FOR BHF USE

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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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0044768

Facility Name: PRESENCE MARYHAVEN NURSING AND REHAB CENTER

Address: 1700 EAST LAKE AVENUE (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: 847-729-1300 **Fax #** 847-729-9620

HFS ID Number:

Date of Initial License for Current Owners: 03-01-00

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 1/01/18 to 6/30/18 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) Regional Finance Manager

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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	135	Skilled (SNF)	135	24,435	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	135	TOTALS	135	24,435	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	8,101	5,089	2,818	16,008	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,101	5,089	2,818	16,008	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.51%

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 03-01-00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03-01-00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 135 and days of care provided 2,241

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 6-30-18 Fiscal Year: 6-30-18

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

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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			291,014	291,014		291,014		291,014			1
2	Food Purchase		98,745		98,745		98,745	(1,579)	97,166			2
3	Housekeeping	75,550	422		75,972		75,972		75,972			3
4	Laundry	32,170	5,269		37,439		37,439	(5,662)	31,777			4
5	Heat and Other Utilities			99,547	99,547		99,547	303	99,850			5
6	Maintenance	54,240	35,994	50,013	140,247		140,247	22,616	162,863			6
7	Other (specify):* Pastoral	17,749		2,927	20,676		20,676		20,676			7
8	TOTAL General Services	179,709	140,430	443,501	763,640		763,640	15,678	779,318			8
	B. Health Care and Programs											
9	Medical Director	4,875		9,157	14,032		14,032		14,032			9
10	Nursing and Medical Records	1,613,869	62,374	80,760	1,757,003		1,757,003		1,757,003			10
10a	Therapy	447,753	7,727	1,590	457,070		457,070		457,070			10a
11	Activities	56,128	2,429	1,086	59,643		59,643	25	59,668			11
12	Social Services	27,431		936	28,367		28,367		28,367			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,150,056	72,530	93,529	2,316,115		2,316,115	25	2,316,140			16
	C. General Administration											
17	Administrative	155,129	4,266	324,757	484,152		484,152	(205,732)	278,420			17
18	Directors Fees											18
19	Professional Services			5,758	5,758		5,758	8,699	14,457			19
20	Dues, Fees, Subscriptions & Promotions			19,303	19,303		19,303	1,422	20,725			20
21	Clerical & General Office Expenses			14,851	14,851		14,851	37	14,888			21
22	Employee Benefits & Payroll Taxes			571,491	571,491		571,491	12,766	584,257			22
23	Inservice Training & Education			(79)	(79)		(79)	621	542			23
24	Travel and Seminar							2,068	2,068			24
25	Other Admin. Staff Transportation			1,274	1,274		1,274		1,274			25
26	Insurance-Prop.Liab.Malpractice			94,552	94,552		94,552	1,133	95,685			26
27	Other (specify):*											27
28	TOTAL General Administration	155,129	4,266	1,031,907	1,191,302		1,191,302	(178,986)	1,012,316			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,484,894	217,226	1,568,937	4,271,057		4,271,057	(163,283)	4,107,774			29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,552	83,552		83,552	102,639	186,191			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,986	30,986		30,986	(8,808)	22,178			32
33	Real Estate Taxes			185,242	185,242		185,242		185,242			33
34	Rent-Facility & Grounds							13,334	13,334			34
35	Rent-Equipment & Vehicles			23,229	23,229		23,229	435	23,664			35
36	Other (specify):*											36
37	**TOTAL Ownership**			323,009	323,009		323,009	107,600	430,609			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			283,033	283,033		283,033		283,033			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,897	123,897		123,897		123,897			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			406,930	406,930		406,930		406,930			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,484,894	217,226	2,298,876	5,000,996		5,000,996	(55,683)	4,945,313			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 MARYHAVEN NURSING AND REHAB Cl # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	(1,945)	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	(5,662)	4		8
9	Non-Straightline Depreciation	100,236	30		9
10	Interest and Other Investment Income	(9,782)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 82,847		$	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)	(69,265)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (69,265)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,582		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

STATE OF ILLINOIS

PRESENCE MARYHAVEN NURSING AND REHAB CENTER

ID# 0044768

Report Period Beginning: 1/01/18

Ending: 6/30/18

	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 MARYHAVEN NURSING AND REHAB CEN # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,945)	366	0	0	0	0	0	0	0	0	0	(1,579)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,662)	0	0	0	0	0	0	0	0	0	0	(5,662)	4
5	Heat and Other Utilities	0	303	0	0	0	0	0	0	0	0	0	303	5
6	Maintenance	0	3,953	18,663	0	0	0	0	0	0	0	0	22,616	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,607)	4,622	18,663	0	0	0	0	0	0	0	0	15,678	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	25	0	0	0	0	0	0	0	0	0	25	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	25	0	0	0	0	0	0	0	0	0	25	16
	C. General Administration													
17	Administrative	(69,265)	(108,005)	(28,462)	0	0	0	0	0	0	0	0	(205,732)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,699	0	0	0	0	0	0	0	0	0	8,699	19
20	Fees, Subscriptions & Promotions	0	1,422	0	0	0	0	0	0	0	0	0	1,422	20
21	Clerical & General Office Expenses	0	37	0	0	0	0	0	0	0	0	0	37	21
22	Employee Benefits & Payroll Taxes	0	4,184	8,582	0	0	0	0	0	0	0	0	12,766	22
23	Inservice Training & Education	0	621	0	0	0	0	0	0	0	0	0	621	23
24	Travel and Seminar	0	2,068	0	0	0	0	0	0	0	0	0	2,068	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	1,133	0	0	0	0	0	0	0	0	0	1,133	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(69,265)	(89,841)	(19,880)	0	0	0	0	0	0	0	0	(178,986)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,872)	(85,194)	(1,217)	0	0	0	0	0	0	0	0	(163,283)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CEN' # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	100,236	0	2,403	0	0	0	0	0	0	0	0	102,639	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,782)	0	974	0	0	0	0	0	0	0	0	(8,808)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	13,334	0	0	0	0	0	0	0	0	13,334	34
35	Rent-Equipment & Vehicles	0	0	435	0	0	0	0	0	0	0	0	435	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	90,454	0	17,146	0	0	0	0	0	0	0	0	107,600	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)**	13,582	(85,194)	15,929	0	0	0	0	0	0	0	0	(55,683)	45

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 366	$ 366	1
2	V	5	Utilities		Presence Life Connections	100.00%	303	303	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	3,953	3,953	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	25	25	4
5	V	17	Admin - Misc. Other	176,535	Presence Life Connections	100.00%	39	(176,496)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	68,491	68,491	6
7	V	19	Professional Services		Presence Life Connections	100.00%	8,699	8,699	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	1,422	1,422	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	37	37	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	4,184	4,184	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	621	621	11
12	V	24	Travel		Presence Life Connections	100.00%	2,068	2,068	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,133	1,133	13
14	Total			$ 176,535			$ 91,341	$ * (85,194)	14

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

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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%	$ 2,361	$ 2,361	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	13,334	13,334	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	435	435	18
19	V	17	Admin Salaries		Presence Health	100.00%	69,321	69,321	19
20	V	22	Employee Benefits		Presence Health	100.00%	8,582	8,582	20
21	V	30	Depreciation	26,300	Presence Health	100.00%	26,342	42	21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	148,222	Presence Health	100.00%	41,197	(107,025)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	9,242	9,242	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%	18,663	18,663	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	30,986	Presence Health	100.00%	31,960	974	30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	0		31
32	V	39	Ancillary Services - Other	283,033	Presence Senior Services Pharmacy	100.00%	283,033		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 488,541			$ 504,470	$ * 15,929	39

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

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mike Gordon	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Nazarethville	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life Connect	Mokena	Management Comp	4
5			Presence St Benedict Nursing & Rehab Center	Niles	Presence Senior 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 Pl	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 MARYHAVEN NURSING AN # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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 MARYHAVEN NURSING AND REHAB CEI # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	3,730,918	27	$ 7,727	$	176,535	$ 366	1
2	5	Utilities	Management Fee Income	3,730,918	27	6,400		176,535	303	2
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534		176,535	3,953	3
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532		176,535	25	4
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825		176,535	39	5
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	176,535	68,491	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838		176,535	8,699	7
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056		176,535	1,422	8
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772		176,535	37	9
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426		176,535	4,184	10
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119		176,535	621	11
12	24	Travel	Management Fee Income	3,730,918	27	43,709		176,535	2,068	12
13	26	Insurance	Management Fee Income	3,730,918	27	23,947		176,535	1,133	13
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905		176,535	2,361	14
15	32	Interest	Management Fee Income	3,730,918	27	0		176,535	0	15
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793		176,535	13,334	16
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183		176,535	435	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,271,274	$ 1,447,508		$ 107,471	25

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CEI # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	2,845,399	27	$ 1,330,754	$ 1,330,754	148,222	$ 69,321	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		148,222	8,582	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		26,300	26,342	3
4	34	Rent Facility	Operating Expense	2,845,399	27			148,222		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		148,222	41,197	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	148,222	9,242	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			148,222		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			148,222		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			148,222		9
10	6	Information Systems - Equip Mair	Operating Expense	2,845,399	27	358,267		148,222	18,663	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			148,222		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		30,986	31,960	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			148,222		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					$ 4,024,190	$ 1,508,174		$ 205,307	25

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CEI # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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: Des Plaines, 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			$	$		$ 283,033	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					$	$		$ 283,033	25

Facility Name & ID Number PRESENCE MARYHAVEN NURSING ANI # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE MARYHAVEN NURSING AND REHAB CEN COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044768

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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	83,762	2000	$ 2,935,798	1
2					2
3	TOTALS	83,762		$ 2,935,798	3

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	135		2000	1961	$ 5,932,922	$ 23,241	40	$ 74,007	$ 50,766	$ 3,292,665	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1981	344		3			344	9
10	VARIOUS			2000	126,735		10			126,735	10
11	VARIOUS			2001	251,673	85	15	246	160	250,002	11
12	VARIOUS			2002	1,434,032	786	11		(786)	1,434,032	12
13	VARIOUS			2003	1,428	16	15	48	31	1,386	13
14	VARIOUS			2004	1,760	19	15	59	40	1,688	14
15	VARIOUS			2005	61,382	104	9	343	239	59,778	15
16	VARIOUS			2006	107,161	317	11	1,029	712	101,515	16
17	VARIOUS			2007	2,310		8			2,310	17
18	VARIOUS			2008	73,448	589	20	1,836	1,248	38,232	18
19	VARIOUS			2012	44,500	350	6	549	199	40,077	19
20											20
21	Nurse Call Light System			2015	59,990	667	30	2,000	1,333	10,562	21
22	Call Light System East Wing			2015	84,900	689	20	2,123	1,433	16,724	22
23	Exterior Signage			2015	7,434	62	20	186	124	1,022	23
24	New Carpet - East Wing			2015	29,800	993	10	2,980	1,987	20,070	24
25	New Doors - East. West, & Glenn Wings			2015	10,210	68	25	204	136	1,293	25
26	Milwork West Hallway			2015	48,150	401	20	1,204	802	8,226	26
27	New Flooring - East. West, & Glenn Wings			2015	62,000	2,067	5	6,200	4,133	42,367	27
28											28
29	Trane Fan Coil Units			2016	19,994	167	20	500	333	1,749	29
30	Fire Hydrant			2016	8,910	74	20	223	149	891	30
31											31
32	ASPHALT MILL & RESURFACE - FRONT SIDEWALK			2017	76,737	2,841	10	3,837	996	4,476	32
33	NEW EMERGENCY PANEL			2017	4,600	51	15	153	102	332	33
34	Fire Hydrant			2017	12,100	101	20	303	202	504	34
35	NEW FIRE DOOR - FRONT ENTRANCE			2017	5,319	44	20	133	89	199	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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	heating coil unit	2018	$ 5,875	$ 98	15	$ 98	$	$ 98	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,473,715	$ 33,830		$ 98,259	$ 64,429	$ 5,457,277	70

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

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHA # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	$ 1,978,996	$ 23,136	$ 58,489	$ 35,353	15	$ 1,387,580	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,046,674	286	740	454	8	1,046,674	73
74	Home Office Allocation		28,703	28,703				74
75	TOTALS	$ 3,025,670	$ 52,125	$ 87,932	$ 35,807		$ 2,434,254	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,435,183	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,955	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,191	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 100,236	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,891,531	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 MARYHAVEN NURSING AND REHAB CEN # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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: $ 23,229 Description: Nursing 14,837; Admin 8,392; Rehabilitation 0; Home Office
(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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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 MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	3084 hrs	$ 141,040		$	$	3,084	$ 141,040	1
2	Licensed Speech and Language Development Therapist	10a, 1	1345 hrs	63,880				1,345	63,880	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	4548 hrs	193,682				4,548	193,682	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				283,033		283,033	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Director	10a, 1	1034	49,151				1,034	49,151	12
13	Other (specify):									13
14	TOTAL			$ 447,753		$	$ 283,033	10,011	$ 730,786	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 MARYHAVEN NURSING AND REHAB CEN# 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/18 (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	$	$ 6,532,327	1
2	Cash-Patient Deposits	23,599	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,085,280	19,421,139	3
4	Supply Inventory (priced at)	28,015	1,498,530	4
5	Short-Term Investments		122,907	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		153,437	7
8	Accounts Receivable (owners or related parties)		3,870,446	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,136,894	$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	2,935,798	40,692,981	13
14	Buildings, at Historical Cost	8,473,715	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,025,670	5,809,806	16
17	Accumulated Depreciation (book methods)	(7,891,533)	(2,612,112)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		3,822	21
22	Other Long-Term Assets (specify):		2,756,878	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,543,650	$ 146,086,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,680,544	$ 177,822,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (40,750)	$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	373,642	20,902,273	28
29	Short-Term Notes Payable		581,779	29
30	Accrued Salaries Payable		3,490	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		298,218	32
33	Accrued Interest Payable		4,518	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties		518,742	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 332,892	$ 24,480,013	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		586,063	39
40	Mortgage Payable			40
41	Bonds Payable		40,821,612	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement			43
44	General Reserve		2,400,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 43,807,675	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 332,892	$ 68,287,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,347,652	$ 109,534,543	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,680,544	$ 177,822,231	48

***(See instructions.)**

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 179,019,128	1
2	Restatements (describe):		2
3			3
4	**Adj. to reconcile consolidated equity & consolidated income**	(173,851,787)	4
5	**Adj to Rollback Consolidated Fixed Asset Re-valuation**	2,352,363	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,519,704	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(172,052)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		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)**	$ (172,052)	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)**	$ 7,347,652	24 *

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

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REH # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	$ 4,732,201	1
2	Discounts and Allowances for all Levels	(1,340,044)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,392,157	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	970,376	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 970,376	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	1,945	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	448,044	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	5,662	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 455,651	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,782	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,782	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	978	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 978	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,828,944	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	763,640	31
32	Health Care	2,316,115	32
33	General Administration	1,191,302	33
	B. Capital Expense		
34	Ownership	323,009	34
	C. Ancillary Expense		
35	Special Cost Centers	283,033	35
36	Provider Participation Fee	123,897	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,000,996	40
41	**Income before Income Taxes (line 30 minus line 40)****	(172,052)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (172,052)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,289,427	44
45	Private Pay - Net Inpatient Revenue	1,367,065	45
46	Medicare - Net Inpatient Revenue	611,012	46
47	Other-(specify) Insurance	124,653	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,392,157	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 MARYHAVEN NURSING AND REHAB CEN # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	981	1,034	$ 81,281	$ 78.61	1
2	Assistant Director of Nursing	895	965	34,235	35.48	2
3	Registered Nurses	19,921	21,824	896,706	41.09	3
4	Licensed Practical Nurses	2,728	3,072	83,213	27.09	4
5	CNAs & Orderlies	28,428	32,703	501,557	15.34	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	9,143	10,011	447,754	44.73	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	860	1,054	22,808	21.64	9
10	Activity Assistants	2,771	2,918	34,666	11.88	10
11	Social Service Workers	1,171	1,253	27,431	21.89	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	1,951	2,099	54,240	25.84	17
18	Housekeepers	5,027	6,186	75,550	12.21	18
19	Laundry	2,316	2,585	32,170	12.44	19
20	Administrator	866	954	53,565	56.15	20
21	Assistant Administrator	200	208	5,846	28.11	21
22	Other Administrative	0	0	0		22
23	Office Manager	905	1,041	23,303	22.39	23
24	Clerical	2,140	2,368	33,807	14.28	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	4,873		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	634	720	15,530	21.57	31
32	Other Health C: Admissions	1,245	1,440	38,610	26.81	32
33	Other(specify) Pastoral	548	618	17,749	28.72	33
34	TOTAL (lines 1 - 33)	82,730	93,053	$ 2,484,894 *	$ 26.70	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	9,157	9,3	36
37	Medical Records Consultant	0	0	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				44
45	Social Service Consultant	104	6,923	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	104	$ 16,080		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10,3	50
51	Licensed Practical Nurses			10,3	51
52	Certified Nurse Assistants/Aides	1,620	35,321	10,3	52
53	TOTAL (lines 50 - 52)	1,620	$ 35,321		53

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHA # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Florczak	Administrator		$ 53,565
Administrative Staff	Office Manager		23,303
Administrative Staff	Receptionists		33,807
Administrative Staff	Admissions		38,610
Administrative Staff	Other Administrative		5,846
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 155,131

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 324,757
TOTAL (agree to Schedule V, line 17, col. 3)	$ 324,757
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PACIFIC INTERPRETERS INC	Over the phone interpreting	$ 16
POLSINELLI PC	Legal	5,742
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,468
Unemployment Compensation Insurance	2,583
FICA Taxes	183,894
Employee Health Insurance	253,297
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	12,766
Dental	5,044
Life Insurance	1,609
Disability Insurance	8,698
Pension	74,852
Tuition Reimbursement	8,358
Other Benefits	687
TOTAL (agree to Schedule V, line 22, col.8)	$ 583,257

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 29)	
Patient Background Checks 131	
Employee Recruitment	
Dues & Subscriptions	19,303
Advertising & Public Relations	
Home Office Allocation	1,422
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,725

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	
Home Office Allocation	2,068
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,068

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE MARYHAVEN NURSING AND REHAB CENTER # 0044768 Report Period Beginning: 1/01/18 Ending: 6/30/18

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. **5732.5**

(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. $ **19,753** 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. $ **123,897**
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. $ **1,945**

(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: **KPGM**

(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