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: 0044784

Facility Name: PRESENCE ST BENEDICT NURSING AND REHAB CENTER

Address: 6930 WEST TOUHY AVENUE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: 847-647-0003 **Fax #** 847-647-1936

HFS ID Number:

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

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 ST BENEDICT NURSING AND REHAB CENTER # 0044784 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	99	Skilled (SNF)	99	17,919	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	5,249	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	23,168	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	2,013	7,628	5,072	14,713	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,552		3,552	12
13	DD 16 OR LESS					13
14	TOTALS	2,013	11,180	5,072	18,265	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.84%

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 99 and days of care provided 3,995

Medicare Intermediary _____

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 ST BENEDICT NURSING AND # 0044784 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		14,998	333,743	348,741		348,741		348,741			1
2	Food Purchase		113,831		113,831		113,831	(1,498)	112,333			2
3	Housekeeping	90,668	16,341		107,009		107,009		107,009			3
4	Laundry	46,670	11,641	307	58,618		58,618	(7,174)	51,444			4
5	Heat and Other Utilities			113,501	113,501		113,501	384	113,885			5
6	Maintenance	49,857	9,165	90,816	149,838		149,838	24,490	174,328			6
7	Other (specify):* Pastoral	20,355		2,265	22,620		22,620		22,620			7
8	TOTAL General Services	207,550	165,976	540,632	914,158		914,158	16,202	930,360			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,452,669	79,406	177,004	1,709,079		1,709,079		1,709,079			10
10a	Therapy	483,864	9,693		493,557		493,557		493,557			10a
11	Activities	79,437	2,025	7,283	88,745		88,745	32	88,777			11
12	Social Services	44,245	675	216	45,136		45,136		45,136			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Shelter	59,929			59,929		59,929	(59,929)				15
16	TOTAL Health Care and Programs	2,120,144	91,799	184,503	2,396,446		2,396,446	(59,897)	2,336,549			16
	C. General Administration											
17	Administrative	168,881	4,963	378,518	552,362		552,362	(254,548)	297,814			17
18	Directors Fees											18
19	Professional Services			14,931	14,931		14,931	11,028	25,959			19
20	Dues, Fees, Subscriptions & Promotions			12,823	12,823		12,823	1,316	14,139			20
21	Clerical & General Office Expenses			8,112	8,112		8,112	46	8,158			21
22	Employee Benefits & Payroll Taxes			582,014	582,014		582,014	(11,685)	570,329			22
23	Inservice Training & Education			2,108	2,108		2,108	787	2,895			23
24	Travel and Seminar			390	390		390	2,622	3,012			24
25	Other Admin. Staff Transportation			315	315		315		315			25
26	Insurance-Prop.Liab.Malpractice			94,552	94,552		94,552	1,437	95,989			26
27	Other (specify):*											27
28	TOTAL General Administration	168,881	4,963	1,093,763	1,267,607		1,267,607	(248,997)	1,018,610			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,496,575	262,738	1,818,898	4,578,211		4,578,211	(292,692)	4,285,519			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			105,795	105,795		105,795	75,312	181,107			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,891	27,891		27,891	(4,096)	23,795			32
33	Real Estate Taxes			4,770	4,770		4,770	(4,770)				33
34	Rent-Facility & Grounds							16,904	16,904			34
35	Rent-Equipment & Vehicles			6,968	6,968		6,968	551	7,519			35
36	Other (specify):*											36
37	**TOTAL Ownership**			145,424	145,424		145,424	83,901	229,325			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			411,067	411,067		411,067		411,067			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,721	97,721		97,721		97,721			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			508,788	508,788		508,788		508,788			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,496,575	262,738	2,473,110	5,232,423		5,232,423	(208,791)	5,023,632			45

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB Cl # 0044784 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	(1,962)	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	(7,174)	4		8
9	Non-Straightline Depreciation	72,275	30		9
10	Interest and Other Investment Income	(4,973)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(487)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 57,679		$	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)	(87,912)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,912)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,233)		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 ST BENEDICT NURSING AND REHAB CENTER

ID# 0044784

Report Period Beginning: 1/01/18

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Assisted/Ind Living - Wages	$ (59,929)	15	1
2	Assisted/Ind Living - Benefits	(25,947)	22	2
3				3
4	Real Estate Tax	(4,770)	33	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(90,646)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEN # 0044784 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	(1,962)	464	0	0	0	0	0	0	0	0	0	(1,498)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(7,174)	0	0	0	0	0	0	0	0	0	0	(7,174)	4
5	Heat and Other Utilities	0	384	0	0	0	0	0	0	0	0	0	384	5
6	Maintenance	0	5,011	19,479	0	0	0	0	0	0	0	0	24,490	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,136)	5,859	19,479	0	0	0	0	0	0	0	0	16,202	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	32	0	0	0	0	0	0	0	0	0	32	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):*	(59,929)	0	0	0	0	0	0	0	0	0	0	(59,929)	15
16	**TOTAL Health Care and Programs**	(59,929)	32	0	0	0	0	0	0	0	0	0	(59,897)	16
	C. General Administration													
17	Administrative	(87,912)	(136,929)	(29,707)	0	0	0	0	0	0	0	0	(254,548)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,028	0	0	0	0	0	0	0	0	0	11,028	19
20	Fees, Subscriptions & Promotions	(487)	1,803	0	0	0	0	0	0	0	0	0	1,316	20
21	Clerical & General Office Expenses	0	46	0	0	0	0	0	0	0	0	0	46	21
22	Employee Benefits & Payroll Taxes	(25,947)	5,305	8,957	0	0	0	0	0	0	0	0	(11,685)	22
23	Inservice Training & Education	0	787	0	0	0	0	0	0	0	0	0	787	23
24	Travel and Seminar	0	2,622	0	0	0	0	0	0	0	0	0	2,622	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	1,437	0	0	0	0	0	0	0	0	0	1,437	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(114,346)	(113,901)	(20,750)	0	0	0	0	0	0	0	0	(248,997)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(183,411)	(108,010)	(1,271)	0	0	0	0	0	0	0	0	(292,692)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEN' # 0044784 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	72,275	0	3,037	0	0	0	0	0	0	0	0	75,312	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,973)	0	877	0	0	0	0	0	0	0	0	(4,096)	32
33	Real Estate Taxes	(4,770)	0	0	0	0	0	0	0	0	0	0	(4,770)	33
34	Rent-Facility & Grounds	0	0	16,904	0	0	0	0	0	0	0	0	16,904	34
35	Rent-Equipment & Vehicles	0	0	551	0	0	0	0	0	0	0	0	551	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	62,532	0	21,369	0	0	0	0	0	0	0	0	83,901	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)**	(120,879)	(108,010)	20,098	0	0	0	0	0	0	0	0	(208,791)	45

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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%	$ 464	$ 464	1
2	V	5	Utilities		Presence Life Connections	100.00%	384	384	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	5,011	5,011	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	32	32	4
5	V	17	Admin - Misc. Other	223,812	Presence Life Connections	100.00%	49	(223,763)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	86,834	86,834	6
7	V	19	Professional Services		Presence Life Connections	100.00%	11,028	11,028	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	1,803	1,803	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	46	46	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	5,305	5,305	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	787	787	11
12	V	24	Travel		Presence Life Connections	100.00%	2,622	2,622	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,437	1,437	13
14	Total			$ 223,812			$ 115,802	$ * (108,010)	14

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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%	$ 2,994	$ 2,994	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	16,904	16,904	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	551	551	18
19	V	17	Admin Salaries		Presence Health	100.00%	72,354	72,354	19
20	V	22	Employee Benefits		Presence Health	100.00%	8,957	8,957	20
21	V	30	Depreciation	27,180	Presence Health	100.00%	27,223	43	21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	154,706	Presence Health	100.00%	42,999	(111,707)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	9,646	9,646	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%	19,479	19,479	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	27,891	Presence Health	100.00%	28,768	877	30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	0		31
32	V	39	Ancillary Services - Other	411,067	Presence Senior Services Pharmacy	100.00%	411,067		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 620,844			$ 640,942	$ * 20,098	39

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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 Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior 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 ST BENEDICT NURSING AN # 0044784 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 ST BENEDICT NURSING AND REHAB CE! # 0044784 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	$	223,812	$ 464	1
2	5	Utilities	Management Fee Income	3,730,918	27	6,400		223,812	384	2
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534		223,812	5,011	3
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532		223,812	32	4
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825		223,812	49	5
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	223,812	86,834	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838		223,812	11,028	7
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056		223,812	1,803	8
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772		223,812	46	9
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426		223,812	5,305	10
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119		223,812	787	11
12	24	Travel	Management Fee Income	3,730,918	27	43,709		223,812	2,622	12
13	26	Insurance	Management Fee Income	3,730,918	27	23,947		223,812	1,437	13
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905		223,812	2,994	14
15	32	Interest	Management Fee Income	3,730,918	27	0		223,812	0	15
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793		223,812	16,904	16
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183		223,812	551	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,271,274	$ 1,447,508		$ 136,251	25

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEI # 0044784 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	154,706	$ 72,354	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		154,706	8,957	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		27,180	27,223	3
4	34	Rent Facility	Operating Expense	2,845,399	27			154,706		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		154,706	42,999	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	154,706	9,646	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			154,706		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			154,706		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			154,706		9
10	6	Information Systems - Equip Mair	Operating Expense	2,845,399	27	358,267		154,706	19,479	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			154,706		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		27,891	28,768	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			154,706		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		$ 209,426	25

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CE! # 0044784 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: DesPlaines, IL 60016
Phone Number: (847-410-4900
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 411,067	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					$	$		$ 411,067	25

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND # 0044784 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 ST BENEDICT NURSING AND REHAB CENTER # 0044784 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 ST BENEDICT NURSING AND REHAB CEN COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) 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 ST BENEDICT NURSING AND REHAB CENTER # 0044784 Report Period Beginning: 1/01/18 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	56,961	2000	$ 2,910,262	1
2					2
3	TOTALS	56,961		$ 2,910,262	3

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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	99		2000	1991	$ 5,342,488	$ 44,399	40	$ 67,342	$ 22,943	$ 2,673,729	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	92,057	667	7		(667)	92,057	9
10	VARIOUS			2001	273,061	103	12	301	198	270,989	10
11	VARIOUS			2002	29,538	41	16	128	87	28,623	11
12	VARIOUS			2003	8,200	26	15	83	57	7,426	12
13	VARIOUS			2004	12,982	107	15	331	225	10,346	13
14	VARIOUS			2005	191,740	1,360	10	4,471	3,111	176,483	14
15	VARIOUS			2006	86,586	345	10	1,015	670	80,070	15
16	VARIOUS			2008	1,284	11	20	32	21	673	16
17	VARIOUS			2012	15,524	111	23	335	224	4,011	17
18											18
19	REMOVING TOP 2 inch OF ASPHALT			2014	50,900	2,086	8	3,181	1,095	25,097	19
20	RENOVATIONS FOR CONVERSION OF			2014	50,400	411	20	1,260	849	9,953	20
21	REPLACE AIR COOLED CHILLER MOD			2014	125,000	1,024	20	3,125	2,101	24,746	21
22											22
23	: DEPOSIT TO INSTALL NEW LIGHT			2015	6,477	54	20	162	108	891	23
24	BARIATRIC BED, ELECTRONIC, WID			2015	6,884	76	18	229	153	1,262	24
25	BARIATRIC POWERED ALTERNATING			2015	9,997	83	18	250	167	1,291	25
26											26
27	NEW Bathroom - (ILC) Independent Living			2016	9,350	78	20	234	156	974	27
28	: Electrical work for new phone system			2016	3,335	28	20	83	55	403	28
29	: INSTALL RESILIENT FLOORING - (ILC) Independent Living			2016	7,494	62	20	187	125	937	29
30	NEW CARRIER MAKE UP AIR			2016	60,000	500	20	1,500	1,000	4,750	30
31	New window			2016	3,525	29	20	88	59	279	31
32	GALVANIZED STEEL INSULATD DOOR			2016	3,635	30	20	91	61	364	32
33	2ND FLOOR CORRIDOR LED LIGHTS			2016	4,318	29	25	86	57	432	33
34	ILC Roof Replacement			2016	78,623	655	20	1,966	1,311	7,207	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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	AIR HANDLER	2017	$ 66,112	$ 441	25	$ 1,322	$ 881	$ 3,526	37
38	ASPHALT NEW PARKING LOT	2017	98,921	3,680	10	4,946	1,266	5,770	38
39	SKYLIGHT SPINKLER - Front Entrance	2017	3,695	31	20	92	61	139	39
40	FLOOR IN ACTIVITES ROOM	2017	5,925	198	5	593	395	1,185	40
41	NEW WINDOW - Independent Living	2017	3,525	29	20	88	59	250	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,651,575	$ 56,693		$ 93,521	$ 36,828	$ 3,433,863	70

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHA# 0044784 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	$ 1,885,394	$ 19,394	$ 60,068	$ 40,674	13	$ 1,380,099	71
72	Current Year Purchases	3,366	56	56		10	56	72
73	Fully Depreciated Assets	696,551	1,366	3,245	1,879	7	696,551	73
74	Home Office Allocation		30,217	30,217				74
75	TOTALS	$ 2,585,311	$ 51,033	$ 93,586	$ 42,553		$ 2,076,706	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,147,148	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 107,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 187,107	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 79,381	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,510,569	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEN # 0044784 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: $ 6,968 Description: Nursing 783; Admin 6,185; 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 ST BENEDICT NURSING AND REHAB CENTER # 0044784 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 ST BENEDICT NURSING AND REHAB CENTER # 0044784 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	4402 hrs	$ 192,172		$	$	4,402	$ 192,172	1
2	Licensed Speech and Language Development Therapist	10a, 1	1005 hrs	45,139				1,005	45,139	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	4562 hrs	194,537				4,562	194,537	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				411,067		411,067	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Director	10a, 1	1034	52,016				1,034	52,016	12
13	Other (specify):									13
14	TOTAL			$ 483,864		$	$ 411,067	11,003	$ 894,931	14

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEN# 0044784 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	641	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	927,590	19,421,139	3
4	Supply Inventory (priced at)	28,802	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)**	$ 957,033	$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	2,910,262	40,692,981	13
14	Buildings, at Historical Cost	6,651,575	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,585,311	5,809,806	16
17	Accumulated Depreciation (book methods)	(5,510,567)	(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)**	$ 6,636,581	$ 146,086,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,593,614	$ 177,822,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (16,090)	$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	185,640	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)**	$ 169,550	$ 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)**	$ 169,550	$ 68,287,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,424,064	$ 109,534,543	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,593,614	$ 177,822,231	48

*(See instructions.)

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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**	(173,559,653)	4
5	**Adj to Rollback Consolidated Fixed Asset Re-valuation**	1,222,743	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,682,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	741,846	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)**	$ 741,846	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)**	$ 7,424,064	24 *

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REH # 0044784 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	$ 4,872,748	1
2	Discounts and Allowances for all Levels	(711,058)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,161,690	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,151,738	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,151,738	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	1,962	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	632,415	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	7,174	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 641,551	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,973	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,973	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	14,317	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,317	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,974,269	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	914,158	31
32	Health Care	2,396,446	32
33	General Administration	1,267,607	33
	B. Capital Expense		
34	Ownership	145,424	34
	C. Ancillary Expense		
35	Special Cost Centers	411,067	35
36	Provider Participation Fee	97,721	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,232,423	40
41	**Income before Income Taxes (line 30 minus line 40)****	741,846	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 741,846	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 631,361	44
45	Private Pay - Net Inpatient Revenue	2,135,175	45
46	Medicare - Net Inpatient Revenue	1,183,655	46
47	Other-(specify) Insurance	211,500	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,161,691	49

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

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

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

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

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CEN # 0044784 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	991	1,034	$ 48,351	$ 46.76	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	16,549	18,784	793,216	42.23	3
4	Licensed Practical Nurses	3,192	3,528	97,715	27.70	4
5	CNAs & Orderlies	32,762	36,972	549,038	14.85	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	9,814	11,003	483,865	43.98	7
8	Rehab/Therapy Aides	4	4	195	48.75	8
9	Activity Director	1,735	2,028	50,924	25.11	9
10	Activity Assistants	2,188	2,404	28,513	11.86	10
11	Social Service Workers	1,873	2,060	44,245	21.48	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	1,855	1,990	49,857	25.05	17
18	Housekeepers	5,419	5,896	90,668	15.38	18
19	Laundry	3,161	3,736	46,670	12.49	19
20	Administrator	720	994	66,132	66.53	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	2,225	2,358	30,642	12.99	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	89	89	13,029	146.39	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	843	971	24,083	24.80	31
32	Other Health C: Admissions	1,818	2,121	59,077	27.85	32
33	Other(specify) Pastoral	758	792	20,355	25.70	33
34	TOTAL (lines 1 - 33)	85,996	96,764	$ 2,496,575 *	$ 25.80	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	4	220	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	$ 220		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	1,427	33,091	10,3	52
53	TOTAL (lines 50 - 52)	1,427	$ 33,091		53

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHA | # 0044784 | Report Period Beginning: 1/01/18 | Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristen Felkner	Administrator		$ 66,132
Administrative Staff	Receptionists		30,642
Administrative Staff	Admissions		59,077
Administrative Staff	Other Administrative		13,355
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,206

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 378,518
TOTAL (agree to Schedule V, line 17, col. 3)	$ 378,518
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BIOMETRIC IMPRESSIONS CORP	Fingerprinting	$ 115
CUSTOM APPLIANCE APPLIANC	Carpet and Vinyl Installation	1,815
FAST TRAK MEDIVAN TRANSPO	Transportation services	239
LIFECYCLE SYSTEMS LLC	Aviary Service	569
LIFESTAR MEDICAR INC	Transportation services	401
MONAHAN LAW GROUP LLC	Legal	9,491
PACIFIC INTERPRETERS INC	Over the phone interpreting	32
POLSINELLI PC	Legal	2,269
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 14,931

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,638
Unemployment Compensation Insurance	2,662
FICA Taxes	178,933
Employee Health Insurance	265,062
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	(11,685)
Dental	6,255
Life Insurance	1,670
Disability Insurance	9,018
Pension	77,101
Tuition Reimbursement	5,555
Other Benefits	3,121
TOTAL (agree to Schedule V, line 22, col.8)	$ 570,329

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 39)	
Patient Background Checks 222	
Employee Recruitment	
Dues & Subscriptions	12,115
Advertising & Public Relations	708
Home Office Allocation	1,803
Less: Public Relations Expense	( )
Non-allowable advertising	(708)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,918

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	390
Seminar Expense	
Home Office Allocation	2,622
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,012

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST BENEDICT NURSING AND REHAB CENTER # 0044784 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. **6635**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,958** 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. $ **97,721**
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. $ **1,962**

(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