679		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	68,273,740		16
17	Accumulated Depreciation (book methods)	(187,356,794)		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):	2,149,114		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 155,443,930	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 214,420,409	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,011,382	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,457,867		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,069		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,368		32
33	Accrued Interest Payable	5,594		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties	(1,918,871)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 32,152,409	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	757,059		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	114,984		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 872,043	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 33,024,452	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 181,395,957	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 214,420,409	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	7,108,969	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 183,011,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,217,948)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	515,397	11
12	Expenditures for Specific Purposes	(913,464)	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)**	$ (1,616,015)	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)**	$ 181,395,957	24 *

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	$ 9,725,435	1
2	Discounts and Allowances for all Levels	(3,654,261)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,071,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,534,393	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,534,393	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	7,042	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	969,179	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)**	$ 976,221	23
	D. Non-Operating Revenue		
24	Contributions	84,720	24
25	Interest and Other Investment Income***	9,862	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 94,582	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)**	$ 8,676,370	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,063,115	31
32	Health Care	3,726,703	32
33	General Administration	2,703,521	33
	B. Capital Expense		
34	Ownership	695,879	34
	C. Ancillary Expense		
35	Special Cost Centers	574,250	35
36	Provider Participation Fee	130,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,894,318	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,217,948)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,217,948)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 887,071	44
45	Private Pay - Net Inpatient Revenue	3,259,685	45
46	Medicare - Net Inpatient Revenue	1,243,230	46
47	Other-(specify) Insurance	681,188	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,071,174	49

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

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

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

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

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	2,316	2,450	$ 117,657	$ 48.02	1
2	Assistant Director of Nursing	830	901	31,387	34.84	2
3	Registered Nurses	19,411	20,779	695,459	33.47	3
4	Licensed Practical Nurses	18,132	19,288	529,171	27.44	4
5	CNAs & Orderlies	49,560	53,612	735,646	13.72	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	16,643	17,729	676,234	38.14	7
8	Rehab/Therapy Aides	982	1,070	11,804	11.03	8
9	Activity Director	3,534	3,896	72,307	18.56	9
10	Activity Assistants	10,847	11,721	141,167	12.04	10
11	Social Service Workers	3,570	3,919	76,279	19.46	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,460	6,892	145,504	21.11	17
18	Housekeepers	9,033	10,110	118,026	11.67	18
19	Laundry	2,259	2,292	24,384	10.64	19
20	Administrator	1,901	2,084	120,317	57.73	20
21	Assistant Administrator	161	329	9,314	28.31	21
22	Other Administrative	1,955	2,019	32,186	15.94	22
23	Office Manager	1,415	1,822	40,332	22.14	23
24	Clerical	5,027	5,521	69,860	12.65	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health C: Admissions	2,856	3,129	62,290	19.91	32
33	Other(specify) Pastoral	1,548	1,754	38,537	21.97	33
34	TOTAL (lines 1 - 33)	158,440	171,317	$ 3,747,861 *	$ 21.88	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	21,000	9,3	36
37	Medical Records Consultant	23	1,553	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	648	39,549	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,774		44
45	Social Service Consultant	288	1,774	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	987	$ 65,650		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,746	$ 262,242	10,3	50
51	Licensed Practical Nurses	1,648	74,141	10,3	51
52	Certified Nurse Assistants/Aides	4,725	47,254	10,3	52
53	TOTAL (lines 50 - 52)	10,119	$ 383,637		53

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gilihan	Administrator		$ 120,317
Administrative Staff	Office Manager		40,332
Administrative Staff	Receptionists		32,540
Administrative Staff	Administrative Asst		9,314
Administrative Staff	Admissions		62,290
Administrative Staff	Other Administrative		117,417
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 382,210

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,006,638
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,006,638

C. Professional Services

Vendor/Payee	Type	Amount
Iron Mountain	Shredding/Storage	$ 6,078
Advanced Technologies Group Inc	Software Maintenance	5,850
Cardinal Glass Company	Glass Installation	2,201
KJWW Engineering Consultants	Engineering/Survey	1,055
Living Design Inc	Aviary Maintenance	2,050
Sebert Landscaping	Landscaping	15,864
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 33,098

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,722
Unemployment Compensation Insurance	13,830
FICA Taxes	273,924
Employee Health Insurance	427,885
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	52,570
Dental	13,444
Life Insurance	3,132
Disability Insurance	16,863
Pension	190,540
Tuition Reimbursement	8,644
Other Benefits	22,506
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,075,060

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 59)	
Patient Background Checks 211	
Employee Recruitment	1,216
Dues & Subscriptions	38,953
Advertising & Public Relations	925
Home Office Allocation	2,964
Less: Public Relations Expense	( )
Non-allowable advertising	(925)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,133

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	241
Seminar Expense	
Home Office Allocation	4,820
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,061

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE COR MARIAE CENTER # 0041046 Report Period Beginning: 1/01/16 Ending: 12/31/16

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 $7,072.99**

(3) Did the nursing home make political contributions or payments to a politica
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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **9,666** 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 fo
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 Departmen
during this cost report period. $ **130,850**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **7,042**

(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 fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees