FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0041731

Facility Name: PRESENCE ST ANNE CENTER

Address: 4405 HIGHCREST ROAD (Number) ROCKFORD (City) 61107 (Zip Code)

County: WINNEBAGO

Telephone Number: 815-229-1999 **Fax #** 815-229-1560

HFS ID Number:

Date of Initial License for Current Owners: 10-06-86

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) GEORGE VIEU
(Title) INTERIM CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	21,535	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,656	9,465	18,608	46,729	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,656	9,465	18,608	46,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.52%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 10-06-86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10-06-86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 12,117

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		32,641	760,666	793,307		793,307		793,307			1
2	Food Purchase		348,987		348,987		348,987	(64,973)	284,014			2
3	Housekeeping	133,115	1,444		134,559		134,559		134,559			3
4	Laundry	11,577		127,415	138,992		138,992		138,992			4
5	Heat and Other Utilities			315,038	315,038		315,038	2,608	317,646			5
6	Maintenance	138,077	60,850	153,473	352,400		352,400	133,388	485,788			6
7	Other (specify):* Pastoral	57,464	319	12,600	70,383		70,383		70,383			7
8	TOTAL General Services	340,233	444,241	1,369,192	2,153,666		2,153,666	71,023	2,224,689			8
	B. Health Care and Programs											
9	Medical Director			21,118	21,118		21,118		21,118			9
10	Nursing and Medical Records	4,243,759	392,607	725,363	5,361,729		5,361,729		5,361,729			10
10a	Therapy	1,395,105	2,720	41	1,397,866		1,397,866		1,397,866			10a
11	Activities	88,785	2,353	8,315	99,453		99,453	62	99,515			11
12	Social Services	117,765		646	118,411		118,411		118,411			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,845,414	397,680	755,483	6,998,577		6,998,577	62	6,998,639			16
	C. General Administration											
17	Administrative	473,241	22,644	1,309,673	1,805,558		1,805,558	(320,368)	1,485,190			17
18	Directors Fees											18
19	Professional Services			17,029	17,029		17,029	25,657	42,686			19
20	Dues, Fees, Subscriptions & Promotions			66,022	66,022		66,022	3,873	69,895			20
21	Clerical & General Office Expenses			34,890	34,890		34,890	1,108	35,998			21
22	Employee Benefits & Payroll Taxes			1,655,123	1,655,123		1,655,123	104,885	1,760,008			22
23	Inservice Training & Education			959	959		959	877	1,836			23
24	Travel and Seminar			959	959		959	5,148	6,107			24
25	Other Admin. Staff Transportation			4,440	4,440		4,440		4,440			25
26	Insurance-Prop.Liab.Malpractice			435,193	435,193		435,193	7,722	442,915			26
27	Other (specify):*											27
28	TOTAL General Administration	473,241	22,644	3,524,288	4,020,173		4,020,173	(171,098)	3,849,075			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,658,888	864,565	5,648,963	13,172,416		13,172,416	(100,013)	13,072,403			29

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

Facility Name & ID Number PRESENCE ST ANNE CENTER #0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			610,248	610,248		610,248	70,769	681,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184,847	184,847		184,847	(22,138)	162,709			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			199,106	199,106		199,106	24,478	223,584			35
36	Other (specify):*											36
37	**TOTAL Ownership**			994,201	994,201		994,201	73,109	1,067,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,378,176	1,378,176		1,378,176		1,378,176			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,596	326,596		326,596		326,596			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,704,772	1,704,772		1,704,772		1,704,772			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,658,888	864,565	8,347,936	15,871,389		15,871,389	(26,904)	15,844,485			45

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(66,462)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	62,039	30		9
10	Interest and Other Investment Income	(22,138)	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	(343)	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)**	$ (26,904)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (26,904)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESENCE ST ANNE CENTER

ID# 0041731

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
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(66,462)	1,489	0	0	0	0	0	0	0	0	0	(64,973)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,608	0	0	0	0	0	0	0	0	0	2,608	5
6	Maintenance	0	12,067	121,321	0	0	0	0	0	0	0	0	133,388	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(66,462)	16,164	121,321	0	0	0	0	0	0	0	0	71,023	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	62	0	0	0	0	0	0	0	0	0	62	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	62	0	0	0	0	0	0	0	0	0	62	16
	C. General Administration													
17	Administrative	0	(107,064)	(213,304)	0	0	0	0	0	0	0	0	(320,368)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,657	0	0	0	0	0	0	0	0	0	25,657	19
20	Fees, Subscriptions & Promotions	(343)	4,216	0	0	0	0	0	0	0	0	0	3,873	20
21	Clerical & General Office Expenses	0	1,108	0	0	0	0	0	0	0	0	0	1,108	21
22	Employee Benefits & Payroll Taxes	0	12,902	91,983	0	0	0	0	0	0	0	0	104,885	22
23	Inservice Training & Education	0	877	0	0	0	0	0	0	0	0	0	877	23
24	Travel and Seminar	0	5,148	0	0	0	0	0	0	0	0	0	5,148	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	7,722	0	0	0	0	0	0	0	0	0	7,722	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(343)	(49,434)	(121,321)	0	0	0	0	0	0	0	0	(171,098)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(66,805)	(33,208)	0	0	0	0	0	0	0	0	0	(100,013)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 **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	62,039	0	8,730	0	0	0	0	0	0	0	0	70,769	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,138)	0	0	0	0	0	0	0	0	0	0	(22,138)	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	24,478	0	0	0	0	0	0	0	0	24,478	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	39,901	0	33,208	0	0	0	0	0	0	0	0	73,109	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)**	(26,904)	(33,208)	33,208	0	0	0	0	0	0	0	0	(26,904)	45

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

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 Villa Franciscan	Joliet	Presence Care @ Hom	Various	Home Equipment
		Presence Heritage Village	Kankakee	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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 1,489	$ 1,489	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,608	2,608	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	12,067	12,067	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	62	62	4
5	V	17	Admin - Misc. Other	387,995	Presence Life Connections	100.00%	(63)	(388,058)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	280,994	280,994	6
7	V	19	Professional Services		Presence Life Connections	100.00%	25,657	25,657	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	4,216	4,216	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,108	1,108	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	12,902	12,902	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	877	877	11
12	V	24	Travel		Presence Life Connections	100.00%	5,148	5,148	12
13	V	26	Insurance		Presence Life Connections	100.00%	7,722	7,722	13
14	Total			$ 387,995			$ 354,787	$ * (33,208)	14

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Presence Life Connections	100.00%	$ 8,730	$ 8,730	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	0		17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	24,478	24,478	18
19	V	17	Admin Salaries		Presence Health	100.00%	510,893	510,893	19
20	V	22	Employee Benefits		Presence Health	100.00%	91,983	91,983	20
21	V	30	Depreciation	253,125	Presence Health	100.00%	253,125		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	921,678	Presence Health	100.00%	302,845	(618,833)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	0		24
25	V	17	Information Systems - Other		Presence Health	100.00%	0		25
26	V	17	Admin Salaries		Presence Health	100.00%	0		26
27	V	17	Information Systems Salaries		Presence Health	100.00%	0		27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	121,321	121,321	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	184,847	Presence Health	100.00%	184,847		30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	(105,364)	(105,364)	31
32	V	39	Ancillary Services - Other	1,378,176	Presence Senior Services Pharmacy	100.00%	1,378,176		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,737,826			$ 2,771,034	$ * 33,208	39

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Maryhaven Nursing & Rehab Center	Glenview	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Nazarethville	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Wendell Provost	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life Connecti	Mokena	Management Comp	4
5			Presence St Benedict Nursing & Rehab Center	Niles	Presence Senior Servic	Kankakee	Pharmacy	5
6			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence St. Joseph Ac	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 H	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Car	Northlake	Independent Living	13
14					Presence Ambulatory S	Various	Parent	14
15					Resurrection Developn	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Esta	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column 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 ST ANNE CENTER # 0041731 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	5,620,989	33	$ 21,575	$	387,995	$ 1,489	1
2	5	Utilities	Management Fee Income	5,620,989	33	37,782		387,995	2,608	2
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812		387,995	12,067	3
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894		387,995	62	4
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)		387,995	(63)	5
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	387,995	280,994	6
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695		387,995	25,657	7
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085		387,995	4,216	8
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056		387,995	1,108	9
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921		387,995	12,902	10
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708		387,995	877	11
12	24	Travel	Management Fee Income	5,620,989	33	74,575		387,995	5,148	12
13	26	Insurance	Management Fee Income	5,620,989	33	111,873		387,995	7,722	13
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474		387,995	8,730	14
15	32	Interest	Management Fee Income	5,620,989	33	0		387,995	0	15
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0		387,995	0	16
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619		387,995	24,478	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,620,989	$ 4,070,831		$ 387,995	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	13,936,478	35	$ 7,725,094	$ 7,725,094	921,678	$ 510,893	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		921,678	91,983	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		253,125	253,125	3
4	34	Rent Facility	Operating Expense	13,936,478	35			921,678		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		921,678	302,845	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			921,678		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			921,678		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			921,678		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			921,678		9
10	6	Information Systems - Equip Mair	Operating Expense	13,936,478	35	1,834,459		921,678	121,321	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			921,678		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		184,847	184,847	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		921,678	(105,364)	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		$ 1,359,650	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,378,176	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,378,176	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PRESENCE ST ANNE CENTER **#** 0041731 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 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 ST ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1984	$ 639,976	1
2					2
3	TOTALS			$ 639,976	3

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1986	1986	$ 3,516,907	$ 19,087	63	$ 55,824	$ 36,737	$ 2,909,314	4
5	59		1993	1993	2,722,251	24,603	56	48,612	24,009	1,943,162	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	34,784	1,172	31	1,122	(50)	30,974	9
10	VARIOUS			1994	5,000		10			5,000	10
11	VARIOUS			1995	40,225		18			34,665	11
12	VARIOUS			1996	7,038	741	10	752	11	7,038	12
13	VARIOUS			1997	41,666		7			41,666	13
14	VARIOUS			1998	22,342		5			22,342	14
15	VARIOUS			1999	6,927		5			6,927	15
16	VARIOUS			2000	22,910		5			22,910	16
17	VARIOUS			2001	280,006	6,712	6	6,328	(384)	258,752	17
18	VARIOUS			2002	9,766	167	10	167		9,766	18
19	VARIOUS			2003	31,300		9			31,300	19
20	VARIOUS			2004	41,705	153	7	147	(6)	41,501	20
21	VARIOUS			2005	21,795	143	10	139	(4)	21,247	21
22	VARIOUS			2006	90,920	3,438	12	3,513	75	78,115	22
23	VARIOUS			2007	180,781	9,549	12	9,575	26	169,213	23
24	VARIOUS			2008	163,653	14,989	12	14,733	(256)	148,167	24
25	VARIOUS			2009	36,593	2,013	11	2,135	122	32,113	25
26	VARIOUS			2010	86,688	5,569	10	5,739	170	53,804	26
27	VARIOUS			2011	109,875	8,641	12	9,096	455	61,002	27
28	VARIOUS			2012	77,789	4,706	12	4,697	(9)	30,845	28
29	VARIOUS			2013	509,811	52,384	11	52,379	(5)	235,157	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	198 GALLON WATER HEATER	2014	$ 6,740	$ 680	10	$ 674	$ (6)	$ 2,374	37
38	CANOPY FIRE SPRINKLER	2014	3,980	156	25	159	3	708	38
39	DESK TOP WATER PANEL	2014	2,788	529	5	558	29	2,259	39
40	KITCHEN DINING ROOM DOORS	2014	2,570	101	25	103	2	356	40
41	LIFE SAFETY K20 TAGS FIRESTOP	2014	5,540	544	10	554	10	1,915	41
42	OUTER DOOR ALARM	2014	2,740	264	10	274	10	936	42
43	ROOF	2014	260,500	25,807	10	26,050	243	90,607	43
44	SEAL COAT PARKING LO	2014	49,995	6,944	7	7,142	198	24,535	44
45	WALL PAINT FOR F HALL	2014	853	145	5	171	26	708	45
46	WATER SOFTENER	2014	12,000	1,146	10	1,200	54	4,074	46
47									47
48									48
49	FLOOR SCRUBBER	2015	4,169	834	5	834		2,154	49
50	KEYPAD/TIMER/RELAYS FOR FRONT DOOR SECURITY SY	2015	2,850	285	10	285		808	50
51	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	10,675	534	20	534		1,512	51
52	RECESSED LIGHTING IN RES. ROOMS AND DINING ROOM	2015	20,871	1,362	15	1,391	29	4,523	52
53	TWO SHOWERS FOR BATHROOMS IN ST. PAUL UNIT	2015	31,000	1,510	20	1,550	40	5,331	53
54	SUBPANEL TO RELOCATE CIRCUITRY	2015	3,786	151	25	151		366	54
55	WATER HEATER	2015	24,150	2,373	10	2,415	42	6,442	55
56	WINDOWS IN RESIDENT ROOMS	2015	16,650	666	25	666		1,721	56
57	WINDOWS AND TRIM	2016	20,578	1,029	20	1,029		2,058	57
58									58
59	PATIO / PERGOLA	2017	22,000	733	15	733		733	59
60	ASPHALT & CONCRET - Front Walkway & Parking Lot	2017	69,503	579	10	579		579	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)		$ 8,634,670	$ 200,439		$ 262,010	$ 61,571	$ 6,349,679	70

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 1,429,469	$ 123,674	$ 125,691	$ 2,017	13	$ 803,861	71
72	Current Year Purchases	49,660	819	819		15	819	72
73	Fully Depreciated Assets	944,657	9,604	9,604		7	944,657	73
74	Home Office Allocation		261,855	261,855				74
75	TOTALS	$ 2,423,786	$ 395,952	$ 397,969	$ 2,017		$ 1,749,337	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	PLANT ENGINEERING	MINI VAN	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOW	1999	27,428				3	27,428	77
78	PLANT ENGINEERING	FORD F-250	2014	35,951	10,537	8,988	(1,549)	4	35,073	78
79	PLANT ENGINEERING	2015 FORD STARCRAFT VAN	2015	48,201	12,050	12,050		4	33,138	79
80	TOTALS			$ 155,080	$ 22,587	$ 21,038	$ (1,549)		$ 139,139	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,853,511	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 618,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 681,017	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,039	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,238,155	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 ANNE CENTER # 0041731 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	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 223,584 Description: Nursing 179,951; Admin 17,309;Rehab 1,845; Home Office 24,478
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 1	15792	hrs	$ 540,626		$	$	15,792	$ 540,626	1
2	Licensed Speech and Language Development Therapist	10a, 1	1049	hrs	43,621				1,049	43,621	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	18213	hrs	708,447				18,213	708,447	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				1,378,176		1,378,176	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Director	10a, 1	2080		102,411				2,080	102,411	12
13	Other (specify):										13
14	TOTAL				$ 1,395,105		$	$ 1,378,176	37,134	$ 2,773,281	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE ST ANNE CENTER **#** 0041731 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

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 Operating	2 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 Operating	2 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	Due to Third Parties	(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	Conditional Asset Retirement	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.)**

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	(1,707,845)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 179,688,112	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(688,045)	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)**	$ (668,984)	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.**

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,611,748	1
2	Discounts and Allowances for all Levels	(5,399,363)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,212,385	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,738,950	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,738,950	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	66,462	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,082,214	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,148,676	23
	D. Non-Operating Revenue		
24	Contributions	61,195	24
25	Interest and Other Investment Income***	22,138	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 83,333	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,183,344	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,153,666	31
32	Health Care	6,998,577	32
33	General Administration	4,020,173	33
	B. Capital Expense		
34	Ownership	994,201	34
	C. Ancillary Expense		
35	Special Cost Centers	1,378,176	35
36	Provider Participation Fee	326,596	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,871,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	(688,045)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (688,045)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,601,316	44
45	Private Pay - Net Inpatient Revenue	2,043,293	45
46	Medicare - Net Inpatient Revenue	2,391,122	46
47	Other-(specify) Insurance	1,176,654	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,212,385	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 ANNE CENTER # 0041731 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,632	1,832	$ 95,621	$ 52.19	1
2	Assistant Director of Nursing	1,432	1,696	66,546	39.24	2
3	Registered Nurses	40,719	44,101	1,583,000	35.89	3
4	Licensed Practical Nurses	37,920	41,216	1,275,740	30.95	4
5	CNAs & Orderlies	76,301	83,705	1,222,437	14.60	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	34,702	37,134	1,395,105	37.57	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,871	2,101	37,178	17.70	9
10	Activity Assistants	3,932	4,187	50,330	12.02	10
11	Social Service Workers	5,377	5,962	117,765	19.75	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	7,862	8,757	139,979	15.98	17
18	Housekeepers	10,523	11,470	133,115	11.61	18
19	Laundry	1,031	1,031	11,577	11.23	19
20	Administrator	1,424	1,560	110,589	70.89	20
21	Assistant Administrator	1,344	1,520	38,664	25.44	21
22	Other Administrative	0	0	6,429		22
23	Office Manager	2,044	2,260	55,100	24.38	23
24	Clerical	7,260	7,847	113,764	14.50	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health C: Admissions	5,905	6,321	148,485	23.49	32
33	Other(specify) Pastoral	2,396	2,517	57,464	22.83	33
34	TOTAL (lines 1 - 33)	243,675	265,217	$ 6,658,888 *	$ 25.11	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	21,118	9,3	36
37	Medical Records Consultant	38	2,611	10,3	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	48	2,640	11,3	44
45	Social Service Consultant	10	646	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	$ 27,015		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,972	$ 208,392	10,3	50
51	Licensed Practical Nurses	2,631	120,910	10,3	51
52	Certified Nurse Assistants/Aides	7,221	169,343	10,3	52
53	TOTAL (lines 50 - 52)	12,824	$ 498,645		53

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shannon Sell	Administrator		$ 110,589
Administrative Staff	Office Manager		55,100
Administrative Staff	Receptionists		35,067
Administrative Staff	Administrative Asst		38,664
Administrative Staff	Admissions		148,485
Administrative Staff	Other Administrative		85,336
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 473,241

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 1,309,673
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,309,673
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DR STILLWATER CO	Water Delivery	$ 297
HEYL ROYSTER VOELKER AND	Legal	2,628
LIVING DESIGN INC	Aviary Service	623
MARCO TECHNOLOGIES LLC	Printing Equipment Service and	1,674
ON HOLD CONCEPTS INC	Music Service	210
PACIFIC INTERPRETERS INC	Over the phone interpreting	16
PER MAR SECURITY AND RESEA	Security Services	5,238
POLSINELLI PC	Legal	6,264
TRACE LEONARD BUSINESS EQU	Custodial Work	79
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 17,029

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,456
Unemployment Compensation Insurance	8,440
FICA Taxes	480,735
Employee Health Insurance	651,213
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	104,885
Dental	19,740
Life Insurance	4,355
Disability Insurance	24,365
Pension	319,822
Tuition Reimbursement	15,679
Other Benefits	25,318
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,760,008

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 93)	
Patient Background Checks 526	
Employee Recruitment	16,557
Dues & Subscriptions	49,122
Advertising & Public Relations	343
Home Office Allocation	4,216
Less: Public Relations Expense	( )
Non-allowable advertising	(343)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,895

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	959
Seminar Expense	
Home Office Allocation	5,148
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,107

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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. **15170**

(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. $ **50,001** 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. $ **326,596**
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. $ **66,462**

(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