FOR BHF USE

LL1

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

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.

I. IDPH License ID Number: 0054072

Facility Name: PRESENCE NAZARETHVILLE

Address: 300 NORTH RIVER ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: 847-297-5900 **Fax #** 847-297-0504

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
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501C3

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 Director

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 NAZARETHVILLE # 0054072 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	34	Skilled (SNF)	34	6,154	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	6,154	3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	2,715	5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	15,023	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			140	140	8
9	SNF/PED					9
10	ICF	7,463	4,624		12,087	10
11	ICF/DD					11
12	SC		401		401	12
13	DD 16 OR LESS					13
14	TOTALS	7,463	5,025	140	12,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.06%

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 34 and days of care provided 87

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

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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			223,262	223,262		223,262		223,262			1
2	Food Purchase		87,976		87,976		87,976	(918)	87,058			2
3	Housekeeping	69,431	1,384	1,771	72,586		72,586		72,586			3
4	Laundry	15,297	9,396	18,563	43,256		43,256	(8,757)	34,499			4
5	Heat and Other Utilities			79,081	79,081		79,081	193	79,274			5
6	Maintenance	78,233	7,484	70,621	156,338		156,338	13,302	169,640			6
7	Other (specify):* Pastoral	37,942		845	38,787		38,787		38,787			7
8	**TOTAL General Services**	200,903	106,240	394,143	701,286		701,286	3,820	705,106			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,043,254	40,794	26,987	1,111,035		1,111,035		1,111,035			10
10a	Therapy			11,948	11,948		11,948		11,948			10a
11	Activities	64,889	1,771	634	67,294		67,294	16	67,310			11
12	Social Services	19,054		473	19,527		19,527		19,527			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,127,197	42,565	40,042	1,209,804		1,209,804	16	1,209,820			16
	C. General Administration											
17	Administrative	101,239	16,696	198,067	316,002		316,002	(85,220)	230,782			17
18	Directors Fees											18
19	Professional Services			1,711	1,711		1,711	5,539	7,250			19
20	Dues, Fees, Subscriptions & Promotions			14,948	14,948		14,948	906	15,854			20
21	Clerical & General Office Expenses			4,350	4,350		4,350	23	4,373			21
22	Employee Benefits & Payroll Taxes			379,219	379,219		379,219	7,623	386,842			22
23	Inservice Training & Education							395	395			23
24	Travel and Seminar							1,317	1,317			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,934	21,934		21,934	722	22,656			26
27	Other (specify):*											27
28	**TOTAL General Administration**	101,239	16,696	620,229	738,164		738,164	(68,695)	669,469			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,429,339	165,501	1,054,414	2,649,254		2,649,254	(64,859)	2,584,395			29

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

Facility Name & ID Number PRESENCE NAZARETHVILLE #0054072 Report Period Beginning: 1/01/18 Ending: 6/30/18

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			41,945	41,945		41,945	49,057	91,002			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,518	14,518		14,518	(6,771)	7,747			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							8,490	8,490			34
35	Rent-Equipment & Vehicles			2,104	2,104		2,104	277	2,381			35
36	Other (specify):*											36
37	**TOTAL Ownership**			58,567	58,567		58,567	51,053	109,620			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			119,118	119,118		119,118		119,118			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,538	90,538		90,538		90,538			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			209,656	209,656		209,656		209,656			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,429,339	165,501	1,322,637	2,917,477		2,917,477	(13,806)	2,903,671			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 NAZARETHVILLE # 0054072 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	(1,151)	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	(8,757)	4		8
9	Non-Straightline Depreciation	47,529	30		9
10	Interest and Other Investment Income	(7,228)	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)**	$ 30,393		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 30,393		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 NAZARETHVILLE

ID# 0054072

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 NAZARETHVILLE # 0054072 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 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	(1,151)	233	0	0	0	0	0	0	0	0	0	(918)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(8,757)	0	0	0	0	0	0	0	0	0	0	(8,757)	4
5	Heat and Other Utilities	0	193	0	0	0	0	0	0	0	0	0	193	5
6	Maintenance	0	2,517	10,785	0	0	0	0	0	0	0	0	13,302	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,908)	2,943	10,785	0	0	0	0	0	0	0	0	3,820	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	16	0	0	0	0	0	0	0	0	0	16	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	16	0	0	0	0	0	0	0	0	0	16	16
	C. General Administration													
17	Administrative	0	(68,772)	(16,448)	0	0	0	0	0	0	0	0	(85,220)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,539	0	0	0	0	0	0	0	0	0	5,539	19
20	Fees, Subscriptions & Promotions	0	906	0	0	0	0	0	0	0	0	0	906	20
21	Clerical & General Office Expenses	0	23	0	0	0	0	0	0	0	0	0	23	21
22	Employee Benefits & Payroll Taxes	0	2,664	4,959	0	0	0	0	0	0	0	0	7,623	22
23	Inservice Training & Education	0	395	0	0	0	0	0	0	0	0	0	395	23
24	Travel and Seminar	0	1,317	0	0	0	0	0	0	0	0	0	1,317	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	722	0	0	0	0	0	0	0	0	0	722	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(57,206)	(11,489)	0	0	0	0	0	0	0	0	(68,695)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,908)	(54,247)	(704)	0	0	0	0	0	0	0	0	(64,859)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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 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	47,529	0	1,528	0	0	0	0	0	0	0	0	49,057	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,228)	0	457	0	0	0	0	0	0	0	0	(6,771)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,490	0	0	0	0	0	0	0	0	8,490	34
35	Rent-Equipment & Vehicles	0	0	277	0	0	0	0	0	0	0	0	277	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	40,301	0	10,752	0	0	0	0	0	0	0	0	51,053	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)**	30,393	(54,247)	10,048	0	0	0	0	0	0	0	0	(13,806)	45

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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%	$ 233	$ 233	1
2	V	5	Utilities		Presence Life Connections	100.00%	193	193	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,517	2,517	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	16	16	4
5	V	17	Admin - Misc. Other	112,409	Presence Life Connections	100.00%	25	(112,384)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	43,612	43,612	6
7	V	19	Professional Services		Presence Life Connections	100.00%	5,539	5,539	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	906	906	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	23	23	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	2,664	2,664	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	395	395	11
12	V	24	Travel		Presence Life Connections	100.00%	1,317	1,317	12
13	V	26	Insurance		Presence Life Connections	100.00%	722	722	13
14	Total			$ 112,409			$ 58,162	$ * (54,247)	14

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 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%	$ 1,504	$ 1,504	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	8,490	8,490	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	277	277	18
19	V	17	Admin Salaries		Presence Health	100.00%	40,061	40,061	19
20	V	22	Employee Benefits		Presence Health	100.00%	4,959	4,959	20
21	V	30	Depreciation	14,886	Presence Health	100.00%	14,910	24	21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	85,658	Presence Health	100.00%	23,808	(61,850)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	5,341	5,341	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%	10,785	10,785	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	14,518	Presence Health	100.00%	14,975	457	30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	0		31
32	V	39	Ancillary Services - Other	119,118	Presence Senior Services Pharmacy	100.00%	119,118		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 234,180			$ 244,228	$ * 10,048	39

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 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 Maryhaven Nursing & Rehab Center	Glenview	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 NAZARETHVILLE # 0054072 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 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	$	112,409	$ 233	1
2	5	Utilities	Management Fee Income	3,730,918	27	6,400		112,409	193	2
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534		112,409	2,517	3
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532		112,409	16	4
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825		112,409	25	5
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	112,409	43,612	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838		112,409	5,539	7
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056		112,409	906	8
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772		112,409	23	9
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426		112,409	2,664	10
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119		112,409	395	11
12	24	Travel	Management Fee Income	3,730,918	27	43,709		112,409	1,317	12
13	26	Insurance	Management Fee Income	3,730,918	27	23,947		112,409	722	13
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905		112,409	1,504	14
15	32	Interest	Management Fee Income	3,730,918	27	0		112,409	0	15
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793		112,409	8,490	16
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183		112,409	277	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,271,274	$ 1,447,508		$ 68,433	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	85,658	$ 40,061	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		85,658	4,959	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		14,886	14,910	3
4	34	Rent Facility	Operating Expense	2,845,399	27			85,658		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		85,658	23,808	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	85,658	5,341	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			85,658		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			85,658		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			85,658		9
10	6	Information Systems - Equip Mair	Operating Expense	2,845,399	27	358,267		85,658	10,785	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			85,658		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		14,518	14,975	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			85,658		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		$ 114,839	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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			$	$		$ 119,118	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					$	$		$ 119,118	25

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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 NAZARETHVILLE # 0054072 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 NAZARETHVILLE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0054072

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) 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 NAZARETHVILLE # 0054072 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? [ ] (a) Own the Facility [X] (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			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CHAPEL RENOVATIONS			2014	36,000	405	30	1,200	795	9,668	9
10	L M TO EXTEND 20 AMP 3 PHASE 2			2014	2,738	18	25	55	37	434	10
11	L M TO INSTALL TWO DOOR RESTRI			2014	2,350	19	20	59	40	464	11
12	NEW ARMSTRONG VINYL SHEET IN 7			2014	25,550	276	15	852	576	6,697	12
13	NEW KARNDEAN DESIGN FLOORING			2014	64,426	874	25	2,684	1,810	21,190	13
14	REPLACEMENT OF DOORS TO PATIO			2014	2,100	23	15	70	47	556	14
15	REPLACEMENT OF FLOORING IN CHA			2014	21,579	363	10	1,079	716	8,679	15
16	SOFFIT FASCIA REPLACEMENT GUT			2014	20,755	169	20	519	350	4,099	16
17	SUMP PUMP SYSTEM			2015	6,389	106	10	319	213	2,023	17
18	Naz Room Expansion Project			2015	14,400		40	360	360	1,980	18
19	BOILER BURNER & CONTROLS UPGRD			2015	55,935		20	1,398	1,398	7,691	19
20	ELEVATOR UPGRADES-HEAT DETECTR			2015	26,627		20	666	666	3,661	20
21	FAN COILS AND BACK PLATES			2015	50,669		20	1,267	1,267	6,967	21
22	FIRE DAMPER DUCTWORK MAIN BOIL			2015	18,300		20	458	458	2,516	22
23	FLOORING FOR ADM OFFICE			2015	3,885	65	10	194	129	1,068	23
24	INSTALL FIRE DAMPERS BOILR RM			2015	5,600		20	140	140	770	24
25	INSTALL LIGHTING FIXTURES			2015	42,645	190	20	1,066	876	5,864	25
26	L & M INSTALL VFDS			2015	300,810	157	20	7,520	7,363	41,361	26
27	L M TO INSTALL TWO DOOR RESTRI			2015	2,350	19	40	59	40	464	27
28	L M TO INSTALL TWO WALL PACK L			2015	14,871	121	20	372	251	2,929	28
29	MATERIAL LED EXIT RETROFIT			2015	66,902	175	20	1,673	1,498	9,199	29
30	MATERIAL, CONTROLLERS VFD PROJ			2015	152,700	69	20	3,818	3,749	20,996	30
31	MATL CONTROLLERS VFD PROJECT			2015	14,400		20	360	360	1,980	31
32	NEWSPRINKLER HEADS 2+3 FL			2015	18,300		20	458	458	2,516	32
33	NEW THERMOSTATS			2015	17,640		20	441	441	2,426	33
34	NEW ROOF			2015	177,980	1,978	15	5,933	3,955	34,607	34
35	NEW SPRIKLER HEADS			2015	39,850		20	996	996	5,479	35
36	AUTOMATIC DOOR OPENER			2015	4,697	39	20	117		646	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 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	: Door Levers for Resident R	2016	$ 19,930	$ 332	10	$ 997	$ 665	$ 4,318	37
38	: Sidewalk Replacement	2016	5,000	56	15	167	111	833	38
39	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,667	14	20	42	28	139	39
40	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	8,275	69	20	207	138	655	40
41	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	1,143	10	20	29	19	143	41
42	LIFT GATE - Front Entrance Common Area	2016	53		20	1	1	6	42
43	Paint, Walls, Flooring - COMINGLE AREA - Front	2016	3,540	30	20	89	59	369	43
44	Electric Sliding Doors - Front Entrance	2016	13,266	111	20	332	221	1,603	44
45									45
46	NEW DYER VENTING	2017	7,100	59	20	178	119	207	46
47	NEW PARKING LOT	2017	33,910	202	15	605	403	1,513	47
48	NEW WATER PIPING SYSTEM	2017	799,399	4,526	40	10,838	6,312	27,022	48
49									49
50	EM Power For Command Center	2017	10,160	85	20	254	169	254	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,113,891	$ 10,560		$ 47,872	$ 37,234	$ 243,992	70

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	$ 529,348	$ 16,498	$ 26,716	$ 10,218	12	$ 227,948	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	545,537				6	545,537	73
74	Home Office Allocation		16,414	16,414				74
75	TOTALS	$ 1,074,885	$ 32,912	$ 43,130	$ 10,218		$ 773,485	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,188,776	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,472	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 91,002	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 47,530	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,017,477	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 NAZARETHVILLE # 0054072 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: $ 2,104 Description: Nursing 1,183; Admin 643; Environmental Services 60; Activities 54; Home Office ; Spiritual Care 163
(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 NAZARETHVILLE # 0054072 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.

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, 3	hrs	$	97	$ 5,751	$	97	$ 5,751	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		8	487		8	487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		96	5,710		96	5,710	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				119,118		119,118	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	201	$ 11,948	$ 119,118	201	$ 131,066	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 NAZARETHVILLE # 0054072 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	3,824	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	589,289	19,421,139	3
4	Supply Inventory (priced at)	1,907	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)**	$ 595,020	$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land		40,692,981	13
14	Buildings, at Historical Cost	2,127,612	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,084,714	5,809,806	16
17	Accumulated Depreciation (book methods)	(1,017,478)	(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)**	$ 2,194,848	$ 146,086,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,789,868	$ 177,822,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (11,674)	$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	139,295	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)**	$ 127,621	$ 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)**	$ 127,621	$ 68,287,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,662,247	$ 109,534,543	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,789,868	$ 177,822,231	48

*(See instructions.)

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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**	(178,506,972)	4
5	**Adj to Rollback Consolidated Fixed Asset Re-valuation**	2,064,239	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,576,395	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,852	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)**	$ 85,852	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)**	$ 2,662,247	24 *

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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	$ 4,019,644	1
2	Discounts and Allowances for all Levels	(1,336,465)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,683,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,713	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 34,713	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	1,151	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,368	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	8,757	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 274,276	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,228	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,228	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,933	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,933	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,003,329	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	701,286	31
32	Health Care	1,209,804	32
33	General Administration	738,164	33
	B. Capital Expense		
34	Ownership	58,567	34
	C. Ancillary Expense		
35	Special Cost Centers	119,118	35
36	Provider Participation Fee	90,538	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,917,477	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,852	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,852	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,067,955	44
45	Private Pay - Net Inpatient Revenue	1,571,514	45
46	Medicare - Net Inpatient Revenue	53,693	46
47	Other-(specify)	(9,983)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,683,179	49

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

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

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

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

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 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	752	1,034	$ 48,712	$ 47.11	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	12,333	13,810	511,539	37.04	3
4	Licensed Practical Nurses	1,713	1,877	50,845	27.09	4
5	CNAs & Orderlies	22,790	26,198	407,369	15.55	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	953	1,061	18,476	17.41	9
10	Activity Assistants	4,251	4,695	68,548	14.60	10
11	Social Service Workers	1,000	1,044	19,054	18.25	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	2,406	2,783	78,233	28.11	17
18	Housekeepers	3,690	4,115	69,431	16.87	18
19	Laundry	1,210	1,345	15,297	11.37	19
20	Administrator	934	1,034	40,786	39.44	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	61	77	3,331	43.26	22
23	Office Manager	474	508	10,906	21.47	23
24	Clerical	2,085	2,241	28,012	12.50	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	3	3	374	124.67	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	784	940	20,484	21.79	31
32	Other Health C: Admissions	0	0	0		32
33	Other(specify) Pastoral	1,499	1,620	37,942	23.42	33
34	TOTAL (lines 1 - 33)	56,938	64,385	$ 1,429,339 *	$ 22.20	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	6	420	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6	$ 420		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	780	18,194	10,3	52
53	TOTAL (lines 50 - 52)	780	$ 18,194		53

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 Report Period Beginning: 1/01/18 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Ann McKeogh	Administrator		$ 40,786
Administrative Staff	Office Manager		10,906
Administrative Staff	Receptionists		28,012
Administrative Staff	Other Administrative		21,773
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,477

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 198,067
TOTAL (agree to Schedule V, line 17, col. 3)	$ 198,067
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SHRED-IT USA LLC	Shredding Service	$ 1,711
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,728
Unemployment Compensation Insurance	1,778
FICA Taxes	101,681
Employee Health Insurance	175,929
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	7,623
Dental	4,170
Life Insurance	1,112
Disability Insurance	6,008
Pension	51,568
Tuition Reimbursement	3,701
Other Benefits	11,542
TOTAL (agree to Schedule V, line 22, col.8)	$ 386,842

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 19)	
Patient Background Checks 27	
Employee Recruitment	
Dues & Subscriptions	14,948
Advertising & Public Relations	
Home Office Allocation	906
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	
Home Office Allocation	1,317
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,317

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE NAZARETHVILLE # 0054072 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. **3562.5**

(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. $ **15,521** 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. $ **90,538**
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. $ **1,151**

(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