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: 0041871

Facility Name: PRESENCE ST JOSEPH CENTER

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

County: STEPHENSON

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

HFS ID Number:

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

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code 501C3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 ST JOSEPH CENTER # 0041871 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	124	Skilled (SNF)	124	45,384	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,384	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,405	8,221	7,268	36,894	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,405	8,221	7,268	36,894	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.29%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 3,683

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		638	554,035	554,673		554,673		554,673			1
2	Food Purchase		314,249		314,249		314,249	(40,490)	273,759			2
3	Housekeeping	119,876	362	41,466	161,704		161,704		161,704			3
4	Laundry		(141)	77,669	77,528		77,528		77,528			4
5	Heat and Other Utilities			157,150	157,150		157,150	2,367	159,517			5
6	Maintenance	136,119	58,992	148,148	343,259		343,259	9,883	353,142			6
7	Other (specify):* Pastoral	39,485	214	232	39,931		39,931		39,931			7
8	TOTAL General Services	295,480	374,314	978,700	1,648,494		1,648,494	(28,240)	1,620,254			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	2,541,230	39,741	151,666	2,732,637		2,732,637		2,732,637			10
10a	Therapy	495,660	5,620	8,828	510,108		510,108		510,108			10a
11	Activities	76,609	655	5,915	83,179		83,179	115	83,294			11
12	Social Services	61,143		1,410	62,553		62,553		62,553			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,174,642	46,016	183,819	3,404,477		3,404,477	115	3,404,592			16
	C. General Administration											
17	Administrative	277,978	111,305	863,584	1,252,867		1,252,867	(28,185)	1,224,682			17
18	Directors Fees											18
19	Professional Services			17,736	17,736		17,736	24,567	42,303			19
20	Dues, Fees, Subscriptions & Promotions			33,621	33,621		33,621	471	34,092			20
21	Clerical & General Office Expenses			27,153	27,153		27,153	1,455	28,608			21
22	Employee Benefits & Payroll Taxes			1,138,571	1,138,571		1,138,571	75,421	1,213,992			22
23	Inservice Training & Education			199	199		199	549	748			23
24	Travel and Seminar			3,593	3,593		3,593	4,091	7,684			24
25	Other Admin. Staff Transportation			1,268	1,268		1,268		1,268			25
26	Insurance-Prop.Liab.Malpractice			131,784	131,784		131,784	864	132,648			26
27	Other (specify):*											27
28	TOTAL General Administration	277,978	111,305	2,217,509	2,606,792		2,606,792	79,233	2,686,025			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,748,100	531,635	3,380,028	7,659,763		7,659,763	51,108	7,710,871			29

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER #0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			525,115	525,115		525,115	16,169	541,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			175,012	175,012		175,012	3,793	178,805			32
33	Real Estate Taxes			(1,321,038)	(1,321,038)		(1,321,038)		(1,321,038)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,203	34,203		34,203	16,802	51,005			35
36	Other (specify):*											36
37	**TOTAL Ownership**			(586,708)	(586,708)		(586,708)	36,764	(549,944)			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			596,836	596,836		596,836		596,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			264,796	264,796		264,796		264,796			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			861,632	861,632		861,632		861,632			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,748,100	531,635	3,654,952	7,934,687		7,934,687	87,872	8,022,559			45

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 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	(41,653)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	11,134	30		9
10	Interest and Other Investment Income	3,793	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	(2,045)	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)**	$ (28,771)		$	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)	116,643		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 116,643		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 87,872		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 ST JOSEPH CENTER

ID# 0041871

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
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(41,653)	1,163	0	0	0	0	0	0	0	0	0	(40,490)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,367	0	0	0	0	0	0	0	0	0	2,367	5
6	Maintenance	0	7,964	1,919	0	0	0	0	0	0	0	0	9,883	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(41,653)	11,494	1,919	0	0	0	0	0	0	0	0	(28,240)	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	115	0	0	0	0	0	0	0	0	0	115	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	115	0	0	0	0	0	0	0	0	0	115	16
	C. General Administration													
17	Administrative	0	(122,866)	94,681	0	0	0	0	0	0	0	0	(28,185)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,567	0	0	0	0	0	0	0	0	0	24,567	19
20	Fees, Subscriptions & Promotions	(2,045)	2,516	0	0	0	0	0	0	0	0	0	471	20
21	Clerical & General Office Expenses	0	1,455	0	0	0	0	0	0	0	0	0	1,455	21
22	Employee Benefits & Payroll Taxes	0	63,951	11,470	0	0	0	0	0	0	0	0	75,421	22
23	Inservice Training & Education	0	549	0	0	0	0	0	0	0	0	0	549	23
24	Travel and Seminar	0	4,091	0	0	0	0	0	0	0	0	0	4,091	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	864	0	0	0	0	0	0	0	0	0	864	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,045)	(24,873)	106,151	0	0	0	0	0	0	0	0	79,233	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,698)	(13,264)	108,070	0	0	0	0	0	0	0	0	51,108	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **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 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)	
	D. Ownership													
30	Depreciation	11,134	0	5,035	0	0	0	0	0	0	0	0	16,169	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	3,793	0	0	0	0	0	0	0	0	0	0	3,793	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	16,802	0	0	0	0	0	0	0	0	16,802	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	14,927	0	21,837	0	0	0	0	0	0	0	0	36,764	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)**	(28,771)	(13,264)	129,907	0	0	0	0	0	0	0	0	87,872	45

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Commu
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 1,163	$ 1,163	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,367	2,367	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	7,964	7,964	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	115	115	4
5	V	17	Admin - Misc. Other	369,522	Presence Life Connections	100.00%	4,041	(365,481)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	242,615	242,615	6
7	V	19	Professional Services		Presence Life Connections	100.00%	24,567	24,567	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,516	2,516	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,455	1,455	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	63,951	63,951	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	549	549	11
12	V	24	Travel		Presence Life Connections	100.00%	4,091	4,091	12
13	V	26	Insurance		Presence Life Connections	100.00%	864	864	13
14	Total			$ 369,522			$ 356,258	$ * (13,264)	14

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Presence Life Connections	100.00%	$ 5,035	$ 5,035	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%	16,802	16,802	18
19	V	17	Admin Salaries		Presence Health	100.00%	0		19
20	V	22	Employee Benefits		Presence Health	100.00%	11,470	11,470	20
21	V	30	Depreciation	142,337	Presence Health	100.00%	142,337		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	494,204	Presence Health	100.00%	442,105	(52,099)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	0		24
25	V	17	Information Systems - Other		Presence Health	100.00%	105,595	105,595	25
26	V	17	Admin Salaries		Presence Health	100.00%	0		26
27	V	17	Information Systems Salaries		Presence Health	100.00%	32,418	32,418	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	1,919	1,919	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	8,767	8,767	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	0		30
31	V	39	Ancillary Services - Other	596,836	Presence Senior Services Pharmacy	100.00%	596,836		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,233,377			$ 1,363,284	$ * 129,907	39

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Michael Gordon	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Susan Enright	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connecti	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral H	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Car	Northlake	Independent Living	13
14					Presence Ambulatory S	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 ST JOSEPH CENTER # 0041871 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 ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	9,455,191	33	$ 29,753	$	369,522	$ 1,163	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575		369,522	2,367	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785		369,522	7,964	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934		369,522	115	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412		369,522	4,041	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	369,522	242,615	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607		369,522	24,567	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374		369,522	2,516	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236		369,522	1,455	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354		369,522	63,951	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049		369,522	549	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676		369,522	4,091	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118		369,522	864	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835		369,522	5,035	14
15	32	Interest	Management Fee Income	9,455,191	33	0		369,522	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0		369,522	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912		369,522	16,802	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,674,560	$ 6,207,940		$ 378,095	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	6,841,683	23	$	$	494,204	$	1
2	22	Employee Benefits	Operating Expense	6,841,683	23	158,790		494,204	11,470	2
3	30	Depreciation	Operating Expense	1,848,371	23	1,848,371		142,337	142,337	3
4	34	Rent Facility	Operating Expense	6,841,683	23			494,204		4
5	17	Admin Consulting,Other	Operating Expense	6,841,683	23	6,120,437		494,204	442,105	5
6	17	Information Systems Salaries	Operating Expense	6,841,683	23			494,204		6
7	17	Information Systems - Other	Operating Expense	6,841,683	23	1,461,845		494,204	105,595	7
8	17	Admin Salaries	Direct Cost	6,841,683	23			494,204		8
9	17	Information Systems Salaries	Direct Cost	6,841,683	23	448,784	448,784	494,204	32,418	9
10	6	Information Systems - Equip Mair	Direct Cost	6,841,683	23	26,573		494,204	1,919	10
11	17	Admin Consulting,Other	Direct Cost	6,841,683	23	121,366		494,204	8,767	11
12	32	Admin - Interest Expense	Direct Cost	6,841,683	23					12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 10,186,166	$ 448,784		$ 744,611	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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			$	$		$ 596,836	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					$	$		$ 596,836	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Home Office Allocation						$	$			$ 8,767	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 8,767	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 8,767	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 ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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 ST JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

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.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 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	120		1996	1996	$ 2,500,000	$ 39,593	53	$ 47,170	$ 7,577	$ 1,209,939	4
5	10		2013	2013	3,002,792	77,487	35	77,291	(196)	270,780	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698	2,134	13	2,227	93	73,007	11
12	VARIOUS			2001	19,599	255	10	262	7	18,409	12
13	VARIOUS			2002	28,056	692	13	713	21	27,064	13
14	VARIOUS			2003	77,639	1,190	11	1,115	(75)	76,151	14
15	VARIOUS			2004	16,330	101	10	112	11	16,035	15
16	VARIOUS			2005	93,561	2,434	12	2,469	35	72,532	16
17	VARIOUS			2006	47,671	3,189	10	2,635	(554)	42,437	17
18	VARIOUS			2007	163,794	10,561	13	10,062	(500)	100,165	18
19	VARIOUS			2008	197,106	14,142	14	14,612	470	155,317	19
20	VARIOUS			2009	153,368	11,998	12	12,758	760	96,529	20
21	VARIOUS			2010	128,973	11,403	10	12,318	915	91,269	21
22	VARIOUS			2011	39,476	3,647	10	3,673	25	23,389	22
23	VARIOUS			2012	9,244	737	13	759	22	3,812	23
24											24
25	A WING COMPRESSOR			2013	2,754	231	12	230	(2)	806	25
26	ARCHITECTURAL SERVICES 12 ROOM			2013	422,752	10,477	40	10,569	92	36,866	26
27	DESIGN BUILD TABERNACLE FOR CH			2013	4,599	307	15	307	(0)	1,073	27
28	LANDSCAPPING			2013	1,500	145	10	150	5	519	28
29	LIGHTING 16 PORT DKT INTERFACE			2013	3,297	316	10	330	13	1,136	29
30	PARKING LOT SEALED GRINDING JO			2013	9,350		2			9,350	30
31	RESHAPE EXISTING STONE ASPHALT			2013	25,973	3,071	8	3,247	175	11,129	31
32	ROLLER SHADES			2013	2,051	358	5	410	53	1,366	32
33	WALL MOUNT DISPENSER DOUBLE RO			2013	1,029	135	7	147	12	499	33
34	WANDER SYSTEM FOR DINING ROOM			2013	4,240	403	10	424	21	1,455	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 ST JOSEPH CENTER # 0041871 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	ADD CELL PHONE CAPABILITY	2014	$ 2,972	$ 279	10	$ 297	$ 18	$ 1,016	37
38	CEILING TILES FOR OCEANVIEW	2014	2,846	268	10	285	17	973	38
39	COMPRESSOR FOR CARRIER CONDENS	2014	5,090	424	12	424	(0)	1,060	39
40	CONTRACT LABOR MATERIAL AND EQ	2014	9,251	1,090	8	1,156	66	2,802	40
41	DESIGN BUILD INSTALL HIGH ALTA	2014	3,774	255	15	252	(3)	633	41
42	DOOR ENTRANCE STORM	2014	6,855	440	15	457	17	1,577	42
43	FIRE ALARM SYSTEM MODIFICATION	2014	2,735	107	25	109	2	380	43
44	FIRE DOORS	2014	2,828	138	20	141	4	490	44
45	GENERATOR	2014	4,700	383	12	392	9	967	45
46	NEW BOILER	2014	22,230	1,121	20	1,112	(10)	2,792	46
47	PARKING LOT	2014	9,750	1,794	5	1,950	156	4,667	47
48	NORTH ROOF OF ONEILL H	2014	11,850	1,132	10	1,185	53	2,891	48
49	TUCKPOINTING ADC CHAPEL	2014	9,700	138	70	139	1	346	49
50									50
51	AIR COND. CONDENSING UNIT FOR SUNSHINE COURT	2015	26,832	2,683	10	2,683		3,578	51
52	DOOR ALARMS WEST UNIT	2015	2,740	274	10	274		457	52
53	CIRCUIT BREAKER AND WIRING NODES FOR BUILDING	2015	10,514	526	20	526		570	53
54	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	2,674	107	25	107		187	54
55	LIGHTING EQUIP. FOR RESIDENT ROOMS AND HALLWAY	2015	11,017	734	15	734	(0)	1,408	55
56	COUNTERTOP/SINKS/TOILETS/STALLS FOR MENS ROOM	2015	13,691	685	20	685	(0)	1,312	56
57	ROOF REPAIR ADC BLDG	2015	71,175	7,118	10	7,118		10,083	57
58	ROOFTOP HEATING AC UNIT	2015	3,746	105	35	107	2	266	58
59	WALK-IN TUB, TILE AND MIRROR FOR BATHROOM IN CL	2015	10,337	503	20	517	13	1,274	59
60	WINDOW REPLACEMENT CLF	2015	3,380	169	20	169		324	60
61	YORK ROOF TOP	2015	11,140	1,114	10	1,114		2,042	61
62	CIRCLE DRIVE PROJECT	2015	1,400	82	20	70	(12)	82	62
63	PARKING LOT PROJECT	2015	5,000	292	20	250	(42)	292	63
64	NURSE STATION UPGRADE	2015	1,660	104	20	83	(21)	104	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,308,495	$ 217,068		$ 226,322	$ 9,254	$ 2,388,360	70

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 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	
1	Totals from Page 12A, Carried Forward		$ 7,308,495	$ 217,068		$ 226,322	$ 9,254	$ 2,388,360	1
2	: FURNISH AND INSTALL NEW 4" Piping & RPZ Backflow	2016	8,203	91	15	46	(46)	91	2
3	New Network Control Engine	2016	4,150	138	20	121	(17)	138	3
4	FIRE SPRINKLER WORK/SKYLIGHTS	2016	3,940	197	20	197	(0)	197	4
5	FRONT ENTRY PLASTER WORK	2016	2,073	138	15	138	0	138	5
6	NURSE STATION UPGRADE	2016	820	41	20	41	(0)	41	6
7									7
8									8
9	DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(470)	-15	(484)	(14)	(2,643)	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,320,421	$ 217,205		$ 226,381	$ 9,176	$ 2,386,323	34

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,282,823	$ 144,349	$ 145,968	$ 1,619	13	$ 759,696	71
72	Current Year Purchases	52,460	2,031	1,840	(191)	9	2,031	72
73	Fully Depreciated Assets	824,782	4,285	4,285		9	824,782	73
74	Home Office Allocation		147,372	147,372				74
75	TOTALS	$ 2,160,065	$ 298,037	$ 299,465	$ 1,428		$ 1,586,508	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TOTAL			$ 229,693	$ 14,908	$ 15,439	$ 530		$ 219,173	76
77	SEE VEHICLE ATTACHMENT									77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 229,693	$ 14,908	$ 15,439	$ 530		$ 219,173	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,110,179	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 530,150	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 541,284	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,134	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,192,004	85	

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

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

G. Construction-in-Progress

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

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

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$ 0	$ 0	$ 0	5	$ 24,090	76
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123	0	0	0	3	23,123	77
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275	0	0	0	4	34,275	78
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649	0	0	0	4	15,649	79
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155	0	0	0	4	48,155	79
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232	8,897	8,897	0	4	58,232	79
79C	PLANT ENGINEERING	2014 BUICK ENCORE 4WD	2014	26,169	6,012	6,542	530	4	15,649	
80	TOTALS			$ 229,693	$ 14,908	$ 15,439	$ 0		$ 219,173	80

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home Office Allocation				0			5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 51,005 Description: Nursing 28,055; Admin 6,148; Home Office 16,802
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 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	3979	hrs	$ 142,540		$	$	3,979	$ 142,540	1
2	Licensed Speech and Language Development Therapist	10a, 1	930	hrs	40,619				930	40,619	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	5644	hrs	230,040				5,644	230,040	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				596,836		596,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Director	10a, 1	1804		82,461				1,804	82,461	12
13	Other (specify):										13
14	TOTAL				$ 495,660		$	$ 596,836	12,357	$ 1,092,496	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 ST JOSEPH CENTER **#** 0041871 **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 ST JOSEPH CENTER # 0041871 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	5,097,309	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 181,000,312	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	793,712	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)**	$ 395,645	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 ST JOSEPH CENTER # 0041871 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	$ 7,924,273	1
2	Discounts and Allowances for all Levels	(1,256,832)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,667,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,212,672	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,212,672	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	41,653	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	790,481	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 832,134	23
	D. Non-Operating Revenue		
24	Contributions	19,945	24
25	Interest and Other Investment Income***	(3,793)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,152	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,728,399	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,648,494	31
32	Health Care	3,404,477	32
33	General Administration	2,606,792	33
	B. Capital Expense		
34	Ownership	(586,708)	34
	C. Ancillary Expense		
35	Special Cost Centers	596,836	35
36	Provider Participation Fee	264,796	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,934,687	40
41	**Income before Income Taxes (line 30 minus line 40)****	793,712	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 793,712	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,078,788	44
45	Private Pay - Net Inpatient Revenue	1,853,048	45
46	Medicare - Net Inpatient Revenue	888,893	46
47	Other-(specify) Insurance	846,712	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,667,441	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 ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,876	2,097	$ 76,642	$ 36.55	1
2	Assistant Director of Nursing	1,847	2,140	68,605	32.06	2
3	Registered Nurses	25,239	27,418	754,206	27.51	3
4	Licensed Practical Nurses	24,488	26,247	683,687	26.05	4
5	CNAs & Orderlies	69,133	75,131	976,633	13.00	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	11,471	12,356	495,659	40.11	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,743	1,970	35,850	18.20	9
10	Activity Assistants	3,549	3,763	40,759	10.83	10
11	Social Service Workers	3,453	3,776	61,143	16.19	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	8,083	8,985	136,119	15.15	17
18	Housekeepers	10,008	11,193	119,876	10.71	18
19	Laundry	0	0	0		19
20	Administrator	1,786	2,055	82,577	40.18	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	38	38	1,155	30.39	22
23	Office Manager	1,788	2,059	41,364	20.09	23
24	Clerical	9,671	10,545	134,340	12.74	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health C: Admissions	0	0	0		32
33	Other(specify) Pastoral	1,429	1,599	39,485	24.69	33
34	TOTAL (lines 1 - 33)	175,602	191,372	$ 3,748,100 *	$ 19.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	16,000	9,3	36
37	Medical Records Consultant	30	2,048	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	32	1,924	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	494	11,3	44
45	Social Service Consultant	14	963	12,3	45
46	Other(specify) MDS	180	20,369	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	$ 41,798		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	791	35,605	10,3	51
52	Certified Nurse Assistants/Aides	2,122	53,041	10,3	52
53	TOTAL (lines 50 - 52)	2,913	$ 88,646		53

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 82,577
Administrative Staff	Office Manager		41,364
Administrative Staff	Receptionists		54,317
Administrative Staff	Administrative Asst		
Administrative Staff	Admissions		81,142
Administrative Staff	Other Administrative		18,578
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 277,978

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 863,584
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 863,584

C. Professional Services

Vendor/Payee	Type	Amount
HEYL ROYSTER VOELKER AND	Legal	$ 416
POLSINELLI PC	Legal	1,627
Federal Express Corp	Ground Charges	604
ADVANCED TECHNOLOGIES GR	Network/Software Maint	3,420
AQUARIUM ADVENTURES AND P	Aviary Maint	2,324
Living Design	Aviary Maint	700
Freeport Industrial Roofing INC	Survey/Engineering	8,645
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 17,736

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,557
Unemployment Compensation Insurance	15,634
FICA Taxes	268,804
Employee Health Insurance	476,606
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	75,421
Dental	15,093
Life Insurance	3,545
Disability Insurance	18,828
Pension	212,417
Tuition Reimbursement	9,481
Other Benefits	60,605
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,213,992

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 28)	
Patient Background Checks 290	
Employee Recruitment	760
Dues & Subscriptions	30,816
Advertising & Public Relations	2,045
Home Office Allocation	2,516
Less: Public Relations Expense	( )
Non-allowable advertising	(2,045)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,092

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,593
Seminar Expense	
Home Office Allocation	4,091
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,684

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 $5,720.75**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,258** 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. $ **264,796**
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. $ **41,653**

(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