



Facility Name & ID Number PRESENCE ST BENEDICT N & R

# 0044784 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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,585	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	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	4,748	17,972	9,922	32,642	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		7,822		7,822	12
13	DD 16 OR LESS					13
14	TOTALS	4,748	25,794	9,922	40,464	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 86.61%

**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 99 and days of care provided 7,421

Medicare Intermediary \_\_\_\_\_

**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 ST BENEDICT N & R** # **0044784** 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
	<b>A. General Services</b>										
1	Dietary		32,329	661,693	694,022	694,022		694,022			1
2	Food Purchase		240,114		240,114	240,114	(4,344)	235,770			2
3	Housekeeping	168,689	21,972	18,314	208,975	208,975		208,975			3
4	Laundry	86,260	12,103		98,363	98,363	(15,436)	82,927			4
5	Heat and Other Utilities			182,482	182,482	182,482	1,738	184,220			5
6	Maintenance	109,958	42,940	199,219	352,117	352,117	96,013	448,130			6
7	Other (specify):* <b>Pastoral</b>	39,745		5,640	45,385	45,385		45,385			7
8	<b>TOTAL General Services</b>	404,652	349,458	1,067,348	1,821,458	1,821,458	77,971	1,899,429			8
	<b>B. Health Care and Programs</b>										
9	Medical Director	24,908			24,908	24,908		24,908			9
10	Nursing and Medical Records	3,077,795	159,383	238,427	3,475,605	3,475,605		3,475,605			10
10a	Therapy	987,815	16,759		1,004,574	1,004,574		1,004,574			10a
11	Activities	156,775	5,324	12,443	174,542	174,542	41	174,583			11
12	Social Services	87,639	1,413	2,420	91,472	91,472		91,472			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Shelter</b>	127,822		234	128,056	128,056	(128,056)				15
16	<b>TOTAL Health Care and Programs</b>	4,462,754	182,879	253,524	4,899,157	4,899,157	(128,015)	4,771,142			16
	<b>C. General Administration</b>										
17	Administrative	316,517	13,257	926,871	1,256,645	1,256,645	(226,012)	1,030,633			17
18	Directors Fees										18
19	Professional Services			18,714	18,714	18,714	17,097	35,811			19
20	Dues, Fees, Subscriptions & Promotions			48,303	48,303	48,303	2,323	50,626			20
21	Clerical & General Office Expenses			15,533	15,533	15,533	739	16,272			21
22	Employee Benefits & Payroll Taxes			1,234,652	1,234,652	1,234,652	22,893	1,257,545			22
23	Inservice Training & Education			2,281	2,281	2,281	585	2,866			23
24	Travel and Seminar						3,430	3,430			24
25	Other Admin. Staff Transportation			109	109	109		109			25
26	Insurance-Prop.Liab.Malpractice			187,051	187,051	187,051	5,146	192,197			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	316,517	13,257	2,433,514	2,763,288	2,763,288	(173,799)	2,589,489			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,183,923	545,594	3,754,386	9,483,903	9,483,903	(223,843)	9,260,060			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			429,595	429,595		429,595	48,841	478,436		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			126,379	126,379		126,379	(8,858)	117,521		32
33	Real Estate Taxes			8,826	8,826		8,826	(8,826)			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			13,071	13,071		13,071	16,311	29,382		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			577,871	577,871		577,871	47,468	625,339		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			771,376	771,376		771,376		771,376		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			199,708	199,708		199,708		199,708		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			971,084	971,084		971,084		971,084		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,183,923	545,594	5,303,341	11,032,858		11,032,858	(176,375)	10,856,483		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	(5,336)	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	(15,436)	4		8
9	Non-Straightline Depreciation	43,024	30		9
10	Interest and Other Investment Income	(8,858)	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	(487)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 12,907		\$	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)		2 17	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 12,909		37

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

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

		1	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

PRESENCE ST BENEDICT N & R

ID# 0044784

Report Period Beginning: 1/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Assisted/Ind Living - Wages	\$ (128,056)	15	1
2	Assisted/Ind Living - Benefits	(52,404)	22	2
3				3
4	Real Estate Tax	(8,826)	33	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	<b>Total</b>	(189,286)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PRESENCE ST BENEDICT N &amp; R

# 0044784

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	(5,336)	992	0	0	0	0	0	0	0	0	0	(4,344)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(15,436)	0	0	0	0	0	0	0	0	0	0	(15,436)	4
5	Heat and Other Utilities	0	1,738	0	0	0	0	0	0	0	0	0	1,738	5
6	Maintenance	0	8,041	87,972	0	0	0	0	0	0	0	0	96,013	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(20,772)</b>	<b>10,771</b>	<b>87,972</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>77,971</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	41	0	0	0	0	0	0	0	0	0	41	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):*	(128,056)	0	0	0	0	0	0	0	0	0	0	(128,056)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(128,056)</b>	<b>41</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(128,015)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	2	(71,344)	(154,670)	0	0	0	0	0	0	0	0	(226,012)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,097	0	0	0	0	0	0	0	0	0	17,097	19
20	Fees, Subscriptions & Promotions	(487)	2,810	0	0	0	0	0	0	0	0	0	2,323	20
21	Clerical & General Office Expenses	0	739	0	0	0	0	0	0	0	0	0	739	21
22	Employee Benefits & Payroll Taxes	(52,404)	8,598	66,699	0	0	0	0	0	0	0	0	22,893	22
23	Inservice Training & Education	0	585	0	0	0	0	0	0	0	0	0	585	23
24	Travel and Seminar	0	3,430	0	0	0	0	0	0	0	0	0	3,430	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	5,146	0	0	0	0	0	0	0	0	0	5,146	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(52,889)</b>	<b>(32,939)</b>	<b>(87,971)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(173,799)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(201,717)</b>	<b>(22,127)</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(223,843)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	43,024	0	5,817	0	0	0	0	0	0	0	0	48,841	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,858)	0	0	0	0	0	0	0	0	0	0	(8,858)	32
33	Real Estate Taxes	(8,826)	0	0	0	0	0	0	0	0	0	0	(8,826)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	16,311	0	0	0	0	0	0	0	0	16,311	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>25,340</b>	<b>0</b>	<b>22,128</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>47,468</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(176,377)</b>	<b>(22,127)</b>	<b>22,129</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(176,375)</b>	<b>45</b>



**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%	\$ 992	\$	992	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,738		1,738	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	8,041		8,041	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	41		41	4
5	V	17 Admin - Misc. Other	258,546	Presence Life Connections	100.00%	(42)		(258,588)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	187,244		187,244	6
7	V	19 Professional Services		Presence Life Connections	100.00%	17,097		17,097	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	2,810		2,810	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	739		739	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	8,598		8,598	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	585		585	11
12	V	24 Travel		Presence Life Connections	100.00%	3,430		3,430	12
13	V	26 Insurance		Presence Life Connections	100.00%	5,146		5,146	13
14	Total		\$ 258,546			\$ 236,419	\$ *	(22,127)	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%	\$ 5,817	\$ 5,817
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%	16,311	16,311
19	V	17 Admin Salaries		Presence Health	100.00%	370,458	370,458
20	V	22 Employee Benefits		Presence Health	100.00%	66,699	66,699
21	V	30 Depreciation	162,639	Presence Health	100.00%	162,639	
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	668,325	Presence Health	100.00%	219,598	(448,727)
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%	87,972	87,972
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	126,379	Presence Health	100.00%	126,379	
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	(76,401)	(76,401)
32	V	39 Ancillary Services - Other	771,376	Presence Senior Services Pharmacy	100.00%	771,376	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,728,719			\$ 1,750,848	\$ * 22,129

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

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

# 0044784

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 Nazarethville	Des Plaines	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence 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	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 W	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 S	Various	Parent	14
15					Resurrection Developm	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 Retirement	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 BENEDICT N & R** # **0044784** 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								<b>TOTAL</b>	\$		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 BENEDICT N & R

# 0044784

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	Unit of Allocation	Number of	Total Indirect	Amount of Salary	Facility	Allocation				
Line	(i.e.,Days, Direct Cost,	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6				
Reference	Square Feet)	Allocated Among	Allocated	in Column 6						
Item	Total Units									
1	2	Food	Management Fee Income	5,620,989	33	\$ 21,575	\$ 258,546	\$ 992	1	
2	5	Utilities	Management Fee Income	5,620,989	33	37,782	258,546	1,738	2	
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812	258,546	8,041	3	
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894	258,546	41	4	
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)	258,546	(42)	5	
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	258,546	187,244	6
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695	258,546	17,097	7	
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085	258,546	2,810	8	
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056	258,546	739	9	
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921	258,546	8,598	10	
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708	258,546	585	11	
12	24	Travel	Management Fee Income	5,620,989	33	74,575	258,546	3,430	12	
13	26	Insurance	Management Fee Income	5,620,989	33	111,873	258,546	5,146	13	
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474	258,546	5,817	14	
15	32	Interest	Management Fee Income	5,620,989	33	0	258,546	0	15	
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0	258,546	0	16	
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619	258,546	16,311	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 5,620,989	\$ 4,070,831	\$ 258,547	25	

Facility Name & ID Number PRESENCE ST BENEDICT N & R

# 0044784

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

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

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

1	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	668,325	\$ 370,458	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		668,325	66,699	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		162,639	162,639	3
4	34	Rent Facility	Operating Expense	13,936,478	35			668,325		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		668,325	219,598	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			668,325		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			668,325		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			668,325		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			668,325		9
10	6	Information Systems - Equip Main	Operating Expense	13,936,478	35	1,834,459		668,325	87,972	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			668,325		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		126,379	126,379	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		668,325	(76,401)	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		\$ 957,344	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R

# 0044784

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 DesPlaines, 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		\$	\$		\$ 771,376	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				\$	\$		\$ 771,376	25

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

# 0044784

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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	
			<b>FOR BHF USE ONLY</b>
	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 ST BENEDICT N & R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

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. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <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 ST BENEDICT N & R

# 0044784

Report Period Beginning:

1/01/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

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

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

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

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

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

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

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: N/A 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, 56,961, 2000, \$ 2,910,262, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 56,961, (blank), \$ 2,910,262, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	2000	1991	\$ 5,342,488	\$ 123,433	40	\$ 134,685	\$ 11,252	\$ 2,606,387	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	VARIOUS		2000	92,057		7			92,057	9
10	VARIOUS		2001	273,061	617	12	602	(15)	270,688	10
11	VARIOUS		2002	29,538	607	16	616	9	28,495	11
12	VARIOUS		2003	8,200	156	15	166	10	7,343	12
13	VARIOUS		2004	12,982	639	15	662	23	10,015	13
14	VARIOUS		2005	191,740	8,258	10	9,037	779	172,012	14
15	VARIOUS		2006	86,586	2,068	10	2,030	(38)	79,055	15
16	VARIOUS		2008	1,284	64	20	64		641	16
17	VARIOUS		2012	15,524	667	23	670	3	3,676	17
18										18
19	REMOVING TOP 2 inch OF ASPHALT		2014	50,900	6,211	8	6,363	152	21,915	19
20	RENOVATIONS FOR CONVERSION OF		2014	50,400	2,465	20	2,520	55	8,693	20
21	REPLACE AIR COOLED CHILLER MOD		2014	125,000	6,141	20	6,250	109	21,621	21
22										22
23	: DEPOSIT TO INSTALL NEW LIGHT		2015	6,477	324	20	324		729	23
24	BARIATRIC BED, ELECTRONIC, WID		2015	6,884	459	18	459		1,033	24
25	BARIATRIC POWERED ALTERNATING		2015	9,997	500	18	500		1,041	25
26										26
27	NEW Bathroom - (ILC) Independent Living		2016	9,350	468	20	468		740	27
28	: Electrical work for new phone system		2016	3,335	167	20	167		320	28
29	: INSTALL RESILIENT FLOORING - (ILC) Independent Living		2016	7,494	375	20	375		749	29
30	NEW CARRIER MAKE UP AIR		2016	60,000	3,000	20	3,000		3,250	30
31	New window		2016	3,525	176	20	176		191	31
32	GALVANIZED STEEL INSULATD DOOR		2016	3,635	182	20	182		273	32
33	2ND FLOOR CORRIDOR LED LIGHTS		2016	4,318	173	25	173		345	33
34	ILC Roof Replacement		2016	78,623	3,931	20	3,931		5,242	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

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 AIR HANDLER	2017	\$ 66,112	\$ 2,204	25	\$ 2,204	\$	\$ 2,204	37
38 ASPHALT NEW PARKING LOT	2017	98,921	824	10	824		824	38
39 SKYLIGHT SPINKLER - Front Entrance	2017	3,695	46	20	46		46	39
40 FLOOR IN ACTIVITES ROOM	2017	5,925	593	5	593		593	40
41 NEW WINDOW - Independent Living	2017	3,525	162	20	162		162	41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 6,651,575	\$ 164,910		\$ 177,249	\$ 12,339	\$ 3,340,340	70

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R

# 0044784

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	\$ 1,969,861	\$ 98,583	\$ 129,268	\$ 30,685	13	\$ 1,405,195	71
72	Current Year Purchases	4,225	282	282		15	282	72
73	Fully Depreciated Assets	607,859	3,181	3,181		7	607,859	73
74	Home Office Allocation		168,456	168,456				74
75	TOTALS	\$ 2,581,945	\$ 270,502	\$ 301,187	\$ 30,685		\$ 2,013,336	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)	\$ 12,143,782	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 435,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 478,436	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,024	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,353,676	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

# 0044784

Report Period Beginning: 1/01/17

Ending: 12/31/17

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 29,382 Description: Nursing 783; Admin 11,788; Rehab 284; Activities 216; Home Office 16,311

(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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

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

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



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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a, 1	9142	hrs	\$ 399,734		\$	\$	9,142	\$ 399,734	1
2	Licensed Speech and Language Development Therapist	10a, 1	2084	hrs	92,756				2,084	92,756	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	9360	hrs	392,660				9,360	392,660	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				771,376		771,376	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Director</u>	10a, 1	2080		102,665				2,080	102,665	12
13	Other (specify): _____										13
14	<b>TOTAL</b>				\$ 987,815		\$	\$ 771,376	22,666	\$ 1,759,191	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.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 53,642,932	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 151,322,601	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 204,965,533	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Third Parties</u>	(2,518,894)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 25,270,159	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	629,027		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	47,219		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 676,246	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 25,946,405	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 179,019,128	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 204,965,533	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>181,395,957</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Adj. to reconcile consolidated equity &amp; consolidated income</b>	<b>(4,278,357)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>177,117,600</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,882,467</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>1,390,900</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes	<b>(1,371,839)</b>	<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,901,528</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>179,019,128</b>	<b>24</b> *

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

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

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,653,048	1
2	Discounts and Allowances for all Levels	(1,199,731)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,453,317	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,350,278	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,350,278	8
<b>C. Other Operating Revenue</b>			
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	5,336	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,047,894	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	15,436	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,068,666	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,520	24
25	Interest and Other Investment Income***	8,858	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 10,378	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	32,686	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 32,686	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,915,325	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,821,458	31
32	Health Care	4,899,157	32
33	General Administration	2,763,288	33
<b>B. Capital Expense</b>			
34	Ownership	577,871	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	771,376	35
36	Provider Participation Fee	199,708	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,032,858	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,882,467	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,882,467	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,436,339	44
45	Private Pay - Net Inpatient Revenue	5,177,774	45
46	Medicare - Net Inpatient Revenue	2,266,368	46
47	Other-(specify) <u>Insurance</u>	572,836	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,453,317	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 BENEDICT N & R**

# **0044784**

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	1,780	2,104	\$ 96,506	\$ 45.87	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	36,333	40,156	1,683,253	41.92	3
4	Licensed Practical Nurses	6,939	7,918	212,899	26.89	4
5	CNAs & Orderlies	71,621	80,693	1,189,613	14.74	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	20,442	22,666	987,815	43.58	7
8	Rehab/Therapy Aides	3	3	94	31.33	8
9	Activity Director	3,585	4,153	101,874	24.53	9
10	Activity Assistants	4,494	4,896	54,901	11.21	10
11	Social Service Workers	3,739	4,151	87,639	21.11	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,912	4,530	109,978	24.28	17
18	Housekeepers	11,131	11,996	168,689	14.06	18
19	Laundry	6,271	7,045	86,260	12.24	19
20	Administrator	1,568	2,072	112,991	54.53	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,572	4,850	60,162	12.40	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	180	180	24,908	138.38	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	1,677	1,985	48,140	24.25	31
32	Other Health C: Admissions	3,676	4,265	118,455	27.77	32
33	Other(specify) <u>Pastoral</u>	1,400	1,575	39,745	25.23	33
34	TOTAL (lines 1 - 33)	183,323	205,238	\$ 5,183,922 *	\$ 25.26	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	44	2,420	12,3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	44	\$ 2,420	49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	6,283	152,728	10,3 52
53	TOTAL (lines 50 - 52)	6,283	\$ 152,728	53



Facility Name &amp; ID Number PRESENCE ST BENEDICT N &amp; R

# 0044784

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. 13419
- (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. \$ 38,368 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. \$ 199,708  
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. \$ 5,336
- (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