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: 0041871

Facility Name: PRESENCE ST JOSEPH CENTER

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

County: STEPHENSON

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		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 JOSEPH CENTER # 0041871 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	124	Skilled (SNF)	124	45,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,260	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	18,749	9,163	6,870	34,782	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,749	9,163	6,870	34,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.85%

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 07-01-96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07-01-96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 3,980

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 JOSEPH CENTER # 0041871 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			554,983	554,983		554,983		554,983			1
2	Food Purchase		254,577		254,577		254,577	(42,590)	211,987			2
3	Housekeeping	103,077	14,269	176	117,522		117,522		117,522			3
4	Laundry		41	114,759	114,800		114,800		114,800			4
5	Heat and Other Utilities			198,727	198,727		198,727	1,501	200,228			5
6	Maintenance	144,123	72,985	221,094	438,202		438,202	81,770	519,972			6
7	Other (specify):* Pastoral	51,536		5,046	56,582		56,582		56,582			7
8	TOTAL General Services	298,736	341,872	1,094,785	1,735,393		1,735,393	40,681	1,776,074			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	2,661,090	56,305	282,091	2,999,486		2,999,486		2,999,486			10
10a	Therapy	489,256	11,700		500,956		500,956		500,956			10a
11	Activities	85,968	322	7,809	94,099		94,099	36	94,135			11
12	Social Services	61,672	6	912	62,590		62,590		62,590			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,297,986	68,333	311,812	3,678,131		3,678,131	36	3,678,167			16
	C. General Administration											
17	Administrative	287,460	116,375	791,753	1,195,588		1,195,588	(193,176)	1,002,412			17
18	Directors Fees											18
19	Professional Services			12,770	12,770		12,770	14,766	27,536			19
20	Dues, Fees, Subscriptions & Promotions			50,077	50,077		50,077	2,045	52,122			20
21	Clerical & General Office Expenses			44,921	44,921		44,921	638	45,559			21
22	Employee Benefits & Payroll Taxes			1,117,352	1,117,352		1,117,352	64,157	1,181,509			22
23	Inservice Training & Education			1,950	1,950		1,950	505	2,455			23
24	Travel and Seminar			5,186	5,186		5,186	2,962	8,148			24
25	Other Admin. Staff Transportation			2,327	2,327		2,327		2,327			25
26	Insurance-Prop.Liab.Malpractice			241,137	241,137		241,137	4,444	245,581			26
27	Other (specify):*											27
28	TOTAL General Administration	287,460	116,375	2,267,473	2,671,308		2,671,308	(103,659)	2,567,649			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,884,182	526,580	3,674,070	8,084,832		8,084,832	(62,942)	8,021,890			29

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER #0041871 Report Period Beginning: 1/01/17 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			488,275	488,275		488,275	15,599	503,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,389	168,389		168,389	(19,983)	148,406			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,014	20,014		20,014	14,087	34,101			35
36	Other (specify):*											36
37	**TOTAL Ownership**			676,678	676,678		676,678	9,703	686,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			577,915	577,915		577,915		577,915			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,876	258,876		258,876		258,876			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			836,791	836,791		836,791		836,791			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,884,182	526,580	5,187,539	9,598,301		9,598,301	(53,239)	9,545,062			45

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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	(43,447)	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	10,575	30		9
10	Interest and Other Investment Income	(19,983)	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	(382)	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)**	$ (53,237)		$	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)	(1)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,238)		37

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

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

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

PRESENCE ST JOSEPH CENTER

ID# 0041871

Report Period Beginning: 1/01/17

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 JOSEPH CENTER # 0041871 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	(43,447)	857	0	0	0	0	0	0	0	0	0	(42,590)	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	1,501	0	0	0	0	0	0	0	0	0	1,501	5
6	Maintenance	0	6,944	74,826	0	0	0	0	0	0	0	0	81,770	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(43,447)	9,302	74,826	0	0	0	0	0	0	0	0	40,681	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	36	0	0	0	0	0	0	0	0	0	36	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	36	0	0	0	0	0	0	0	0	0	36	16
	C. General Administration													
17	Administrative	(1)	(61,616)	(131,559)	0	0	0	0	0	0	0	0	(193,176)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,766	0	0	0	0	0	0	0	0	0	14,766	19
20	Fees, Subscriptions & Promotions	(382)	2,427	0	0	0	0	0	0	0	0	0	2,045	20
21	Clerical & General Office Expenses	0	638	0	0	0	0	0	0	0	0	0	638	21
22	Employee Benefits & Payroll Taxes	0	7,425	56,732	0	0	0	0	0	0	0	0	64,157	22
23	Inservice Training & Education	0	505	0	0	0	0	0	0	0	0	0	505	23
24	Travel and Seminar	0	2,962	0	0	0	0	0	0	0	0	0	2,962	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	4,444	0	0	0	0	0	0	0	0	0	4,444	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(383)	(28,449)	(74,827)	0	0	0	0	0	0	0	0	(103,659)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,830)	(19,111)	(1)	0	0	0	0	0	0	0	0	(62,942)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 **Report Period Beginning:** 1/01/17 **Ending:** 12/31/17

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,575	0	5,024	0	0	0	0	0	0	0	0	15,599	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,983)	0	0	0	0	0	0	0	0	0	0	(19,983)	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	14,087	0	0	0	0	0	0	0	0	14,087	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,408)	0	19,111	0	0	0	0	0	0	0	0	9,703	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)**	(53,238)	(19,111)	19,110	0	0	0	0	0	0	0	0	(53,239)	45

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 McAuley Manor	Aurora	Presence Health	Chicago	Parent Company
		Presence St. Anne Center	Rockford	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%	$ 857	$ 857	1
2	V	5	Utilities		Presence Life Connections	100.00%	1,501	1,501	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	6,944	6,944	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	36	36	4
5	V	17	Admin - Misc. Other	223,294	Presence Life Connections	100.00%	(36)	(223,330)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	161,714	161,714	6
7	V	19	Professional Services		Presence Life Connections	100.00%	14,766	14,766	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,427	2,427	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	638	638	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	7,425	7,425	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	505	505	11
12	V	24	Travel		Presence Life Connections	100.00%	2,962	2,962	12
13	V	26	Insurance		Presence Life Connections	100.00%	4,444	4,444	13
14	Total			$ 223,294			$ 204,183	$ * (19,111)	14

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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%	$ 5,024	$ 5,024	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%	14,087	14,087	18
19	V	17	Admin Salaries		Presence Health	100.00%	315,101	315,101	19
20	V	22	Employee Benefits		Presence Health	100.00%	56,732	56,732	20
21	V	30	Depreciation	142,711	Presence Health	100.00%	142,711		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	568,459	Presence Health	100.00%	186,784	(381,675)	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%	74,826	74,826	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	168,389	Presence Health	100.00%	168,389		30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	(64,985)	(64,985)	31
32	V	39	Ancillary Services - Other	577,915	Presence Senior Services Pharmacy	100.00%	577,915		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,457,474			$ 1,476,584	$ * 19,110	39

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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 Ca	Northlake	Independent Living	13
14					Presence Ambulatory S	Various	Parent	14
15					Resurrection Developn	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Esta	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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 JOSEPH CENTER # 0041871 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	$	223,294	$ 857	1
2	5	Utilities	Management Fee Income	5,620,989	33	37,782		223,294	1,501	2
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812		223,294	6,944	3
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894		223,294	36	4
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)		223,294	(36)	5
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	223,294	161,714	6
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695		223,294	14,766	7
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085		223,294	2,427	8
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056		223,294	638	9
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921		223,294	7,425	10
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708		223,294	505	11
12	24	Travel	Management Fee Income	5,620,989	33	74,575		223,294	2,962	12
13	26	Insurance	Management Fee Income	5,620,989	33	111,873		223,294	4,444	13
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474		223,294	5,024	14
15	32	Interest	Management Fee Income	5,620,989	33	0		223,294	0	15
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0		223,294	0	16
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619		223,294	14,087	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,620,989	$ 4,070,831		$ 223,294	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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	568,459	$ 315,101	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		568,459	56,732	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		142,711	142,711	3
4	34	Rent Facility	Operating Expense	13,936,478	35			568,459		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		568,459	186,784	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			568,459		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			568,459		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			568,459		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			568,459		9
10	6	Information Systems - Equip Mair	Operating Expense	13,936,478	35	1,834,459		568,459	74,826	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			568,459		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		168,389	168,389	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		568,459	(64,985)	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		$ 879,558	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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			$	$		$ 577,915	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					$	$		$ 577,915	25

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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 JOSEPH CENTER # 0041871 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 JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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 JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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		1996	1996	$ 2,500,000	$ 39,593	53	$ 47,170	$ 7,577	$ 1,249,531	4
5	10		2013	2013	3,148,390	94,178	35	94,068	(110)	419,128	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1997	1,037		5			1,037	9
10	VARIOUS			1998	3,718		10			3,718	10
11	VARIOUS			1999	78,698	2,134	13	2,227	93	75,141	11
12	VARIOUS			2001	19,599	255	10	262	7	18,664	12
13	VARIOUS			2002	28,056	518	13	523	5	27,582	13
14	VARIOUS			2003	77,639	1,190	11	1,115	(75)	77,341	14
15	VARIOUS			2004	16,330	101	10	112	11	16,136	15
16	VARIOUS			2005	93,561	2,434	12	2,469	35	74,966	16
17	VARIOUS			2006	47,671	1,068	10	1,125	57	43,504	17
18	VARIOUS			2007	163,794	9,323	13	9,204	(119)	109,489	18
19	VARIOUS			2008	197,106	8,747	14	8,621	(126)	164,063	19
20	VARIOUS			2009	153,368	11,902	12	12,559	657	108,431	20
21	VARIOUS			2010	128,973	11,403	10	12,318	915	102,672	21
22	VARIOUS			2011	39,476	2,692	10	2,717	25	26,081	22
23	VARIOUS			2012	9,244	737	13	759	22	4,548	23
24	VARIOUS			2013	507,163	18,437	12	18,774	337	93,044	24
25											25
26	ADD CELL PHONE CAPABILITY			2014	2,972	279	10	297	18	1,296	26
27	CEILING TILES FOR OCEANVIEW			2014	2,846	268	10	285	17	1,241	27
28	COMPRESSOR FOR CARRIER CONDENS			2014	5,090	424	12	424		1,485	28
29	CONTRACT LABOR MATERIAL AND EQ			2014	9,251	1,090	8	1,156	66	3,892	29
30	DESIGN BUILD INSTALL HIGH ALTA			2014	3,774	255	15	252	(3)	888	30
31	DOOR ENTRANCE STORM			2014	6,855	440	15	457	17	2,017	31
32	FIRE ALARM SYSTEM MODIFICATION			2014	2,735	107	25	109	2	487	32
33	FIRE DOORS			2014	2,828	138	20	141	3	627	33
34	GENERATOR			2014	4,700	383	12	392	9	1,350	34
35	NEW BOILER			2014	22,230	1,121	20	1,112	(9)	3,913	35
36	PARKING LOT			2014	9,750	1,794	5	1,950	156	6,461	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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	NORTH ROOF OF ONEILL H	2014	$ 11,850	$ 1132	10	$ 1,185	$ 53	$ 4,023	37
38	TUCKPOINTING ADC CHAPEL	2014	9,700	138	70	139	1	483	38
39									39
40	AIR COND. CONDENSING UNIT FOR SUNSHINE COURT	2015	26,832	2683	10	2,683		6,261	40
41	DOOR ALARMS WEST UNIT	2015	2,740	274	10	274		731	41
42	CIRCUIT BREAKER AND WIRING NODES FOR BUILDING	2015	10,514	526	20	526		1,095	42
43	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	2,674	107	25	107		294	43
44	LIGHTING EQUIP. FOR RESIDENT ROOMS AND HALLWAY	2015	11,017	734	15	734		2,142	44
45	COUNTERTOP/SINKS/TOILETS/STALLS FOR MENS ROOM	2015	13,691	685	20	685		1,997	45
46	ROOF REPAIR ADC BLDG	2015	71,175	7118	10	7,118		17,201	46
47	ROOFTOP HEATING AC UNIT	2015	3,746	105	35	107	2	371	47
48	WALK-IN TUB, TILE AND MIRROR FOR BATHROOM IN CL	2015	10,337	503	20	517	14	1,778	48
49	WINDOW REPLACEMENT CLF	2015	3,380	169	20	169		493	49
50	YORK ROOF TOP	2015	11,140	1114	10	1114		3,156	50
51	CIRCLE DRIVE PROJECT	2015	1,400	70	20	70		152	51
52	PARKING LOT PROJECT	2015	5,000	250	20	250		542	52
53	NURSE STATION UPGRADE	2015	1,660	83	20	83		187	53
54									54
55	: FURNISH AND INSTALL NEW 4" Piping & RPZ Backflow	2016	8,203	547	15	547		638	55
56	New Network Control Engine	2016	4,150	208	20	208		346	56
57	FIRE SPRINKLER WORK/SKYLIGHTS	2016	3,940	197	20	197		394	57
58	FRONT ENTRY PLASTER WORK	2016	2,073	138	15	138		276	58
59	NURSE STATION UPGRADE	2016	820	41	20	41		82	59
60									60
61	ADC Roof Replacement	2017	5,250	263	15	263		263	61
62	Natural Gas Line Replacement	2017	28,377	616	15	616		616	62
63	STJ/ADC New Floor	2017	14,155	417	15	417		417	63
64	Therapy Room Renovation - Flooring & Walls	2017	26,848	873	15	873		873	64
65									65
66									66
67									67
68	DEDUCTION FOR NON-CARE ASSETS	2011							68
69	DEDUCTION FOR NON-CARE ASSETS	2017							69
70	TOTAL (lines 4 thru 69)		$ 7,577,526	$ 230,002		$ 239,659	$ 9,657	$ 2,683,544	70

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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	$ 1,175,511	$ 100,354	$ 100,742	$ 388	12	$ 686,088	71
72	Current Year Purchases	30,107	840	840		15	840	72
73	Fully Depreciated Assets	617,362	8,356	8,356		8	617,362	73
74	Home Office Allocation		147,735	147,735				74
75	TOTALS	$ 1,822,980	$ 257,285	$ 257,673	$ 388		$ 1,304,290	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TOTAL			$ 229,693	$ 6,012	$ 6,542	$ 530	4	$ 225,184	76
77	SEE VEHICLE ATTACHMENT									77
78	FOR DETAILS									78
79										79
80	TOTALS			$ 229,693	$ 6,012	$ 6,542	$ 530		$ 225,184	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)	$ 11,030,199	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 493,299	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 503,874	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,575	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,213,018	85

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

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

G. Construction-in-Progress

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

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

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	1997 DODGE 2500 (3/4 TON) PICKUP TRU	1997	$ 24,090	$ 0	$ 0	$ 0	5	$ 24,090	76
77	PLANT ENGINEERING	2001 MERCURY SABLE	2001	23,123	0	0	0	3	23,123	77
78	PLANT ENGINEERING	2003 FORD TURTLE TOP VAN	2003	34,275	0	0	0	4	34,275	78
79	PLANT ENGINEERING	2006 CHEVY UPLANDER (MAROON)	2006	15,649	0	0	0	4	15,649	79
79A	PLANT ENGINEERING	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155	0	0	0	4	48,155	79
79B	PLANT ENGINEERING	2012 FORD ELDORADO, 14 PASSENGER VEH	2012	58,232	0	0	0	4	58,232	79
79C	PLANT ENGINEERING	2014 BUICK ENCORE 4WD	2014	26,169	6,012	6,542	530	4	21,660	
80	TOTALS			$ 229,693	$ 6,012	$ 6,542	$ 530		$ 225,184	80

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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: $ 34,101 Description: Nursing 7,893; Admin 12,121; Home Office 14,087
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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.

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	4148 hrs	$ 152,844		$	$	4,148	$ 152,844	1
2	Licensed Speech and Language Development Therapist	10a, 1	705 hrs	34,518				705	34,518	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	5164 hrs	204,493				5,164	204,493	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				577,915		577,915	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Director	10a, 1	2080	97,401				2,080	97,401	12
13	Other (specify):									13
14	TOTAL			$ 489,256		$	$ 577,915	12,097	$ 1,067,171	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.

STATE OF ILLINOIS

Facility Name & ID Number PRESENCE ST JOSEPH CENTER **#** 0041871 **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 JOSEPH CENTER # 0041871 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	(1,165,073)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 180,230,884	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,230,817)	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)**	$ (1,211,756)	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 JOSEPH CENTER # 0041871 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	$ 7,546,163	1
2	Discounts and Allowances for all Levels	(1,342,469)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,203,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,110,413	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,110,413	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	43,447	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	944,538	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)**	$ 987,985	23
	D. Non-Operating Revenue		
24	Contributions	45,409	24
25	Interest and Other Investment Income***	19,983	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 65,392	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,367,484	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,735,393	31
32	Health Care	3,678,131	32
33	General Administration	2,671,308	33
	B. Capital Expense		
34	Ownership	676,678	34
	C. Ancillary Expense		
35	Special Cost Centers	577,915	35
36	Provider Participation Fee	258,876	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,598,301	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,230,817)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,230,817)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,595,939	44
45	Private Pay - Net Inpatient Revenue	1,892,655	45
46	Medicare - Net Inpatient Revenue	939,545	46
47	Other-(specify) Insurance	775,555	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,203,694	49

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

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

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

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

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 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	1,556	1,992	$ 76,477	$ 38.39	1
2	Assistant Director of Nursing	1,084	1,508	52,533	34.84	2
3	Registered Nurses	17,545	18,782	589,772	31.40	3
4	Licensed Practical Nurses	25,899	28,358	806,483	28.44	4
5	CNAs & Orderlies	70,700	76,520	1,053,915	13.77	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	10,995	12,097	489,254	40.44	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,975	2,124	39,666	18.68	9
10	Activity Assistants	3,798	4,287	47,078	10.98	10
11	Social Service Workers	2,979	3,404	62,405	18.33	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	8,449	9,158	144,123	15.74	17
18	Housekeepers	7,932	9,282	103,077	11.11	18
19	Laundry	0	0	0		19
20	Administrator	1,848	2,080	98,250	47.24	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	163	187	6,847	36.61	22
23	Office Manager	1,864	2,160	44,571	20.63	23
24	Clerical	9,851	10,919	147,507	13.51	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	4,143	4,550	70,688	15.54	32
33	Other(specify) Pastoral	1,820	2,040	51,536	25.26	33
34	TOTAL (lines 1 - 33)	172,601	189,448	$ 3,884,182 *	$ 20.50	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	21,000	9,3	36
37	Medical Records Consultant	42	2,849	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	7	440	11,3	44
45	Social Service Consultant	14	916	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	63	$ 25,205		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	260	$ 16,569	10,3	50
51	Licensed Practical Nurses	2,486	107,884	10,3	51
52	Certified Nurse Assistants/Aides	4,203	97,537	10,3	52
53	TOTAL (lines 50 - 52)	6,949	$ 221,990		53

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 Report Period Beginning: 1/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator		$ 98,250
Administrative Staff	Office Manager		44,571
Administrative Staff	Receptionists		67,104
Administrative Staff	Admissions		70,688
Administrative Staff	Other Administrative		6,847
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 287,460

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 791,753
TOTAL (agree to Schedule V, line 17, col. 3)	$ 791,753
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADVANCED HEARING HEALTHC	Advanced Hearing aids	$ 5,700
HEYL ROYSTER VOELKER AND	Legal	2,543
IRON MOUNTAIN	Storage	348
LIVING DESIGN INC	Aviary Service	281
ON HOLD CONCEPTS INC	Music Service	315
PACIFIC INTERPRETERS INC	Over the phone interpreting	55
POLSINELLI PC	Legal	3,528
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 12,770

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,321
Unemployment Compensation Insurance	5,939
FICA Taxes	284,412
Employee Health Insurance	465,662
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	64,157
Dental	14,083
Life Insurance	3,111
Disability Insurance	17,378
Pension	228,517
Tuition Reimbursement	11,183
Other Benefits	11,746
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,181,509

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 36)	
Patient Background Checks 266	
Employee Recruitment	150
Dues & Subscriptions	49,545
Advertising & Public Relations	382
Home Office Allocation	2,427
Less: Public Relations Expense	( )
Non-allowable advertising	(382)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,122

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,186
Seminar Expense	
Home Office Allocation	2,962
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,148

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST JOSEPH CENTER # 0041871 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. **8825**

(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. $ **32,998** 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. $ **258,876**
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. $ **43,447**

(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