FOR BHF USE

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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: 0044792

Facility Name: PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER

Address: 480 NORTH WOLF ROAD (Number) NORTHLAKE (City) 61064 (Zip Code)

County: COOK

Telephone Number: 708-562-0040 **Fax #** 708-562-5180

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501C3

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) GEORGE VIEU
(Title) Regional Finance Manager

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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	171	Skilled (SNF)	171	30,951	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	14,842	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	45,793	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	21,202	8,021	6,829	36,052	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,202	8,021	6,829	36,052	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.73%

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 171 and days of care provided 5,519

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSIN # 0044792 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		14,026	454,792	468,818		468,818		468,818			1
2	Food Purchase		234,634		234,634		234,634	542	235,176			2
3	Housekeeping	142,823	48,808		191,631		191,631		191,631			3
4	Laundry	64,445	67,809		132,254		132,254	3,420	135,674			4
5	Heat and Other Utilities			195,531	195,531		195,531	542	196,073			5
6	Maintenance	71,068	3,095	301,539	375,702		375,702	41,615	417,317			6
7	Other (specify):* Pastoral	77,453		4,633	82,086		82,086		82,086			7
8	**TOTAL General Services**	355,789	368,372	956,495	1,680,656		1,680,656	46,119	1,726,775			8
	B. Health Care and Programs											
9	Medical Director	4,400		27,000	31,400		31,400		31,400			9
10	Nursing and Medical Records	3,217,183	207,016	24,756	3,448,955		3,448,955		3,448,955			10
10a	Therapy	495,455	8,629		504,084		504,084		504,084			10a
11	Activities	78,759	9,738	1,796	90,293		90,293	45	90,338			11
12	Social Services	80,312	131	1,111	81,554		81,554		81,554			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,876,109	225,514	54,663	4,156,286		4,156,286	45	4,156,331			16
	C. General Administration											
17	Administrative	218,950	9,674	590,214	818,838		818,838	(369,763)	449,075			17
18	Directors Fees											18
19	Professional Services			49,836	49,836		49,836	15,564	65,400			19
20	Dues, Fees, Subscriptions & Promotions			19,250	19,250		19,250	2,228	21,478			20
21	Clerical & General Office Expenses			30,698	30,698		30,698	65	30,763			21
22	Employee Benefits & Payroll Taxes			1,038,611	1,038,611		1,038,611	23,370	1,061,981			22
23	Inservice Training & Education			1,069	1,069		1,069	1,111	2,180			23
24	Travel and Seminar			870	870		870	3,701	4,571			24
25	Other Admin. Staff Transportation			1,153	1,153		1,153		1,153			25
26	Insurance-Prop.Liab.Malpractice			95,002	95,002		95,002	2,027	97,029			26
27	Other (specify):*											27
28	**TOTAL General Administration**	218,950	9,674	1,826,703	2,055,327		2,055,327	(321,697)	1,733,630			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,450,848	603,560	2,837,861	7,892,269		7,892,269	(275,533)	7,616,736			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			242,374	242,374		242,374	177,647	420,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,030	61,030		61,030	(14,679)	46,351			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							23,857	23,857			34
35	Rent-Equipment & Vehicles			62,812	62,812		62,812	777	63,589			35
36	Other (specify):*											36
37	**TOTAL Ownership**			366,216	366,216		366,216	187,602	553,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			659,680	659,680		659,680		659,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,367	245,367		245,367		245,367			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			905,047	905,047		905,047		905,047			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,450,848	603,560	4,109,124	9,163,532		9,163,532	(87,931)	9,075,601			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 VILLA SCALABRINI NURSING AND REI # 0044792 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	(112)	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	3,420	4		8
9	Non-Straightline Depreciation	173,344	30		9
10	Interest and Other Investment Income	(16,598)	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	(317)	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)**	$ 159,737		$	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)	(123,834)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (123,834)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 35,903		37

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

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

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

PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER

ID# 0044792

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 VILLA SCALABRINI NURSING AND REHAI # 0044792 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	(112)	654	0	0	0	0	0	0	0	0	0	542	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	3,420	0	0	0	0	0	0	0	0	0	0	3,420	4
5	Heat and Other Utilities	0	542	0	0	0	0	0	0	0	0	0	542	5
6	Maintenance	0	7,072	34,543	0	0	0	0	0	0	0	0	41,615	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,308	8,268	34,543	0	0	0	0	0	0	0	0	46,119	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	45	0	0	0	0	0	0	0	0	0	45	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	45	0	0	0	0	0	0	0	0	0	45	16
	C. General Administration													
17	Administrative	(123,834)	(193,249)	(52,680)	0	0	0	0	0	0	0	0	(369,763)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,564	0	0	0	0	0	0	0	0	0	15,564	19
20	Fees, Subscriptions & Promotions	(317)	2,545	0	0	0	0	0	0	0	0	0	2,228	20
21	Clerical & General Office Expenses	0	65	0	0	0	0	0	0	0	0	0	65	21
22	Employee Benefits & Payroll Taxes	0	7,486	15,884	0	0	0	0	0	0	0	0	23,370	22
23	Inservice Training & Education	0	1,111	0	0	0	0	0	0	0	0	0	1,111	23
24	Travel and Seminar	0	3,701	0	0	0	0	0	0	0	0	0	3,701	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	2,027	0	0	0	0	0	0	0	0	0	2,027	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(124,151)	(160,750)	(36,796)	0	0	0	0	0	0	0	0	(321,697)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(120,843)	(152,437)	(2,253)	0	0	0	0	0	0	0	0	(275,533)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHA | # 0044792 | 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	173,344	0	4,303	0	0	0	0	0	0	0	0	177,647	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,598)	0	1,919	0	0	0	0	0	0	0	0	(14,679)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	23,857	0	0	0	0	0	0	0	0	23,857	34
35	Rent-Equipment & Vehicles	0	0	777	0	0	0	0	0	0	0	0	777	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	156,746	0	30,856	0	0	0	0	0	0	0	0	187,602	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)**	35,903	(152,437)	28,603	0	0	0	0	0	0	0	0	(87,931)	45

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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%	$ 654	$ 654	1
2	V	5	Utilities		Presence Life Connections	100.00%	542	542	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	7,072	7,072	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	45	45	4
5	V	17	Admin - Misc. Other	315,868	Presence Life Connections	100.00%	70	(315,798)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	122,549	122,549	6
7	V	19	Professional Services		Presence Life Connections	100.00%	15,564	15,564	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,545	2,545	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	65	65	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	7,486	7,486	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,111	1,111	11
12	V	24	Travel		Presence Life Connections	100.00%	3,701	3,701	12
13	V	26	Insurance		Presence Life Connections	100.00%	2,027	2,027	13
14	Total			$ 315,868			$ 163,431	$ * (152,437)	14

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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%	$ 4,225	$ 4,225	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	23,857	23,857	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	777	777	18
19	V	17	Admin Salaries		Presence Health	100.00%	128,308	128,308	19
20	V	22	Employee Benefits		Presence Health	100.00%	15,884	15,884	20
21	V	30	Depreciation	49,047	Presence Health	100.00%	49,125	78	21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	274,347	Presence Health	100.00%	76,253	(198,094)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	17,106	17,106	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%	34,543	34,543	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	0		29
30	V	32	Admin - Interest Expense	61,030	Presence Health	100.00%	62,949	1,919	30
31	V	17	Admin Int Inc Offset		Presence Health	100.00%	0		31
32	V	39	Ancillary Services - Other	659,680	Presence Senior Services Pharmacy	100.00%	659,680		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,044,104			$ 1,072,707	$ * 28,603	39

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTEF # 0044792 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 St Benedict Nursing & Rehab Center	Niles	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 VILLA SCALABRINI NURSI # 0044792 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 VILLA SCALABRINI NURSING AND REH/ # 0044792 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	$	315,868	$ 654	1
2	5	Utilities	Management Fee Income	3,730,918	27	6,400		315,868	542	2
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534		315,868	7,072	3
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532		315,868	45	4
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825		315,868	70	5
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	315,868	122,549	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838		315,868	15,564	7
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056		315,868	2,545	8
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772		315,868	65	9
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426		315,868	7,486	10
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119		315,868	1,111	11
12	24	Travel	Management Fee Income	3,730,918	27	43,709		315,868	3,701	12
13	26	Insurance	Management Fee Income	3,730,918	27	23,947		315,868	2,027	13
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905		315,868	4,225	14
15	32	Interest	Management Fee Income	3,730,918	27	0		315,868	0	15
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793		315,868	23,857	16
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183		315,868	777	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,271,274	$ 1,447,508		$ 192,290	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REH/ # 0044792 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	274,347	$ 128,308	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		274,347	15,884	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		49,047	49,125	3
4	34	Rent Facility	Operating Expense	2,845,399	27			274,347		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		274,347	76,253	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	274,347	17,106	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			274,347		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			274,347		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			274,347		9
10	6	Information Systems - Equip Mair	Operating Expense	2,845,399	27	358,267		274,347	34,543	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			274,347		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		61,030	62,949	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			274,347		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		$ 384,168	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REH/ # 0044792 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			$	$		$ 659,680	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					$	$		$ 659,680	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSIN # 0044792 Report Period Beginning: 1/01/18 Ending: 6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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 VILLA SCALABRINI NURSING AND REHA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044792

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 VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 Report Period Beginning: 1/01/18 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete 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 [ ] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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	253		2000		$ 7,510,695	$ 78,274	40	$ 93,843	$ 15,569	$ 4,170,896	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	87,374		8			87,374	9
10	VARIOUS			2001	22,045		10			22,045	10
11	VARIOUS			2002	2,385		10			2,385	11
12	VARIOUS			2004	23,112	191	20	578	387	16,730	12
13	VARIOUS			2005	74,417	322	11	1,060	738	70,802	13
14	VARIOUS			2006	2,077,086	13,497	15	41,601	28,104	1,248,116	14
15	VARIOUS			2007	87,391	287	16	900	613	71,913	15
16	VARIOUS			2008	7,411	61	20	185	125	3,873	16
17	VARIOUS			2012	321,297	19,323	14	11,314	(8,009)	142,457	17
18	VARIOUS			2013	867,185	8,247	18	20,215	11,969	201,268	18
19											19
20	33 NEW SMOKE DETECTORS 4 PULL			2014	12,662	204	20	633	429	5,658	20
21	ARCHITECTURAL SERVICE FOR ALL			2014	46,000	508	15	1,533	1,025	12,224	21
22	INSTALL NEW FLOOR IN WALK IN F			2014	9,050	154	10	453	299	3,661	22
23	RENOVATION OF QUAD UNITS INTO			2014	638,000	6,703	150	20,200	13,497	161,180	23
24	RENOVATIONS OF QUAD UNITS INTO			2014	101,261	1,153	15	3,375	2,222	27,392	24
25	REPLACEMENT OF DOORS IN SEVERA			2014	17,175	191	15	573	382	4,580	25
26	SIDEWALK ADDED FROM THERAPY RO			2014	8,000	90	15	267	177	2,149	26
27											27
28											28
29											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 VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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	: 3 SHOWER REMODEL UNIT 3	2015	$ 11,600	$ 97	20	$ 290	$ 193	$ 1,547	37
38	24 RM CONVERT INTO SHORT TERM	2015	55,467	462	20	1,387	925	7,627	38
39	24 SEMI PRIV RMS TO 15 PRIV SK	2015	110,934	5,167	20	2,773	(2,394)	17,565	39
40	BACKUP GENERATOR FIRE PUMP REP	2015	128,500	1,428	15	4,283	2,855	23,558	40
41	CHANGE ORDER REQUEST #3	2015	10,850	90	20	271	181	1,401	41
42	CONVER 24 RMS TO PRIVIATE SNF	2015	5,666	47	20	142	95	756	42
43	INSTALL NEW R 22 CARRIER AIR C	2015	41,573	446	15	1,386	940	10,861	43
44	PHASE 2 NURSE CALL	2015	4,200	35	20	105	70	560	44
45	PHASE 2 OF WING REMODEL AND NU	2015	375,000	3,125	20	9,375	6,250	56,417	45
46	PHASE 2 WING REMODEL NURSE SUB	2015	257,000	2,142	20	6,425	4,283	34,667	46
47	RENOVATE OF QUAD UNITS INTO 15	2015	8,532	71	20	213	142	1,422	47
48	RENOVATIONS OF QUAD UNITS INTO	2015	67,507	548	20	1,688	1,140	13,298	48
49	REPLACE KITCHEN FLOOR SINK PIP	2015	8,950	30	50	90	60	522	49
50	SPRINKLER HEAD REPLACE	2015	39,700	441	15	1,323	882	7,278	50
51									51
52	: A- wings air handler&AC re	2016	44,708	373	20	1,118	745	3,726	52
53	: Elevator Repair Hydraulic	2016	7,900	66	20	198	132	823	53
54	: INSTALLATION OF NEW Nurse Station Flooring	2016	10,995	122	15	367	245	1,222	54
55	INTERIOR FINISH HANNA Z - Vinyl Flooring Nurse Station	2016	12,951	144	15	432	288	2,086	55
56	PHASE 2 WING REMODEL NURSE Station - Painting	2016	1,750	15	20	44	29	219	56
57	INTERIOR FINISH HANNA Z - Paneling Nurse Station	2016	3,777	42	15	126	84	609	57
58	PHASE 2 WING REMODEL NURSE Station Buildout/Constructi	2016	68,870	574	20	1,722	1,148	8,579	58
59	PHASE 2 WING REMODEL NURSE Station Buildout/Constructi	2016	22,400	187	20	560	373	1,773	59
60									60
61	: A- wings air handler&AC re	2017	134,123	1,118	20	3,353	2,235	9,973	61
62	: Elevator mechanical room controls	2017	13,700	114	20	343	229	658	62
63	copper pipe replacement - Boiler Room	2017	8,500	71	20	213	142	425	63
64	: Asphalt - Parking Lot	2017	84,370	3,125	10	4,219	1,094	4,922	64
65									65
66	POLE LIGHTS AND BASES - Courtyard Walkway	2017	19,600	570	20	490	(80)	490	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,471,668	$ 149,854		$ 239,666	$ 89,812	$ 6,467,686	70

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND# 0044792 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	$ 4,066,148	$ 41,893	$ 125,385	$ 83,492	15	$ 2,992,022	71
72	Current Year Purchases	27,355	543	543		13	543	72
73	Fully Depreciated Assets	1,080,958	701	1,077	376	7	1,080,958	73
74	Home Office Allocation		53,350	53,350				74
75	TOTALS	$ 5,174,461	$ 96,487	$ 180,355	$ 83,868		$ 4,073,523	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)	$ 20,146,129	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 246,341	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 420,021	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 173,680	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,541,209	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 VILLA SCALABRINI NURSING AND REHA # 0044792 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: $ 62,812 Description: Nursing 43,688; Admin 11,897; Dietary 6,032; Environmental Services 60; Rehab 1,026; Spiritual 109; Hon
(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 VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 Report Period Beginning: 1/01/18 Ending: 6/30/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 1	4180 hrs	$ 164,064		$	$	4,180	$ 164,064	1
2	Licensed Speech and Language Development Therapist	10a, 1	901 hrs	38,565				901	38,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	6064 hrs	246,819				6,064	246,819	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				659,680		659,680	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Director	10a, 1	929	46,007				929	46,007	12
13	Other (specify):									13
14	TOTAL			$ 495,455		$	$ 659,680	12,074	$ 1,155,135	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 VILLA SCALABRINI NURSING AND REHA # 0044792 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	25,906	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,583,705	19,421,139	3
4	Supply Inventory (priced at)	21,185	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)**	$ 1,630,796	$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	1,500,000	40,692,981	13
14	Buildings, at Historical Cost	13,506,893	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,174,461	5,809,806	16
17	Accumulated Depreciation (book methods)	(10,541,207)	(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)**	$ 9,640,147	$ 146,086,133	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,270,943	$ 177,822,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (324,939)	$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	546,133	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)**	$ 221,194	$ 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)**	$ 221,194	$ 68,287,688	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,049,749	$ 109,534,543	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,270,943	$ 177,822,231	48

*(See instructions.)

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENT # 0044792 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**	(169,644,026)	4
5	**Adj to Rollback Consolidated Fixed Asset Re-valuation**	1,924,430	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,299,532	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(249,444)	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	(339)	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)**	$ (249,783)	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)**	$ 11,049,749	24 *

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

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AN # 0044792 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	$ 10,417,423	1
2	Discounts and Allowances for all Levels	(3,717,016)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,700,407	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,086,088	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,086,088	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	112	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,142,497	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	(3,420)	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,139,189	23
	D. Non-Operating Revenue		
24	Contributions	(44,878)	24
25	Interest and Other Investment Income***	16,598	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (28,280)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	16,684	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,684	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,914,088	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,680,656	31
32	Health Care	4,156,286	32
33	General Administration	2,055,327	33
	B. Capital Expense		
34	Ownership	366,216	34
	C. Ancillary Expense		
35	Special Cost Centers	659,680	35
36	Provider Participation Fee	245,367	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,163,532	40
41	**Income before Income Taxes (line 30 minus line 40)****	(249,444)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (249,444)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,507,183	44
45	Private Pay - Net Inpatient Revenue	1,920,550	45
46	Medicare - Net Inpatient Revenue	1,060,938	46
47	Other-(specify)	211,736	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,700,407	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 VILLA SCALABRINI NURSING AND REHA # 0044792 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	919	1,034	$ 56,137	$ 54.29	1
2	Assistant Director of Nursing	910	1,034	51,926	50.22	2
3	Registered Nurses	44,514	49,494	1,924,969	38.89	3
4	Licensed Practical Nurses	2,774	3,198	98,675	30.86	4
5	CNAs & Orderlies	61,406	66,700	1,027,120	15.40	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	10,909	12,074	495,455	41.03	7
8	Rehab/Therapy Aides	28	28	1,400	50.00	8
9	Activity Director	706	977	19,906	20.37	9
10	Activity Assistants	4,504	4,937	58,853	11.92	10
11	Social Service Workers	3,544	3,982	80,312	20.17	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,740	3,178	71,068	22.36	17
18	Housekeepers	9,433	11,262	142,823	12.68	18
19	Laundry	4,096	5,365	64,445	12.01	19
20	Administrator	853	1,034	56,946	55.07	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	924	1,086	29,520	27.18	22
23	Office Manager	963	1,002	23,565	23.52	23
24	Clerical	5,888	6,832	101,036	14.79	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	218	218	16,170	74.17	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	2,002	2,159	53,069	24.58	32
33	Other(specify) Pastoral	2,277	2,350	77,453	32.96	33
34	TOTAL (lines 1 - 33)	159,608	177,944	$ 4,450,848 *	$ 25.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	27,000	9,3	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	9	603	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	$ 27,603		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				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND # 0044792 Report Period Beginning: 1/01/18 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daryce Fields	Administrator		$ 56,946
Administrative Staff	Office Manager		23,565
Administrative Staff	Receptionists		56,036
Administrative Staff	Admissions		53,069
Administrative Staff	Other Administrative		29,520
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 219,136

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 590,214
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 590,214

C. Professional Services

Vendor/Payee	Type	Amount
AHIMA	Housing Placement Services	$ 135
MONAHAN LAW GROUP LLC	Legal	17,996
POLSINELLI PC	Legal	15,504
LAW OFFICES OF STEVE RAMIN	Legal	3,425
KAREN CALLAHAN	Legal	3,413
MIDWEST CARE MGMT SERVICE	Legal	4,439
DUDA LAW GROUP LLC	Legal	2,025
LAW OFFICES OF MARY J RALEI	Legal	1,200
SEXAUER LAW PC	Legal	1,700
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 49,836

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,228
Unemployment Compensation Insurance	4,821
FICA Taxes	320,272
Employee Health Insurance	478,747
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	23,370
Dental	11,347
Life Insurance	3,032
Disability Insurance	16,371
Pension	140,570
Tuition Reimbursement	10,085
Other Benefits	(5,861)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,061,981

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 88)	
Patient Background Checks 333	
Employee Recruitment	
Dues & Subscriptions	18,988
Advertising & Public Relations	263
Home Office Allocation	2,545
Less: Public Relations Expense	( )
Non-allowable advertising	(263)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,533

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	870
Seminar Expense	
Home Office Allocation	3,701
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,571

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE VILLA SCALABRINI NURSING AND REHAB CENTER # 0044792 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. 10388

(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? 13

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 54,560 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. $ 245,367
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. $ 112

(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