		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0041731

Facility Name: PRESENCE ST ANNE CENTER

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

County: WINNEBAGO

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/18 to 6/30/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) ______ (Date)
	(Type or Print Name) GEORGE VIEU
	(Title) Regional Finance 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 ANNE CENTER # 0041731 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	21,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	10,679	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	32,399	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,935	5,400	7,458	21,793	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,935	5,400	7,458	21,793	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.26%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A-NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 119 and days of care provided 5,165

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 ST ANNE CENTER # 0041731 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		5,495	394,024	399,519		399,519		399,519			1
2	Food Purchase		152,990		152,990		152,990	(31,475)	121,515			2
3	Housekeeping	64,056	175		64,231		64,231		64,231			3
4	Laundry	4,963		34,390	39,353		39,353		39,353			4
5	Heat and Other Utilities			178,284	178,284		178,284	429	178,713			5
6	Maintenance	61,211	19,086	47,587	127,884		127,884	32,500	160,384			6
7	Other (specify):* Pastoral	29,625	270	7,820	37,715		37,715		37,715			7
8	TOTAL General Services	159,855	178,016	662,105	999,976		999,976	1,454	1,001,430			8
	B. Health Care and Programs											
9	Medical Director	34,825		10,500	45,325		45,325		45,325			9
10	Nursing and Medical Records	1,909,509	226,582	284,613	2,420,704		2,420,704		2,420,704			10
10a	Therapy	620,070		58	620,128		620,128		620,128			10a
11	Activities	47,361	(36)	3,990	51,315		51,315	36	51,351			11
12	Social Services	59,943		272	60,215		60,215		60,215			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,671,708	226,546	299,433	3,197,687		3,197,687	36	3,197,723			16
	C. General Administration											
17	Administrative	267,920	17,109	463,718	748,747		748,747	(194,016)	554,731			17
18	Directors Fees											18
19	Professional Services			6,184	6,184		6,184	12,322	18,506			19
20	Dues, Fees, Subscriptions & Promotions			21,024	21,024		21,024	1,672	22,696			20
21	Clerical & General Office Expenses			17,378	17,378		17,378	52	17,430			21
22	Employee Benefits & Payroll Taxes			785,749	785,749		785,749	18,297	804,046			22
23	Inservice Training & Education							879	879			23
24	Travel and Seminar			4,964	4,964		4,964	2,930	7,894			24
25	Other Admin. Staff Transportation			4,126	4,126		4,126		4,126			25
26	Insurance-Prop.Liab.Malpractice			231,632	231,632		231,632	1,605	233,237			26
27	Other (specify):*											27
28	TOTAL General Administration	267,920	17,109	1,534,775	1,819,804		1,819,804	(156,259)	1,663,545			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,099,483	421,671	2,496,313	6,017,467		6,017,467	(154,769)	5,862,698			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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			147,981	147,981		147,981	92,171	240,152			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,010	40,010		40,010	(16,980)	23,030			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							18,887	18,887			34
35	Rent-Equipment & Vehicles			49,472	49,472		49,472	615	50,087			35
36	Other (specify):*											36
37	TOTAL Ownership			237,463	237,463		237,463	94,693	332,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			656,179	656,179		656,179		656,179			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,455	154,455		154,455		154,455			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			810,634	810,634		810,634		810,634			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,099,483	421,671	3,544,410	7,065,564		7,065,564	(60,076)	7,005,488			45

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	(31,993)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	88,764	30		9
10	Interest and Other Investment Income	(18,238)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(343)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 38,190		$	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))**	$ 38,190		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 ANNE CENTER

ID# 0041731

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 ST ANNE CENTER # 0041731 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 A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(31,993)	518	0	0	0	0	0	0	0	0	0	(31,475)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	429	0	0	0	0	0	0	0	0	0	429	5
6	Maintenance	0	5,599	26,901	0	0	0	0	0	0	0	0	32,500	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(31,993)	6,546	26,901	0	0	0	0	0	0	0	0	1,454	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	36	0	0	0	0	0	0	0	0	0	36	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	36	0	0	0	0	0	0	0	0	0	36	16
	C. General Administration													
17	Administrative	0	(152,991)	(41,025)	0	0	0	0	0	0	0	0	(194,016)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,322	0	0	0	0	0	0	0	0	0	12,322	19
20	Fees, Subscriptions & Promotions	(343)	2,015	0	0	0	0	0	0	0	0	0	1,672	20
21	Clerical & General Office Expenses	0	52	0	0	0	0	0	0	0	0	0	52	21
22	Employee Benefits & Payroll Taxes	0	5,927	12,370	0	0	0	0	0	0	0	0	18,297	22
23	Inservice Training & Education	0	879	0	0	0	0	0	0	0	0	0	879	23
24	Travel and Seminar	0	2,930	0	0	0	0	0	0	0	0	0	2,930	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	1,605	0	0	0	0	0	0	0	0	0	1,605	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(343)	(127,261)	(28,655)	0	0	0	0	0	0	0	0	(156,259)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,336)	(120,679)	(1,754)	0	0	0	0	0	0	0	0	(154,769)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 D. Ownership	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)	
30	Depreciation	88,764	0	3,407	0	0	0	0	0	0	0	0	92,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,238)	0	1,258	0	0	0	0	0	0	0	0	(16,980)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	18,887	0	0	0	0	0	0	0	0	18,887	34
35	Rent-Equipment & Vehicles	0	0	615	0	0	0	0	0	0	0	0	615	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	70,526	0	24,167	0	0	0	0	0	0	0	0	94,693	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)**	38,190	(120,679)	22,413	0	0	0	0	0	0	0	0	(60,076)	45

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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 Villa Franciscan	Joliet	Presence Care @ Hom	Various	Home Equipment
		Presence Heritage Village	Kankakee	Presence Hospice	Various	Hospice

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Presence Life Connections	100.00%	$ 518	$ 518	1
2	V	5	Utilities		Presence Life Connections	100.00%	429	429	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	5,599	5,599	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	36	36	4
5	V	17	Admin - Misc. Other	250,065	Presence Life Connections	100.00%	55	(250,010)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	97,019	97,019	6
7	V	19	Professional Services		Presence Life Connections	100.00%	12,322	12,322	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,015	2,015	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	52	52	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	5,927	5,927	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	879	879	11
12	V	24	Travel		Presence Life Connections	100.00%	2,930	2,930	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,605	1,605	13
14	Total			$ 250,065			$ 129,386	$ * (120,679)	14

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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%	$ 3,345	$ 3,345	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	18,887	18,887	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	615	615	18
19	V	17	Admin Salaries		Presence Health	100.00%	99,923	99,923	19
20	V	22	Employee Benefits		Presence Health	100.00%	12,370	12,370	20
21	V	30	Depreciation	39,046	Presence Health	100.00%	39,108	62	21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	213,653	Presence Health	100.00%	59,383	(154,270)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	13,322	13,322	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%	26,901	26,901	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	40,010	Presence Health	100.00%	41,268	1,258	30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	0		31
32	V	39	Ancillary Services - Other	656,179	Presence Senior Services Pharmacy	100.00%	656,179		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 948,888			$ 971,301	$ * 22,413	39

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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 Maryhaven Nursing & Rehab Center	Glenview	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Nazarethville	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Wendell Provost	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lod	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life 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 Ad	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	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 ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 Ending: 6/30/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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								TOTAL	$		13

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	$	250,065	$ 518	1
2	5	Utilities	Management Fee Income	3,730,918	27	6,400		250,065	429	2
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534		250,065	5,599	3
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532		250,065	36	4
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825		250,065	55	5
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	250,065	97,019	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838		250,065	12,322	7
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056		250,065	2,015	8
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772		250,065	52	9
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426		250,065	5,927	10
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119		250,065	879	11
12	24	Travel	Management Fee Income	3,730,918	27	43,709		250,065	2,930	12
13	26	Insurance	Management Fee Income	3,730,918	27	23,947		250,065	1,605	13
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905		250,065	3,345	14
15	32	Interest	Management Fee Income	3,730,918	27	0		250,065	0	15
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793		250,065	18,887	16
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183		250,065	615	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,271,274	$ 1,447,508		$ 152,233	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	213,653	$ 99,923	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		213,653	12,370	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		39,046	39,108	3
4	34	Rent Facility	Operating Expense	2,845,399	27			213,653		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		213,653	59,383	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	213,653	13,322	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			213,653		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			213,653		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			213,653		9
10	6	Information Systems - Equip Mair	Operating Expense	2,845,399	27	358,267		213,653	26,901	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			213,653		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		40,010	41,268	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			213,653		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		$ 292,275	25

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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			$	$		$ 656,179	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					$	$		$ 656,179	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 Ending: 6/30/18

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 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 ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	120		1986	1986	$ 3,516,907	$ 38,984	63	$ 27,912	$ (11,072)	$ 2,937,226	4
5	59		1993	1993	2,722,251	4,100	56	24,306	20,206	1,967,468	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	34,784	195	31	561	366	31,535	9
10	VARIOUS			1994	5,000		10			5,000	10
11	VARIOUS			1995	40,225	124	18	376	253	35,041	11
12	VARIOUS			1996	7,038		10			7,038	12
13	VARIOUS			1997	41,666		7			41,666	13
14	VARIOUS			1998	22,342		5			22,342	14
15	VARIOUS			1999	6,927		5			6,927	15
16	VARIOUS			2000	22,910		5			22,910	16
17	VARIOUS			2001	280,006	1,119	6	3,164	2,045	261,916	17
18	VARIOUS			2002	9,766		10			9,766	18
19	VARIOUS			2003	31,300		9			31,300	19
20	VARIOUS			2004	41,705	26	7	73	48	41,574	20
21	VARIOUS			2005	21,795	13	10	37	24	21,284	21
22	VARIOUS			2006	90,920	573	12	1,756	1,183	79,872	22
23	VARIOUS			2007	180,781	411	12	1,245	834	170,458	23
24	VARIOUS			2008	163,653	1,886	12	5,192	3,306	153,358	24
25	VARIOUS			2009	36,593	335	11	1,067	732	33,180	25
26	VARIOUS			2010	86,688	928	10	2,869	1,941	56,673	26
27	VARIOUS			2011	109,875	2,019	12	4,548	2,529	65,550	27
28	VARIOUS			2012	77,789	403	12	1,204	801	32,050	28
29	VARIOUS			2013	509,811	8,731	11	25,222	16,492	260,380	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	198 GALLON WATER HEATER	2014	$ 6,740	$ 113	10	$ 337	$ 224	$ 2,711	37
38	CANOPY FIRE SPRINKLER	2014	3,980	26	25	80	54	788	38
39	DESK TOP WATER PANEL	2014	2,788	88	5	279	191	2,538	39
40	KITCHEN DINING ROOM DOORS	2014	2,570	17	25	51	34	408	40
41	LIFE SAFETY K20 TAGS FIRESTOP	2014	5,540	91	10	277	186	2,192	41
42	OUTER DOOR ALARM	2014	2,740	44	10	137	93	1,073	42
43	ROOF	2014	260,500	4,301	10	13,025	8,724	103,632	43
44	SEAL COAT PARKING LO	2014	49,995	1,157	7	3,571	2,414	28,106	44
45	WALL PAINT FOR F HALL	2014	853	24	5	85	61	794	45
46	WATER SOFTENER	2014	12,000	191	10	600	409	4,674	46
47									47
48									48
49	FLOOR SCRUBBER	2015	4,169	139	5	417	278	2,571	49
50	KEYPAD/TIMER/RELAYS FOR FRONT DOOR SECURITY SY	2015	2,850	48	10	143	95	950	50
51	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	10,675	89	20	267	178	1,779	51
52	RECESSED LIGHTING IN RES. ROOMS AND DINING ROOM	2015	20,871	227	15	696	469	5,219	52
53	TWO SHOWERS FOR BATHROOMS IN ST. PAUL UNIT	2015	31,000	252	20	775	523	6,106	53
54	SUBPANEL TO RELOCATE CIRCUITRY	2015	3,786	25	25	76	51	442	54
55	WATER HEATER	2015	24,150	396	10	1,208	812	7,650	55
56	WINDOWS IN RESIDENT ROOMS	2015	16,650	111	25	333	222	2,054	56
57									57
58	WINDOWS AND TRIM	2016	20,578	139	20	416	277	2,572	58
59									59
60	PATIO / PERGOLA	2017	22,000	244	15	733	489	1,467	60
61	ASPHALT & CONCRET - Front Walkway & Parking Lot	2017	69,503	2,617	10	3,475	858	4,054	61
62									62
63	Bathroom floor replacement-Room C18	2018	3,650	61	10	61		61	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,638,320	$ 70,246		$ 126,576	$ 56,330	$ 6,476,355	70

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	$ 1,463,101	$ 32,723	$ 63,597	$ 30,874	13	$ 848,855	71
72	Current Year Purchases	3,892	93	93		7	93	72
73	Fully Depreciated Assets	964,578	313	591	278	7	964,578	73
74	Home Office Allocation		42,453	42,453				74
75	TOTALS	$ 2,431,571	$ 75,582	$ 106,734	$ 31,152		$ 1,813,526	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	MINI VAN	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOV	1999	27,428				3	27,428	77
78	PLANT ENGINEERING	FORD F-250	2014	35,951	2,058	878	(1,180)	4	35,951	78
79	PLANT ENGINEERING	2015 FORD STARCRAFT VAN	2015	48,201	3,564	6,025	2,461	4	39,163	79
80	TOTALS			$ 155,080	$ 5,622	$ 6,903	$ 1,281		$ 146,042	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,864,946	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,450	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 240,213	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 88,763	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,435,923	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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 [X] NO
16. Rental Amount for movable equipment: $ 49,472 Description: Nursing 44,021; Admin 12,768;EVS -7,632; Development 315; 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.

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service		3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 1	7297	hrs	$ 260,983		$	$	7,297	$ 260,983	1
2	Licensed Speech and Language Development Therapist	10a, 1	70	hrs	3,233				70	3,233	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	7984	hrs	304,808				7,984	304,808	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				656,179		656,179	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Director	10a, 1	1026		51,046				1,026	51,046	12
13	Other (specify):										13
14	TOTAL				$ 620,070		$	$ 656,179	16,377	$ 1,276,249	14

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 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	4,200	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,378,751	19,421,139	3
4	Supply Inventory (priced at)	29,524	1,498,530	4
5	Short-Term Investments		122,907	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		153,437	7
8	Accounts Receivable (owners or related parties)		3,870,446	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,412,475	$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	639,976	40,692,981	13
14	Buildings, at Historical Cost	8,638,320	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,586,584	5,809,806	16
17	Accumulated Depreciation (book methods)	(8,435,919)	(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)**	$ 3,428,961	$ 146,086,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,841,436	$ 177,822,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (4,693)	$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	422,204	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)**	$ 417,511	$ 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)**	$ 417,511	$ 68,287,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,423,925	$ 109,534,543	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,841,436	$ 177,822,231	48

*(See instructions.)

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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**	(173,677,575)	4
5	**Adj to Rollback Consolidated Fixed Asset Re-valuation**	(863,782)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,477,771	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,157)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	100	11
12	Expenditures for Specific Purposes	(789)	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)**	$ (53,846)	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)**	$ 4,423,925	24 *

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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	$ 6,590,535	1
2	Discounts and Allowances for all Levels	(2,695,470)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,895,065	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,975,208	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,975,208	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	31,993	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,091,014	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,123,007	23
	D. Non-Operating Revenue		
24	Contributions	889	24
25	Interest and Other Investment Income***	18,238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,127	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,012,407	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	999,976	31
32	Health Care	3,197,687	32
33	General Administration	1,819,804	33
	B. Capital Expense		
34	Ownership	237,463	34
	C. Ancillary Expense		
35	Special Cost Centers	656,179	35
36	Provider Participation Fee	154,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,065,564	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,157)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,157)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,218,230	44
45	Private Pay - Net Inpatient Revenue	1,178,497	45
46	Medicare - Net Inpatient Revenue	1,060,949	46
47	Other-(specify) Insurance	437,388	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,895,064	49

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

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

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

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

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 Ending: 6/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	495	535	$ 29,282	$ 54.73	1
2	Assistant Director of Nursing	486	546	24,048	44.04	2
3	Registered Nurses	18,939	20,374	765,698	37.58	3
4	Licensed Practical Nurses	14,682	16,033	491,736	30.67	4
5	CNAs & Orderlies	38,008	41,614	609,694	14.65	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	14,594	16,378	620,070	37.86	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	879	1,043	18,783	18.01	9
10	Activity Assistants	1,837	2,147	27,498	12.81	10
11	Social Service Workers	2,329	2,895	59,943	20.71	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	3,327	3,755	62,536	16.65	17
18	Housekeepers	4,864	5,164	64,056	12.40	18
19	Laundry	419	419	4,963	11.84	19
20	Administrator	947	970	72,870	75.12	20
21	Assistant Administrator	824	840	23,084	27.48	21
22	Other Administrative	80	80	2,050	25.63	22
23	Office Manager	943	1,091	27,690	25.38	23
24	Clerical	2,736	2,899	44,866	15.48	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	361	361	45,012	124.69	27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health C: Admissions	2,952	3,174	75,918	23.92	32
33	Other(specify) Pastoral	1,261	1,314	29,686	22.59	33
34	TOTAL (lines 1 - 33)	110,963	121,632	$ 3,099,483 *	$ 25.48	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,500	9,3	36
37	Medical Records Consultant	17	1,199	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,328	11,3	44
45	Social Service Consultant	8	510	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	$ 13,537		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,050	$ 70,117	10,3	50
51	Licensed Practical Nurses	2,220	113,670	10,3	51
52	Certified Nurse Assistants/Aides	1,611	39,430	10,3	52
53	TOTAL (lines 50 - 52)	4,881	$ 223,217		53

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 Report Period Beginning: 1/01/18 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Fedyk	Administrator		$ 72,870
Administrative Staff	Office Manager		27,690
Administrative Staff	Receptionists		36,866
Administrative Staff	Asst Administrator		23,084
Administrative Staff	Admissions		75,918
Administrative Staff	Other Administrative		31,736
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 268,164

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 463,718
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 463,718

C. Professional Services

Vendor/Payee	Type	Amount
DR STILLWATER CO	Water Delivery	$ 124
MARCO TECHNOLOGIES LLC	Printing Equipment Service and	88
PACIFIC INTERPRETERS INC	Over the phone interpreting	4
PER MAR SECURITY AND RESEA	Security Services	2,438
POLSINELLI PC	Legal	3,531
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 6,184

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,362
Unemployment Compensation Insurance	3,420
FICA Taxes	231,376
Employee Health Insurance	333,828
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	18,297
Dental	7,946
Life Insurance	2,107
Disability Insurance	11,404
Pension	97,342
Tuition Reimbursement	7,025
Other Benefits	49,938
TOTAL (agree to Schedule V, line 22, col.8)	$ 804,046

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 93)	
Patient Background Checks 526	
Employee Recruitment	1,320
Dues & Subscriptions	19,177
Advertising & Public Relations	527
Home Office Allocation	2,015
Less: Public Relations Expense	( )
Non-allowable advertising	(527)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,512

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,964
Seminar Expense	
Home Office Allocation	2,930
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,894

**See instructions.

Facility Name & ID Number **PRESENCE ST ANNE CENTER** # 0041731 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. **7585**

(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. $ **24,506** 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. $ **154,455**
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. $ **31,993**

(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