		FOR BHF USE					

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

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: 0054072

Facility Name: PRESENCE NAZARETHVILLE

Address: 300 NORTH RIVER ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: 847-297-5900 Fax # 847-297-0504

HFS ID Number:

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

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[X] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code 501C3	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name: GEORGE VIEU Telephone Number: 708-478-7943
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/16 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 NAZARETHVILLE # 0054072 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,490	5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF			247	247	8
9	SNF/PED					9
10	ICF	13,086	11,002		24,088	10
11	ICF/DD					11
12	SC		1,999		1,999	12
13	DD 16 OR LESS					13
14	TOTALS	13,086	13,001	247	26,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.69%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified ______ and days of care provided 247

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.

STATE OF ILLINOIS

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary		13,364	378,976	392,340		392,340		392,340			1
2	Food Purchase		186,269		186,269		186,269	(3,407)	182,862			2
3	Housekeeping	128,658	9,118	6,200	143,976		143,976		143,976			3
4	Laundry	39,718	984	61,898	102,600		102,600	(21,889)	80,711			4
5	Heat and Other Utilities			149,027	149,027		149,027	1,486	150,513			5
6	Maintenance	150,515	23,494	140,128	314,137		314,137	4,999	319,136			6
7	Other (specify):* **Pastoral**	67,054	1,478		68,532		68,532		68,532			7
8	**TOTAL General Services**	385,945	234,707	736,229	1,356,881		1,356,881	(18,811)	1,338,070			8
	B. Health Care and Programs											
9	Medical Director	10,841			10,841		10,841		10,841			9
10	Nursing and Medical Records	2,052,418	89,186	21,066	2,162,670		2,162,670		2,162,670			10
10a	Therapy											10a
11	Activities	109,492	2,564	625	112,681		112,681	72	112,753			11
12	Social Services	24,684	910	2,835	28,429		28,429		28,429			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,197,435	92,660	24,526	2,314,621		2,314,621	72	2,314,693			16
	C. General Administration											
17	Administrative	196,652	13,604	597,753	808,009		808,009	(47,321)	760,688			17
18	Directors Fees											18
19	Professional Services			1,955	1,955		1,955	15,421	17,376			19
20	Dues, Fees, Subscriptions & Promotions			19,139	19,139		19,139	1,490	20,629			20
21	Clerical & General Office Expenses			1,309	1,309		1,309	913	2,222			21
22	Employee Benefits & Payroll Taxes			761,314	761,314		761,314	40,142	801,456			22
23	Inservice Training & Education			98	98		98	345	443			23
24	Travel and Seminar							2,568	2,568			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,733	58,733		58,733	543	59,276			26
27	Other (specify):*											27
28	**TOTAL General Administration**	196,652	13,604	1,440,301	1,650,557		1,650,557	14,101	1,664,658			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,780,032	340,971	2,201,056	5,322,059		5,322,059	(4,638)	5,317,421			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 NAZARETHVILLE #0054072 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			221,185	221,185		221,185	(3,456)	217,729			30
31	Amortization of Pre-Op. & Org.			42,050	42,050		42,050		42,050			31
32	Interest			12,887	12,887		12,887	(593)	12,294			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							10,546	10,546			35
36	Other (specify):*											36
37	**TOTAL Ownership**			276,122	276,122		276,122	6,497	282,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			315,752	315,752		315,752		315,752			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			202,296	202,296		202,296		202,296			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			518,048	518,048		518,048		518,048			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,780,032	340,971	2,995,226	6,116,229		6,116,229	1,859	6,118,088			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 NAZARETHVILLE # 0054072 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	(4,137)	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	(21,889)	4		8
9	Non-Straightline Depreciation	(6,617)	30		9
10	Interest and Other Investment Income	(593)	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	(89)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,325)		$	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)	35,184		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 35,184		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,859		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 NAZARETHVILLE

ID# 0054072

Report Period Beginning: 1/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	(4,137)	730	0	0	0	0	0	0	0	0	0	(3,407)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21,889)	0	0	0	0	0	0	0	0	0	0	(21,889)	4
5	Heat and Other Utilities	0	1,486	0	0	0	0	0	0	0	0	0	1,486	5
6	Maintenance	0	4,999	0	0	0	0	0	0	0	0	0	4,999	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(26,026)	7,215	0	0	0	0	0	0	0	0	0	(18,811)	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	72	0	0	0	0	0	0	0	0	0	72	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	72	0	0	0	0	0	0	0	0	0	72	16
	C. General Administration													
17	Administrative	0	(77,123)	29,802	0	0	0	0	0	0	0	0	(47,321)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,421	0	0	0	0	0	0	0	0	0	15,421	19
20	Fees, Subscriptions & Promotions	(89)	1,579	0	0	0	0	0	0	0	0	0	1,490	20
21	Clerical & General Office Expenses	0	913	0	0	0	0	0	0	0	0	0	913	21
22	Employee Benefits & Payroll Taxes	0	40,142	0	0	0	0	0	0	0	0	0	40,142	22
23	Inservice Training & Education	0	345	0	0	0	0	0	0	0	0	0	345	23
24	Travel and Seminar	0	2,568	0	0	0	0	0	0	0	0	0	2,568	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	543	0	0	0	0	0	0	0	0	0	543	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(89)	(15,612)	29,802	0	0	0	0	0	0	0	0	14,101	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,115)	(8,325)	29,802	0	0	0	0	0	0	0	0	(4,638)	29

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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 D. Ownership	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)	
30	Depreciation	(6,617)	0	3,161	0	0	0	0	0	0	0	0	(3,456)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(593)	0	0	0	0	0	0	0	0	0	0	(593)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	10,546	0	0	0	0	0	0	0	0	10,546	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,210)	0	13,707	0	0	0	0	0	0	0	0	6,497	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)**	(33,325)	(8,325)	43,509	0	0	0	0	0	0	0	0	1,859	45

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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%	$ 730	$ 730	1
2	V	5	Utilities		Presence Life Connections	100.00%	1,486	1,486	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	4,999	4,999	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	72	72	4
5	V	17	Admin - Misc. Other	231,950	Presence Life Connections	100.00%	2,537	(229,413)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	152,290	152,290	6
7	V	19	Professional Services		Presence Life Connections	100.00%	15,421	15,421	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	1,579	1,579	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	913	913	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	40,142	40,142	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	345	345	11
12	V	24	Travel		Presence Life Connections	100.00%	2,568	2,568	12
13	V	26	Insurance		Presence Life Connections	100.00%	543	543	13
14	Total			$ 231,950			$ 223,625	$ * (8,325)	14

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Presence Life Connections	100.00%	$ 3,161	$ 3,161	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%	10,546	10,546	18
19	V	17	Admin Salaries		Presence Health	100.00%	36,351	36,351	19
20	V	30	Depreciation	92,517	Presence Health	100.00%	92,517		20
21	V	17	Admin Consulting,Other	365,795	Presence Health	100.00%	359,246	(6,549)	21
22	V	39	Ancillary Services - Other	315,752	Presence Senior Services Pharmacy	100.00%	315,752		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 774,064			$ 817,573	$ * 43,509	39

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	Susan Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	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 NAZARETHVILLE # 0054072 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 NAZARETHVILLE # 0054072 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

Name of Related Organization	Presence Life Connections
Street Address	18927 Hickory Creek Dr, Ste 300
City / State / Zip Code	Mokena, IL 60448
Phone Number	(708-478-7900
Fax Number	(708-478-5387

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

	1 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	$	231,950	$ 730	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575		231,950	1,486	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785		231,950	4,999	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934		231,950	72	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412		231,950	2,537	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	231,950	152,290	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607		231,950	15,421	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374		231,950	1,579	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236		231,950	913	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354		231,950	40,142	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049		231,950	345	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676		231,950	2,568	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118		231,950	543	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835		231,950	3,161	14
15	32	Interest	Management Fee Income	9,455,191	33	0		231,950	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0		231,950	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912		231,950	10,546	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,674,560	$ 6,207,940		$ 237,332	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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 [ ]

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

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

	1 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	6,627,442	10	$ 658,602	$ 658,602	365,795	$ 36,351	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		92,517	92,517	2
3	17	Admin Consulting,Other	Operating Expense	6,627,442	10	6,508,786		365,795	359,246	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					$ 8,825,401	$ 658,602		$ 488,114	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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			$	$		$ 315,752	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					$	$		$ 315,752	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ____________ 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 NAZARETHVILLE **#** 0054072 **Report Period Beginning:** 1/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		**8**
	2012		**9**
	2013		**10**
	2014		**11**
	2015		**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 NAZARETHVILLE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054072

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CHAPEL RENOVATIONS			2014	36,000	2,429	30	2,400	(29)	6,039	9
10	L M TO EXTEND 20 AMP 3 PHASE 2			2014	2,738	108	25	110	2	271	10
11	L M TO INSTALL TWO DOOR RESTRI			2014	2,350	115	20	118	3	290	11
12	NEW ARMSTRONG VINYL SHEET IN 7			2014	25,550	1,654	15	1,703	50	4,192	12
13	NEW KARNDEAN DESIGN FLOORING			2014	64,426	5,246	25	5,369	122	13,259	13
14	REPLACEMENT OF DOORS TO PATIO			2014	2,100	138	15	140	2	348	14
15	REPLACEMENT OF FLOORING IN CHA			2014	21,579	2,178	10	2,158	(21)	5,422	15
16	SOFFIT FASCIA REPLACEMENT GUT			2014	20,755	1,015	20	1,038	22	2,564	16
17	SUMP PUMP SYSTEM			2015	6,389	639	10	639		1,065	17
18	Naz Room Expansion Project			2015	14,400	900	40	720	(180)	900	18
19	BOILER BURNER & CONTROLS UPGRD			2015	55,935	3,496	20	2,797	(699)	3,496	19
20	ELEVATOR UPGRADES-HEAT DETECTR			2015	26,627	1,664	20	1,331	(333)	1,664	20
21	FAN COILS AND BACK PLATES			2015	50,669	3,167	20	2,533	(633)	3,167	21
22	FIRE DAMPER DUCTWORK MAIN BOIL			2015	18,300	1,144	20	915	(229)	1,144	22
23	FLOORING FOR ADM OFFICE			2015	3,885	389	10	389		486	23
24	INSTALL FIRE DAMPERS BOILR RM			2015	5,600	350	20	280	(70)	350	24
25	INSTALL LIGHTING FIXTURES			2015	42,645	2,665	20	2,132	(533)	2,665	25
26	L & M INSTALL VFDS			2015	300,810	18,801	20	15,041	(3,760)	18,801	26
27	L M TO INSTALL TWO DOOR RESTRI			2015	2,350	59	40	59		113	27
28	L M TO INSTALL TWO WALL PACK L			2015	14,871	724	20	744	19	1,833	28
29	MATERIAL LED EXIT RETROFIT			2015	66,902	4,181	20	3,345	(836)	4,181	29
30	MATERIAL, CONTROLLERS VFD PROJ			2015	152,700	9,544	20	7,635	(1,909)	9,544	30
31	MATL CONTROLLERS VFD PROJECT			2015	14,400	900	20	720	(180)	900	31
32	NEWSPRINKLER HEADS 2+3 FL			2015	18,300	1,144	20	915	(229)	1,144	32
33	NEW THERMOSTATS			2015	17,640	1,103	20	882	(221)	1,103	33
34	NEW ROOF			2015	177,980	11,865	15	11,865	0	16,809	34
35	NEW SPRIKLER HEADS			2015	39,850	2,491	20	1,993	(498)	2,491	35
36	AUTOMATIC DOOR OPENER			2015	4,697	294	20	235		294	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 NAZARETHVILLE # 0054072 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	: Door Levers for Resident R	2016	$ 19,930	$ 1,329	10	$ 1,163	$ (166)	$ 1,329	37
38	: Sidewalk Replacement	2016	5,000	333	15	333	0	333	38
39	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,667	14	20	7	(7)	14	39
40	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	8,275	34	20		(34)	34	40
41	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,143	57	20	57	0	57	41
42	LIFT GATE - Front Entrance Common Area	2016	53	2	20	2	(0)	2	42
43	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	3,540	103	20	89	(15)	103	43
44	Electric Sliding Doors - Front Entrance	2016	13,266	608	20	553	(55)	608	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,263,322	$ 80,883		$ 70,407	$ (10,417)	$ 107,015	70

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	$ 597,968	$ 45,060	$ 48,986	$ 3,926	19	$ 267,774	71
72	Current Year Purchases	10,506	544	477	(67)	15	544	72
73	Fully Depreciated Assets	425,839	2,181	2,181		13	425,839	73
74	Home Office Allocation		95,678	95,678				74
75	TOTALS	$ 1,034,313	$ 143,463	$ 147,322	$ 3,859		$ 694,157	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,297,636	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 224,346	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 217,729	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,617)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 801,172	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 NAZARETHVILLE # 0054072 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

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	$

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: *

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: $ 12,887 Description: Nursing 5,169; Plant Eng 6,157; Activities 108; Admin 1,202; Pastoral 252
    (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 NAZARETHVILLE # 0054072 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.

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	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a, 1	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Director	10a, 1								12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 NAZARETHVILLE # 0054072 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 NAZARETHVILLE # 0054072 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	5,819,844	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 181,722,847	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,177	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)**	$ (326,890)	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 NAZARETHVILLE # 0054072 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	$ 7,747,352	1
2	Discounts and Allowances for all Levels	(2,030,001)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,717,351	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	4,137	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	440,268	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	21,889	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 466,294	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	593	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 593	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	3,168	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,168	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,187,406	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,356,881	31
32	Health Care	2,314,621	32
33	General Administration	1,650,557	33
	B. Capital Expense		
34	Ownership	276,122	34
	C. Ancillary Expense		
35	Special Cost Centers	315,752	35
36	Provider Participation Fee	202,296	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,116,229	40
41	**Income before Income Taxes (line 30 minus line 40)****	71,177	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 71,177	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,063,753	44
45	Private Pay - Net Inpatient Revenue	3,542,249	45
46	Medicare - Net Inpatient Revenue	111,349	46
47	Other-(specify) Insurance		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,717,351	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 NAZARETHVILLE # 0054072 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	2,094	$ 95,139	$ 45.43	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	24,167	26,871	967,156	35.99	3
4	Licensed Practical Nurses	3,475	3,909	102,711	26.28	4
5	CNAs & Orderlies	49,386	55,652	844,845	15.18	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,922	2,110	34,954	16.57	9
10	Activity Assistants	7,542	8,323	115,735	13.91	10
11	Social Service Workers	1,301	1,386	24,684	17.81	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	4,937	5,485	150,515	27.44	17
18	Housekeepers	7,297	8,724	128,658	14.75	18
19	Laundry	3,538	3,834	39,718	10.36	19
20	Administrator	1,838	2,090	79,456	38.02	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	716	827	17,155	20.74	23
24	Clerical	4,215	4,584	53,345	11.64	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	87	87	10,841	124.61	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	1,940	2,199	48,066	21.86	31
32	Other Health Ca Admissions	0	0	0		32
33	Other(specify) Pastoral	2,349	2,672	67,054	25.10	33
34	TOTAL (lines 1 - 33)	116,494	130,847	$ 2,780,032 *	$ 21.25	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	26	1,785	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	26	$ 1,785		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10,3	50
51	Licensed Practical Nurses	0	0	10,3	51
52	Certified Nurse Assistants/Aides	0	0	10,3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ann McKeogh	Administrator		$ 79,456
Administrative Staff	Office Manager		17,155
Administrative Staff	Receptionists		53,345
Administrative Staff	Administrative Asst		0
Administrative Staff	Admissions		0
Administrative Staff	Other Administrative		46,696
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 196,652

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 597,753
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 597,753

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 0
Collections	Various	0
Shredding/Storage	Various	0
Survey & Analytical Tools	Various	0
Ground Charge	Various	0
Biomed	Various	0
Outsourced Services	Various	1,955
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 1,955

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,464
Unemployment Compensation Insurance	10,680
FICA Taxes	196,663
Employee Health Insurance	326,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	40,142
Dental	10,321
Life Insurance	2,423
Disability Insurance	12,899
Pension	146,571
Tuition Reimbursement	6,513
Other Benefits	9,126
TOTAL (agree to Schedule V, line 22, col.8)	$ 801,456

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 6)	
Patient Background Checks 25	
Employee Recruitment	0
Dues & Subscriptions	19,050
Advertising & Public Relations	89
Home Office Allocation	1,579
Less: Public Relations Expense	( )
Non-allowable advertising	(89)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,629

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	
Home Office Allocation	2,568
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,568

**See instructions.

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 $5,445**

(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? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,056** 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. $ **202,296**
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. $ **4,137**

(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