

		FOR BHF USE					

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**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)**

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>0054072</u></p> <p>Facility Name: <u>PRESENCE NAZARETHVILLE</u></p> <p>Address: <u>300 NORTH RIVER ROAD</u> <u>DES PLAINES</u> <u>60016</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>847-297-5900</u> Fax # <u>847-297-0504</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</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code <u>501C3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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 type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>1/01/17</u> to <u>12/31/17</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Date)</small></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Type or Print Name)</small> <u>GEORGE VIEU</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Title)</small> <u>INTERIM CFO</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Date)</small></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Print Name and Title)</small> _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Firm Name & Address)</small> _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><small>(Telephone)</small> () () <small>Fax #</small> () ()</td> </tr> </table> <p align="center">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) _____		<small>(Date)</small>		<small>(Type or Print Name)</small> <u>GEORGE VIEU</u>		<small>(Title)</small> <u>INTERIM CFO</u>	Paid Preparer	(Signed) _____		<small>(Date)</small>		<small>(Print Name and Title)</small> _____		<small>(Firm Name & Address)</small> _____		<small>(Telephone)</small> () () <small>Fax #</small> () ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																									
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Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072 Report Period Beginning: 1/01/17 Ending: 12/31/17

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		Skilled (SNF)	34	6,256	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	34	18,564	3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,475	5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			723	723	8
9	SNF/PED					9
10	ICF	14,697	8,594		23,291	10
11	ICF/DD					11
12	SC		1,141		1,141	12
13	DD 16 OR LESS					13
14	TOTALS	14,697	9,735	723	25,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.03%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 34 and days of care provided 706

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: 12-31-17 Fiscal Year: 12-31-17

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/17 Ending: 12/31/17

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		1,017	391,187	392,204	392,204		392,204			1
2	Food Purchase		197,064		197,064	197,064	(3,532)	193,532			2
3	Housekeeping	129,223	393	4,636	134,252	134,252		134,252			3
4	Laundry	40,846	54,026	3,217	98,089	98,089	(15,988)	82,101			4
5	Heat and Other Utilities			150,626	150,626	150,626	991	151,617			5
6	Maintenance	152,276	26,689	151,636	330,601	330,601	53,716	384,317			6
7	Other (specify):* Pastoral	70,868		1,417	72,285	72,285		72,285			7
8	TOTAL General Services	393,213	279,189	702,719	1,375,121	1,375,121	35,187	1,410,308			8
	B. Health Care and Programs										
9	Medical Director	6,336			6,336	6,336		6,336			9
10	Nursing and Medical Records	2,093,600	108,173	18,786	2,220,559	2,220,559		2,220,559			10
10a	Therapy			64,701	64,701	64,701		64,701			10a
11	Activities	114,896	3,060	1,659	119,615	119,615	23	119,638			11
12	Social Services	35,005	43	2,695	37,743	37,743		37,743			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,249,837	111,276	87,841	2,448,954	2,448,954	23	2,448,977			16
	C. General Administration										
17	Administrative	198,332	16,123	520,725	735,180	735,180	(127,076)	608,104			17
18	Directors Fees										18
19	Professional Services			2,173	2,173	2,173	9,753	11,926			19
20	Dues, Fees, Subscriptions & Promotions			29,035	29,035	29,035	1,603	30,638			20
21	Clerical & General Office Expenses			5,090	5,090	5,090	421	5,511			21
22	Employee Benefits & Payroll Taxes			766,605	766,605	766,605	42,154	808,759			22
23	Inservice Training & Education						333	333			23
24	Travel and Seminar						1,957	1,957			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,253	58,253	58,253	2,935	61,188			26
27	Other (specify):*										27
28	TOTAL General Administration	198,332	16,123	1,381,881	1,596,336	1,596,336	(67,920)	1,528,416			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,841,382	406,588	2,172,441	5,420,411	5,420,411	(32,710)	5,387,701			29

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

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

Facility Name & ID Number PRESENCE NAZARETHVILLE

#0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			239,946	239,946		239,946	3,429	243,375			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,459	40,459		40,459	(1,728)	38,731			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,800	8,800		8,800	9,305	18,105			35
36	Other (specify):*											36
37	TOTAL Ownership			289,205	289,205		289,205	11,006	300,211			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			255,794	255,794		255,794		255,794			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,075	165,075		165,075		165,075			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			420,869	420,869		420,869		420,869			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,841,382	406,588	2,882,515	6,130,485		6,130,485	(21,704)	6,108,781			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	(4,098)	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	(15,988)	4		8
9	Non-Straightline Depreciation	110	30		9
10	Interest and Other Investment Income	(1,728)	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		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)	\$ (21,704)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,704)		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 NAZARETHVILLE

ID# 0054072

Report Period Beginning: 1/01/17

Ending: 12/31/17

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
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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 NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	(4,098)	566	0	0	0	0	0	0	0	0	0	(3,532)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(15,988)	0	0	0	0	0	0	0	0	0	0	(15,988)	4
5	Heat and Other Utilities	0	991	0	0	0	0	0	0	0	0	0	991	5
6	Maintenance	0	4,587	49,129	0	0	0	0	0	0	0	0	53,716	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(20,086)	6,144	49,129	0	0	0	0	0	0	0	0	35,187	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	23	0	0	0	0	0	0	0	0	0	23	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	23	0	0	0	0	0	0	0	0	0	23	16
	C. General Administration													
17	Administrative	0	(40,698)	(86,378)	0	0	0	0	0	0	0	0	(127,076)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,753	0	0	0	0	0	0	0	0	0	9,753	19
20	Fees, Subscriptions & Promotions	0	1,603	0	0	0	0	0	0	0	0	0	1,603	20
21	Clerical & General Office Expenses	0	421	0	0	0	0	0	0	0	0	0	421	21
22	Employee Benefits & Payroll Taxes	0	4,905	37,249	0	0	0	0	0	0	0	0	42,154	22
23	Inservice Training & Education	0	333	0	0	0	0	0	0	0	0	0	333	23
24	Travel and Seminar	0	1,957	0	0	0	0	0	0	0	0	0	1,957	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	2,935	0	0	0	0	0	0	0	0	0	2,935	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(18,791)	(49,129)	0	0	0	0	0	0	0	0	(67,920)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,086)	(12,624)	0	0	0	0	0	0	0	0	0	(32,710)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	110	0	3,319	0	0	0	0	0	0	0	0	3,429	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,728)	0	0	0	0	0	0	0	0	0	0	(1,728)	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	9,305	0	0	0	0	0	0	0	0	9,305	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,618)	0	12,624	0	0	0	0	0	0	0	0	11,006	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)	(21,704)	(12,624)	12,624	0	0	0	0	0	0	0	0	(21,704)	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%	\$ 566	\$	566	1
2	V	5 Utilities		Presence Life Connections	100.00%	991		991	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	4,587		4,587	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	23		23	4
5	V	17 Admin - Misc. Other	147,488	Presence Life Connections	100.00%	(24)		(147,512)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	106,814		106,814	6
7	V	19 Professional Services		Presence Life Connections	100.00%	9,753		9,753	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	1,603		1,603	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	421		421	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	4,905		4,905	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	333		333	11
12	V	24 Travel		Presence Life Connections	100.00%	1,957		1,957	12
13	V	26 Insurance		Presence Life Connections	100.00%	2,935		2,935	13
14	Total		\$ 147,488			\$ 134,864	\$ *	(12,624)	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%	\$ 3,319	\$ 3,319
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%	9,305	9,305
19	V	17 Admin Salaries		Presence Health	100.00%	206,888	206,888
20	V	22 Employee Benefits		Presence Health	100.00%	37,249	37,249
21	V	30 Depreciation	92,759	Presence Health	100.00%	92,759	
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	373,237	Presence Health	100.00%	122,638	(250,599)
24	V	17 Information Systems Salaries		Presence Health	100.00%	0	
25	V	17 Information Systems - Other		Presence Health	100.00%	0	
26	V	17 Admin Salaries		Presence Health	100.00%	0	
27	V	17 Information Systems Salaries		Presence Health	100.00%	0	
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	49,129	49,129
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	40,459	Presence Health	100.00%	40,459	
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	(42,667)	(42,667)
32	V	39 Ancillary Services - Other	255,794	Presence Senior Services Pharmacy	100.00%	255,794	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 762,249			\$ 774,873	\$ * 12,624

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

Facility Name & ID Number

PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending: 12/31/17

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	Mike Gordon	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life Connect	Mokena	Management Comp	4
5			Presence St Benedict Nursing & Rehab Center	Niles	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			A Merkle C Knipprath Nursing Home	Clifton	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8					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	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 Estates	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/17 Ending: 12/31/17

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending: 12/31/17

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	5,620,989	33	\$ 21,575	\$ 147,488	\$ 566	1	
2	5	Utilities	Management Fee Income	5,620,989	33	37,782	147,488	991	2	
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812	147,488	4,587	3	
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894	147,488	23	4	
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)	147,488	(24)	5	
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	147,488	106,814	6
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695	147,488	9,753	7	
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085	147,488	1,603	8	
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056	147,488	421	9	
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921	147,488	4,905	10	
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708	147,488	333	11	
12	24	Travel	Management Fee Income	5,620,989	33	74,575	147,488	1,957	12	
13	26	Insurance	Management Fee Income	5,620,989	33	111,873	147,488	2,935	13	
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474	147,488	3,319	14	
15	32	Interest	Management Fee Income	5,620,989	33	0	147,488	0	15	
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0	147,488	0	16	
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619	147,488	9,305	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 5,620,989	\$ 4,070,831	\$ 147,488	25	

Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending: 12/31/17

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	13,936,478	35	\$ 7,725,094	\$ 7,725,094	373,237	\$ 206,888	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		373,237	37,249	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		92,759	92,759	3
4	34	Rent Facility	Operating Expense	13,936,478	35			373,237		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		373,237	122,638	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			373,237		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			373,237		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			373,237		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			373,237		9
10	6	Information Systems - Equip Maint	Operating Expense	13,936,478	35	1,834,459		373,237	49,129	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			373,237		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		40,459	40,459	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		373,237	(42,667)	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					\$ 20,673,348	\$ 7,725,094		\$ 506,455	25

Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending: 12/31/17

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 Senior Services Pharmacy
 Street Address 100 North River Road
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (847-410-4900
 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		\$	\$		\$ 255,794	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				\$	\$		\$ 255,794	25

Facility Name & ID Number

PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

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		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						\$	\$			\$	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 2016 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 2017 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:	2012	8	
	2013	9	
	2014	10	
	2015	11	
	2016	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016 \$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE NAZARETHVILLE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054072

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(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		\$ <u> </u>	\$ <u> </u>

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 NAZARETHVILLE

0054072 Report Period Beginning:

1/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME. Row 3: TOTALS.

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	CHAPEL RENOVATIONS		2014	36,000	2,429	30	2,400	(29)	8,468	9
10	LM TO EXTEND 20 AMP 3 PHASE 2		2014	2,738	108	25	110	2	379	10
11	L M TO INSTALL TWO DOOR RESTRI		2014	2,350	115	20	118	3	405	11
12	NEW ARMSTRONG VINYL SHEET IN 7		2014	25,550	1,654	15	1,703	49	5,845	12
13	NEW KARNDEAN DESIGN FLOORING		2014	64,426	5,246	25	5,369	123	18,505	13
14	REPLACEMENT OF DOORS TO PATIO		2014	2,100	138	15	140	2	486	14
15	REPLACEMENT OF FLOORING IN CHA		2014	21,579	2,178	10	2,158	(20)	7,601	15
16	SOFFIT FASCIA REPLACEMENT GUT		2014	20,755	1,015	20	1,038	23	3,580	16
17	SUMP PUMP SYSTEM		2015	6,389	639	10	639		1,704	17
18	Naz Room Expansion Project		2015	14,400	720	40	720		1,620	18
19	BOILER BURNER & CONTROLS UPGRD		2015	55,935	2,797	20	2,797		6,293	19
20	ELEVATOR UPGRADES-HEAT DETECTR		2015	26,627	1,331	20	1,331		2,996	20
21	FAN COILS AND BACK PLATES		2015	50,669	2,533	20	2,533		5,700	21
22	FIRE DAMPER DUCTWORK MAIN BOIL		2015	18,300	915	20	915		2,059	22
23	FLOORING FOR ADM OFFICE		2015	3,885	389	10	389		874	23
24	INSTALL FIRE DAMPERS BOILR RM		2015	5,600	280	20	280		630	24
25	INSTALL LIGHTING FIXTURES		2015	42,645	2,132	20	2,132		4,798	25
26	L & M INSTALL VFDS		2015	300,810	15,041	20	15,041		33,841	26
27	L M TO INSTALL TWO DOOR RESTRI		2015	2,350	59	40	59		171	27
28	L M TO INSTALL TWO WALL PACK L		2015	14,871	724	20	744	20	2,558	28
29	MATERIAL LED EXIT RETROFIT		2015	66,902	3,345	20	3,345		7,526	29
30	MATERIAL, CONTROLLERS VFD PROJ		2015	152,700	7,635	20	7,635		17,179	30
31	MATL CONTROLLERS VFD PROJECT		2015	14,400	720	20	720		1,620	31
32	NEWSPRINKLER HEADS 2+3 FL		2015	18,300	915	20	915		2,059	32
33	NEW THERMOSTATS		2015	17,640	882	20	882		1,985	33
34	NEW ROOF		2015	177,980	11,865	15	11,865		28,675	34
35	NEW SPRIKLER HEADS		2015	39,850	1,993	20	1,993		4,483	35
36	AUTOMATIC DOOR OPENER		2015	4,697	235	20	235		528	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

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 : Door Levers for Resident R	2016	\$ 19,930	\$ 1993	10	\$ 1993	\$	\$ 3,322	37
38 : Sidewalk Replacement	2016	5,000	333	15	333		667	38
39 Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,667	83	20	83		97	39
40 Paint, Walls, Flooring - COMINGLE AREA - Front	2016	8,275	414	20	414		448	40
41 Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,143	57	20	57		114	41
42 LIFT GATE - Front Entrance Common Area	2016	53	3	20	3		5	42
43 Paint, Walls, Flooring - COMINGLE AREA - Front	2016	3,540	177	20	177		280	43
44 Electric Sliding Doors - Front Entrance	2016	13,266	663	20	663		1,271	44
45								45
46 NEW DYER VENTING	2017	7,100	30	20	30		30	46
47 NEW PARKING LOT	2017	33,910	565	15	565		565	47
48 NEW WATER PIPING SYSTEM	2017	799,399	16,754	40	16,754		16,754	48
49								49
50 EM Power For Command Center	2017	10,160		20	508	508		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)		\$ 2,113,891	\$ 89,105		\$ 89,786	\$ 681	\$ 196,121	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	\$ 483,307	\$ 50,688	\$ 50,117	\$ (571)	12	\$ 200,308	71
72	Current Year Purchases	46,041	924	924		15	924	72
73	Fully Depreciated Assets	545,537	6,470	6,470		6	545,537	73
74	Home Office Allocation		96,078	96,078				74
75	TOTALS	\$ 1,074,885	\$ 154,160	\$ 153,589	\$ (571)		\$ 746,769	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)	\$ 3,188,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 243,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,375	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 110	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 942,890	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								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: _____*

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: \$ 18,105 Description: Nursing 7,042; Admin 1,206; Environmental Services 120; Activities 108; Home Office 9,305; Spiritual Care
 (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

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. _____/2018 \$ _____

13. _____/2019 \$ _____

14. _____/2020 \$ _____

* 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, 3	hrs		\$	488	\$ 32,750	\$	488	\$	32,750		488	\$	32,750	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			1	64		1		64		1		64	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a, 3	hrs			473	31,887		473		31,887		473		31,887	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							255,794					255,794	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL				\$	962	\$ 64,701	\$	962	\$	255,794		962	\$	320,495	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 **12/31/17**

(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	\$ 5,899,845	\$	1
2	Cash-Patient Deposits	144,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	32,268,677		3
4	Supply Inventory (priced at)	1,411,420		4
5	Short-Term Investments	116,835		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	13,801,325		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 53,642,932	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	11,514,361		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	248,853,412		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	58,926,661		16
17	Accumulated Depreciation (book methods)	(193,707,894)		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):	2,788,546		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 151,322,601	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 204,965,533	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,918,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,250,139		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,490		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	587,749		32
33	Accrued Interest Payable	4,849		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Third Parties</u>	(2,518,894)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 25,270,159	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	629,027		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	47,219		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 676,246	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,946,405	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 179,019,128	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 204,965,533	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 181,395,957	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	(2,276,114)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 179,119,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(119,776)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,390,900	11
12	Expenditures for Specific Purposes	(1,371,839)	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)	\$ (100,715)	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)	\$ 179,019,128	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,662,771	1
2	Discounts and Allowances for all Levels	(2,347,722)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,315,049	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,295	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,295	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,098	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	512,860	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	15,988	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 532,946	23
D. Non-Operating Revenue			
24	Contributions	9,279	24
25	Interest and Other Investment Income***	1,728	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,007	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,412	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,412	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,010,709	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,375,121	31
32	Health Care	2,448,954	32
33	General Administration	1,596,336	33
B. Capital Expense			
34	Ownership	289,205	34
C. Ancillary Expense			
35	Special Cost Centers	255,794	35
36	Provider Participation Fee	165,075	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,130,485	40
41	Income before Income Taxes (line 30 minus line 40)**	(119,776)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (119,776)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,324,863	44
45	Private Pay - Net Inpatient Revenue	2,778,743	45
46	Medicare - Net Inpatient Revenue	211,443	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,315,049	49

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

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

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

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

Facility Name & ID Number **PRESENCE NAZARETHVILLE**

0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,760	2,084	\$ 97,201	\$ 46.64	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	24,872	27,598	1,018,637	36.91	3
4	Licensed Practical Nurses	3,565	4,034	109,777	27.21	4
5	CNAs & Orderlies	47,741	54,382	826,783	15.20	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,179	2,299	40,544	17.64	9
10	Activity Assistants	7,062	7,880	114,324	14.51	10
11	Social Service Workers	1,731	1,811	35,005	19.33	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	4,856	5,458	152,276	27.90	17
18	Housekeepers	7,313	8,195	129,223	15.77	18
19	Laundry	3,373	3,745	40,846	10.91	19
20	Administrator	1,864	2,080	79,592	38.27	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	892	1,023	21,786	21.30	23
24	Clerical	4,184	4,615	55,375	12.00	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	53	53	6,336	119.55	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	1,690	1,932	42,809	22.16	31
32	Other Health C: Admissions	0	0	0		32
33	Other(specify) <u>Pastoral</u>	2,535	2,863	70,868	24.75	33
34	TOTAL (lines 1 - 33)	115,670	130,052	\$ 2,841,382 *	\$ 21.85	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant	28	1,960	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	\$ 1,960		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 508	10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	296	7,298	10,3	52
53	TOTAL (lines 50 - 52)	304	\$ 7,806		53

Facility Name & ID Number **PRESENCE NAZARETHVILLE**

0054072

Report Period Beginning: **1/01/17**

Ending: **12/31/17**

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		
Mary Ann McKeogh	Administrator		\$ 79,592	Workers' Compensation Insurance	\$ 51,773	IDPH License Fee	\$		
Administrative Staff	Office Manager		21,786	Unemployment Compensation Insurance	4,076	Advertising: Employee Recruitment			
Administrative Staff	Receptionists		49,000	FICA Taxes	204,118	Health Care Worker Background Check			
Administrative Staff	Other Administrative		47,954	Employee Health Insurance	319,673	(Indicate # of checks performed <u>19</u>)			
				Employee Meals		Patient Background Checks	<u>27</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment			
				Home Office Allocation	42,154	Dues & Subscriptions	29,035		
				Dental	9,679	Advertising & Public Relations			
				Life Insurance	2,138	Home Office Allocation	1,603		
				Disability Insurance	11,943				
				Pension	157,078	Less: Public Relations Expense	()		
				Tuition Reimbursement	7,687	Non-allowable advertising	()		
				Other Benefits	(1,560)	Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 198,332	TOTAL (agree to Schedule V, line 22, col.8)		\$ 30,638			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
Corp Office Management Fee			\$ 520,725	N/A		\$	Out-of-State Travel	\$	
							In-State Travel	0	
							Seminar Expense		
							Home Office Allocation	1,957	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 520,725	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,957
C. Professional Services									
Vendor/Payee	Type		Amount						
SHRED-IT USA LLC	Shredding Service		\$ 2,173						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,173						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE NAZARETHVILLE

0054072

Report Period Beginning:

1/01/17

Ending:

12/31/17

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. 7125
- (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. \$ 35,568 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. \$ 165,075
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,098
- (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