

		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.

<p>I. IDPH License ID Number: <u>0044354</u></p> <p>Facility Name: <u>PRESENCE RESURRECT LIFE CTR</u></p> <p>Address: <u>7370 W TALCOTT AVE</u> <u>CHICAGO</u> <u>60631</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>773-594-7400</u> Fax # <u>773-594-7402</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03-01-00</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>GEORGE VIEU</u> Telephone Number: <u>708-478-7943</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u> (Date) _____ </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u> (Date) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u> (Date) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,652	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,810	3
4		Intermediate/DD			4
5	5	Sheltered Care (SC)	5	1,830	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,342	8,577	15,745	43,664	8
9	SNF/PED					9
10	ICF	9,939	2,237		12,176	10
11	ICF/DD					11
12	SC		1,799		1,799	12
13	DD 16 OR LESS					13
14	TOTALS	29,281	12,613	15,745	57,639	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.21%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A-NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 03-01-00

J. Was the facility purchased or leased after January 1, 1978?

YES Date 03-01-00 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 122 and days of care provided 13,941

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **PRESENCE RESURRECT LIFE CTR** # **0044354** 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		19,320	719,005	738,325	738,325		738,325			1
2	Food Purchase		379,228		379,228	379,228	(8,750)	370,478			2
3	Housekeeping	179,718	8,129	12,076	199,923	199,923		199,923			3
4	Laundry	46,662	172,459		219,121	219,121	(52,933)	166,188			4
5	Heat and Other Utilities			194,146	194,146	194,146	3,632	197,778			5
6	Maintenance	87,121	40,263	221,778	349,162	349,162	12,217	361,379			6
7	Other (specify):* Pastoral	93,544	1,705	18,285	113,534	113,534		113,534			7
8	TOTAL General Services	407,045	621,104	1,165,290	2,193,439	2,193,439	(45,834)	2,147,605			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,649,247	284,574	647	4,934,468	4,934,468		4,934,468			10
10a	Therapy	1,211,246	9,412	231,218	1,451,876	1,451,876		1,451,876			10a
11	Activities	135,125	1,256	699	137,080	137,080	176	137,256			11
12	Social Services	132,505	340		132,845	132,845		132,845			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,128,123	295,582	232,564	6,656,269	6,656,269	176	6,656,445			16
	C. General Administration										
17	Administrative	300,200	36,085	1,461,039	1,797,324	1,797,324	(115,504)	1,681,820			17
18	Directors Fees										18
19	Professional Services			87,504	87,504	87,504	37,686	125,190			19
20	Dues, Fees, Subscriptions & Promotions			54,400	54,400	54,400	3,859	58,259			20
21	Clerical & General Office Expenses			12,628	12,628	12,628	2,232	14,860			21
22	Employee Benefits & Payroll Taxes			1,713,361	1,713,361	1,713,361	98,103	1,811,464			22
23	Inservice Training & Education						842	842			23
24	Travel and Seminar						6,276	6,276			24
25	Other Admin. Staff Transportation			110	110	110		110			25
26	Insurance-Prop.Liab.Malpractice			200,311	200,311	200,311	1,326	201,637			26
27	Other (specify):*										27
28	TOTAL General Administration	300,200	36,085	3,529,353	3,865,638	3,865,638	34,820	3,900,458			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,835,368	952,771	4,927,207	12,715,346	12,715,346	(10,838)	12,704,508			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			520,275	520,275		520,275	67,232	587,507		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			160,045	160,045		160,045	(301)	159,744		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			53,591	53,591		53,591	25,774	79,365		35
36	Other (specify):*										36
37	TOTAL Ownership			733,911	733,911		733,911	92,705	826,616		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			1,253,574	1,253,574		1,253,574		1,253,574		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			352,901	352,901		352,901		352,901		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			1,606,475	1,606,475		1,606,475		1,606,475		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,835,368	952,771	7,267,593	15,055,732		15,055,732	81,867	15,137,599		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,534)	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	(52,933)	4		8
9	Non-Straightline Depreciation	59,508	30		9
10	Interest and Other Investment Income	(301)	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				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)	\$ (4,260)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	86,127		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 86,127		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 81,867		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY							
48		49		50		51	
							52

PRESENCE RESURRECT LIFE CTR

ID# 0044354

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
20			20
21			21
22			22
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,534)	1,784	0	0	0	0	0	0	0	0	0	(8,750)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(52,933)	0	0	0	0	0	0	0	0	0	0	(52,933)	4
5	Heat and Other Utilities	0	3,632	0	0	0	0	0	0	0	0	0	3,632	5
6	Maintenance	0	12,217	0	0	0	0	0	0	0	0	0	12,217	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(63,467)	17,633	0	0	0	0	0	0	0	0	0	(45,834)	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	176	0	0	0	0	0	0	0	0	0	176	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	176	0	0	0	0	0	0	0	0	0	176	16
	C. General Administration													
17	Administrative	0	(188,480)	72,976	0	0	0	0	0	0	0	0	(115,504)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	37,686	0	0	0	0	0	0	0	0	0	37,686	19
20	Fees, Subscriptions & Promotions	0	3,859	0	0	0	0	0	0	0	0	0	3,859	20
21	Clerical & General Office Expenses	0	2,232	0	0	0	0	0	0	0	0	0	2,232	21
22	Employee Benefits & Payroll Taxes	0	98,103	0	0	0	0	0	0	0	0	0	98,103	22
23	Inservice Training & Education	0	842	0	0	0	0	0	0	0	0	0	842	23
24	Travel and Seminar	0	6,276	0	0	0	0	0	0	0	0	0	6,276	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	1,326	0	0	0	0	0	0	0	0	0	1,326	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(38,156)	72,976	0	0	0	0	0	0	0	0	34,820	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,467)	(20,347)	72,976	0	0	0	0	0	0	0	0	(10,838)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR # 0044354 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	59,508	0	7,724	0	0	0	0	0	0	0	0	67,232	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(301)	0	0	0	0	0	0	0	0	0	0	(301)	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	25,774	0	0	0	0	0	0	0	0	25,774	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	59,207	0	33,498	0	0	0	0	0	0	0	0	92,705	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)	(4,260)	(20,347)	106,474	0	0	0	0	0	0	0	0	81,867	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 1,784	\$	1,784	1
2	V	5 Utilities		Presence Life Connections	100.00%	3,632		3,632	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	12,217		12,217	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	176		176	4
5	V	17 Admin - Misc. Other	566,860	Presence Life Connections	100.00%	6,200		(560,660)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	372,180		372,180	6
7	V	19 Professional Services		Presence Life Connections	100.00%	37,686		37,686	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	3,859		3,859	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	2,232		2,232	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	98,103		98,103	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	842		842	11
12	V	24 Travel		Presence Life Connections	100.00%	6,276		6,276	12
13	V	26 Insurance		Presence Life Connections	100.00%	1,326		1,326	13
14	Total		\$ 566,860			\$ 546,513	\$ *	(20,347)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 7,724	\$ 7,724
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	0	
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	25,774	25,774
19	V	17 Admin Salaries		Presence Health	100.00%	89,013	89,013
20	V	30 Depreciation	228,944	Presence Health	100.00%	228,944	
21	V	17 Admin Consulting, Other	895,731	Presence Health	100.00%	879,694	(16,037)
22	V	39 Ancillary Services - Other	1,253,574	Presence Senior Services Pharmacy	100.00%	1,253,574	
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,378,249			\$ 2,484,723	\$ * 106,474

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

Facility Name & ID Number

PRESENCE RESURRECT LIFE CTR

0044354

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 House	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lodge	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 Services	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral Health	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem Way	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Carlo	Northlake	Independent Living	13
14					Presence Ambulatory Services	Various	Parent	14
15					Resurrection Development	Chicago	Parent	15
16					Presence Healthcare Services	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care Services	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 Retirement	Chicago	Independent Living	24
25					Resurrection University	Chicago	College	25
26					Presence Health Partners	Various	Parent	26
27					Presence Properties Plus	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Estate	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR # 0044354 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	NA								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	9,455,191	33	\$ 29,753	\$ 566,860	\$ 1,784	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575	566,860	3,632	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785	566,860	12,217	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934	566,860	176	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412	566,860	6,200	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	372,180	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607	566,860	37,686	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374	566,860	3,859	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236	566,860	2,232	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354	566,860	98,103	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049	566,860	842	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676	566,860	6,276	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118	566,860	1,326	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835	566,860	7,724	14
15	32	Interest	Management Fee Income	9,455,191	33	0	566,860	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0	566,860	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912	566,860	25,774	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 9,674,560	\$ 6,207,940	\$ 580,011	25

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	6,627,442	10	\$ 658,602	\$ 658,602	895,731	\$ 89,013	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		228,944	228,944	2
3	17	Admin Consulting,Other	Operating Expense	6,627,442	10	6,508,786		895,731	879,694	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		\$ 1,197,651	25

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		1,253,574	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				\$	\$		1,253,574	25

Facility Name & ID Number

PRESENCE RESURRECT LIFE CTR

0044354

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	<u>Home Office Allocation</u>					\$	\$			\$	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.)

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 RESURRECT LIFE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044354

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)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 RESURRECT LIFE CTR

0044354

Report Period Beginning:

1/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,000 B. General Construction Type: Exterior Brick/Concrete Frame Number of Stories 2

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

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

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

Blank lines for listing other business entities.

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 281,600, 1996, \$ 3,600,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 281,600, (blank), \$ 3,600,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159	1998		\$ 11,729,482	\$ 118,614	40	\$ 178,696	\$ 60,082	\$ 9,541,576	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1999	76,653		12			76,653	9
10	VARIOUS		2000	131,067		11			131,067	10
11	VARIOUS		2001	17,210	165	11	165		17,210	11
12	VARIOUS		2002	24,356	916	12	916		19,774	12
13	VARIOUS		2003	25,777	412	9	485	73	25,194	13
14	VARIOUS		2004	21,803	1,309	13	1,309		19,185	14
15	VARIOUS		2005	6,444		8			6,444	15
16	VARIOUS		2006	62,098	3,561	18	3,561		59,855	16
17	VARIOUS		2008	1,401	70	20	70		561	17
18	VARIOUS		2012	24,172	2,220		2,245	25	10,068	18
19										19
20	LYNXSPRING TRIDIUM		2015	15,340	959	20	767	(192)	959	20
21	PLUMBING DCW BOOSTER		2016	4,215	213	20	213		213	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

*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 RESURRECT LIFE CTR

0044354

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 12,140,018	\$ 128,439		\$ 188,427	\$ 59,988	\$ 9,908,759	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,821,618	\$ 157,388	\$ 157,278	\$ (110)	22	\$ 847,719	71
72	Current Year Purchases	90,416	4,141	3,771	(370)	15	4,141	72
73	Fully Depreciated Assets	1,266,006	1,362	1,362		14	1,266,006	73
74	Home Office Allocation		236,669	236,669				74
75	TOTALS	\$ 3,178,040	\$ 399,560	\$ 399,080	\$ (480)		\$ 2,117,866	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)	\$ 18,918,058	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 527,999	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 587,507	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,508	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,026,625	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5	Home Office Allocation				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 NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 79,365 Description: Nursing 23,914; Admin 18,407; Dietary 619; Pastoral Care 120; Plant Ops 661; Rehabilitation 9,871

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a, 1	11563	hrs	\$ 448,873		\$	\$	11,563	\$ 448,873	1
2	Licensed Speech and Language Development Therapist	10a, 1	2163	hrs	91,945				2,163	91,945	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	14208	hrs	569,188				14,208	569,188	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,3		# of prescripts				1,253,574		1,253,574	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Director</u>	10a, 1	2081		101,240				2,081	101,240	12
13	Other (specify): _____										13
14	TOTAL				\$ 1,211,246		\$	\$ 1,253,574	30,015	\$ 2,464,820	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.

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	2	
		Operating	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	2	
		Operating	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	<u>Due to Third Parties</u>	(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	<u>Conditional Asset Retirement</u>	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.)

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	3,700,979	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 179,603,982	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,190,042	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)	\$ 1,791,975	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.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 18,136,722	1
2	Discounts and Allowances for all Levels	(6,330,565)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,806,157	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,169,325	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,169,325	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	10,534	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,900,304	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	52,933	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,963,771	23
D. Non-Operating Revenue			
24	Contributions	256,195	24
25	Interest and Other Investment Income***	301	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 256,496	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	50,025	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50,025	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,245,774	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,193,439	31
32	Health Care	6,656,269	32
33	General Administration	3,865,638	33
B. Capital Expense			
34	Ownership	733,911	34
C. Ancillary Expense			
35	Special Cost Centers	1,253,574	35
36	Provider Participation Fee	352,901	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,055,732	40
41	Income before Income Taxes (line 30 minus line 40)**	2,190,042	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,190,042	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,323,398	44
45	Private Pay - Net Inpatient Revenue	3,554,776	45
46	Medicare - Net Inpatient Revenue	3,668,346	46
47	Other-(specify) <u>Insurance</u>	259,637	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,806,157	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 RESURRECT LIFE CTR**

0044354

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	11,890	2,030	\$ 97,451	\$ 48.01	1
2	Assistant Director of Nursing	1,676	2,013	86,206	42.82	2
3	Registered Nurses	54,539	61,015	2,296,710	37.64	3
4	Licensed Practical Nurses	12,437	14,076	393,492	27.95	4
5	CNAs & Orderlies	110,813	120,292	1,723,850	14.33	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	28,063	30,015	1,211,246	40.35	7
8	Rehab/Therapy Aides	1,002	1,102	16,364	14.85	8
9	Activity Director	1,846	2,099	49,780	23.72	9
10	Activity Assistants	6,757	7,556	93,035	12.31	10
11	Social Service Workers	5,484	6,119	132,403	21.64	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	3,992	4,256	87,121	20.47	17
18	Housekeepers	11,920	14,685	179,717	12.24	18
19	Laundry	2,973	3,642	46,661	12.81	19
20	Administrator	1,264	1,303	66,055	50.69	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,787	2,059	42,124	20.46	22
23	Office Manager	1,976	2,071	46,418	22.41	23
24	Clerical	3,516	3,658	38,482	10.52	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	1,841	2,132	43,974	20.63	31
32	Other Health C: Admissions	3,572	3,928	90,735	23.10	32
33	Other(specify) <u>Pastoral</u>	3,724	3,929	93,544	23.81	33
34	TOTAL (lines 1 - 33)	271,072	287,980	\$ 6,835,368 *	\$ 23.74	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	347	20,486	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	406	25,554	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	753	\$ 46,040		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Nancy Razo	Administrator		\$ 66,055	Workers' Compensation Insurance	\$ 86,616	IDPH License Fee	\$	
Administrative Staff	Office Manager		46,418	Unemployment Compensation Insurance	23,361	Advertising: Employee Recruitment		
Administrative Staff	Receptionists		36,288	FICA Taxes	488,292	Health Care Worker Background Check		
Administrative Staff	Administrative Asst		0	Employee Health Insurance	714,767	(Indicate # of checks performed 77)		
Administrative Staff	Admissions		90,735	Employee Meals		Patient Background Checks	402	
Administrative Staff	Other Administrative		60,704	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	20,999	
TOTAL (agree to Schedule V, line 17, col. 1)				Home Office Allocation	98,103	Dues & Subscriptions	33,401	
(List each licensed administrator separately.)			\$ 300,200	Dental	22,659	Advertising & Public Relations	0	
B. Administrative - Other				Life Insurance	5,303	Home Office Allocation	3,859	
Description			Amount	Disability Insurance	28,306			
Corp Office Management Fee			\$ 1,461,039	Pension	321,984	Less: Public Relations Expense	()	
				Tuition Reimbursement	14,346	Non-allowable advertising	()	
				Other Benefits	7,726	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,461,039	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,811,464	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Legal	Various		\$ 0	N/A		\$	Out-of-State Travel	\$
Collections	Various		0					
Shredding/Storage	Various		0					
Survey & Analytical Tools	Various		0				In-State Travel	0
Ground Charge	Various		0					
Biomed	Various		0					
Outsourced Services	Various		87,504				Seminar Expense	
							Home Office Allocation	6,276
TOTAL (agree to Schedule V, line 19, column 3)			\$ 87,504	TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,276

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE RESURRECT LIFE CTR

0044354

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 \$14,800.32
- (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. \$ 40,434 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. \$ 352,901
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. \$ 10,534
- (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