

Facility Name & ID Number Presence St Joseph Center

0041871 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	22,614	10,792	6,287	39,693	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,614	10,792	6,287	39,693	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.38%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/01/1996

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/1996 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 120 and days of care provided 3,902

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number

Presence St Joseph Center

0041871

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	418,861	32,785	11,924	463,570		463,570		463,570		1
2	Food Purchase		235,032		235,032		235,032	(54,406)	180,626		2
3	Housekeeping	111,982	21,699		133,681		133,681		133,681		3
4	Laundry		2,131	121,274	123,405		123,405		123,405		4
5	Heat and Other Utilities			112,905	112,905		112,905	4,304	117,209		5
6	Maintenance	134,190	30,936	77,736	242,862		242,862	64,008	306,870		6
7	Other (specify):* Pastoral Care	31,489	1,379	16,744	49,612		49,612	(16,024)	33,588		7
8	TOTAL General Services	696,522	323,962	340,583	1,361,067		1,361,067	(2,118)	1,358,949		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,369,810	187,709	16,657	2,574,176		2,574,176		2,574,176		10
10a	Therapy			399,226	399,226		399,226		399,226		10a
11	Activities	78,063	755	4,047	82,865		82,865	3,239	86,104		11
12	Social Services	24,371		518	24,889		24,889		24,889		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,472,244	188,464	432,448	3,093,156		3,093,156	3,239	3,096,395		16
	C. General Administration										
17	Administrative	308,354	13,795	766,000	1,088,149		1,088,149	(336,214)	751,935		17
18	Directors Fees										18
19	Professional Services			12,529	12,529		12,529	41,508	54,037		19
20	Dues, Fees, Subscriptions & Promotions			31,938	31,938		31,938	(8,422)	23,516		20
21	Clerical & General Office Expenses			41,678	41,678		41,678	4,706	46,384		21
22	Employee Benefits & Payroll Taxes			1,032,328	1,032,328		1,032,328	175,408	1,207,736		22
23	Inservice Training & Education			2,628	2,628		2,628	705	3,333		23
24	Travel and Seminar			1,663	1,663		1,663	4,230	5,893		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			146,726	146,726		146,726	(482)	146,244		26
27	Other (specify):*										27
28	TOTAL General Administration	308,354	13,795	2,035,490	2,357,639		2,357,639	(118,561)	2,239,078		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,477,120	526,221	2,808,521	6,811,862		6,811,862	(117,440)	6,694,422		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Presence St Joseph Center

#0041871

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			281,832	281,832		281,832	49,467	331,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							198,263	198,263			32
33	Real Estate Taxes			118,680	118,680		118,680		118,680			33
34	Rent-Facility & Grounds							22,309	22,309			34
35	Rent-Equipment & Vehicles			6,165	6,165		6,165	1,413	7,578			35
36	Other (specify):*											36
37	TOTAL Ownership			406,677	406,677		406,677	271,452	678,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			415,649	415,649		415,649	(297,299)	118,350			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			382,280	382,280		382,280		382,280			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			797,929	797,929		797,929	(297,299)	500,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,477,120	526,221	4,013,127	8,016,468		8,016,468	(143,287)	7,873,181			45

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

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0041871

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(57,167)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,959	30		9
10	Interest and Other Investment Income	(5,975)	32		10
11	Discounts, Allowances, Rebates & Refunds	(297,299)	39		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	(2,519)	30		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	(14,229)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(472)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (369,702)		\$	30

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	2	
		Amount	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)	242,439		34
35	Other- Attach Schedule	(16,024)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 226,415		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (143,287)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Presence St Joseph Center

ID# 0041871

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ (16,024)	7	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		(16,024)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Presence St Joseph Center

0041871

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(57,167)	2,761	0	0	0	0	0	0	0	0	0	(54,406)	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	4,304	0	0	0	0	0	0	0	0	0	4,304	5
6	Maintenance	0	1,616	62,392	0	0	0	0	0	0	0	0	64,008	6
7	Other (specify):*	(16,024)	0	0	0	0	0	0	0	0	0	0	(16,024)	7
8	TOTAL General Services	(73,191)	8,681	62,392	0	(2,118)	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	3,239	0	0	0	0	0	0	0	0	0	3,239	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	3,239	0	0	0	0	0	0	0	0	0	3,239	16
	C. General Administration													
17	Administrative	0	(284,896)	(51,318)	0	0	0	0	0	0	0	0	(336,214)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,155	17,353	0	0	0	0	0	0	0	0	41,508	19
20	Fees, Subscriptions & Promotions	(14,701)	6,279	0	0	0	0	0	0	0	0	0	(8,422)	20
21	Clerical & General Office Expenses	0	4,706	0	0	0	0	0	0	0	0	0	4,706	21
22	Employee Benefits & Payroll Taxes	0	44,790	130,618	0	0	0	0	0	0	0	0	175,408	22
23	Inservice Training & Education	0	705	0	0	0	0	0	0	0	0	0	705	23
24	Travel and Seminar	0	4,230	0	0	0	0	0	0	0	0	0	4,230	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	(482)	0	0	0	0	0	0	0	0	0	(482)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,701)	(200,513)	96,653	0	(118,561)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,892)	(188,593)	159,045	0	(117,440)	29							

STATE OF ILLINOIS

Facility Name & ID Number Presence St Joseph Center# 0041871

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,440	0	44,027	0	0	0	0	0	0	0	0	49,467	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,975)	0	204,238	0	0	0	0	0	0	0	0	198,263	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	22,309	0	0	0	0	0	0	0	0	22,309	34
35	Rent-Equipment & Vehicles	0	0	1,413	0	0	0	0	0	0	0	0	1,413	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(535)	0	271,987	0	271,452	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	(297,299)	0	0	0	0	0	0	0	0	0	0	(297,299)	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	(297,299)	0	0	0	0	0	0	0	0	0	0	(297,299)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(385,726)	(188,593)	431,032	0	(143,287)	45							

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 C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Vill	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Cai	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	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. 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%	\$ 2,761	\$ 2,761	1
2	V	5 Utilities		Presence Life Connections	100.00%	4,304	4,304	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	1,616	1,616	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	3,239	3,239	4
5	V	17 Admin - Misc. Other	532,200	Presence Life Connections	100.00%	9,623	(522,577)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	237,681	237,681	6
7	V	19 Professional Services		Presence Life Connections	100.00%	24,155	24,155	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	6,279	6,279	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	4,706	4,706	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	44,790	44,790	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	705	705	11
12	V	24 Travel		Presence Life Connections	100.00%	4,230	4,230	12
13	V	26 Insurance		Presence Life Connections	100.00%	(482)	(482)	13
14	Total		\$ 532,200			\$ 343,607	\$ * (188,593)	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 2,282	\$ 2,282
16	V	32 Interest		Presence Life Connections	100.00%	71,256	71,256
17	V	34 Rent - Facility		Presence Life Connections	100.00%	22,309	22,309
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	1,413	1,413
19	V	17 Admin Salaries	74,896	Presence Health	100.00%	79,324	4,428
20	V	22 Employee Benefits		Presence Health	100.00%	41,912	41,912
21	V	30 Depreciation		Presence Health	100.00%	41,745	41,745
22	V	19 Admin Consulting, Other		Presence Health	100.00%	17,353	17,353
23	V	17 Information Systems Salaries	158,904	Presence Health	100.00%	32,879	(126,025)
24	V	22 Information Systems Benefits		Presence Health	100.00%	25,599	25,599
25	V	17 Information Systems - Other		Presence Health	100.00%	23,492	23,492
26	V	17 Admin Salaries		Presence Health	100.00%	16,176	16,176
27	V	22 Employee Benefits		Presence Health	100.00%	20,962	20,962
28	V	17 Information Systems Salaries		Presence Health	100.00%	30,611	30,611
29	V	22 Information Systems Benefits		Presence Health	100.00%	42,145	42,145
30	V	6 Information Systems - Equip Maint		Presence Health	100.00%	62,392	62,392
31	V	32 Admin - Interest Expense		Presence Health	100.00%	132,982	132,982
32	V	39 Ancillary Services - Other	415,649	Presence Senior Services Pharmacy	100.00%	415,649	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 649,449			\$ 1,080,481	\$ * 431,032

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

Facility Name & ID Number

Presence St Joseph Center

0041871

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compat	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	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 Developr	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 Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

Facility Name & ID Number Presence St Joseph Center # 0041871 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Presence St Joseph Center

0041871 Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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 NO

Name of Related Organization Presence Life Connections
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL 60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 7,895,880	23	\$ 40,958	\$	532,200	\$ 2,761	1
2	5	Utilities	Management Fee Income 7,895,880	23	63,861		532,200	4,304	2
3	6	Maintenance - Other	Management Fee Income 7,895,880	23	23,977		532,200	1,616	3
4	11	Activities-Special Events	Management Fee Income 7,895,880	23	48,049		532,200	3,239	4
5	17	Admin - Misc. Other	Management Fee Income 7,895,880	23	142,773		532,200	9,623	5
6	17	Administrative Salaries	Management Fee Income 7,895,880	23	3,526,307	3,526,307	532,200	237,681	6
7	19	Professional Services	Management Fee Income 7,895,880	23	358,375		532,200	24,155	7
8	20	Dues,Subscriptions	Management Fee Income 7,895,880	23	93,150		532,200	6,279	8
9	21	Clerical Supplies	Management Fee Income 7,895,880	23	69,822		532,200	4,706	9
10	22	Employee Benefits	Management Fee Income 7,895,880	23	664,511		532,200	44,790	10
11	23	Education/Conference	Management Fee Income 7,895,880	23	10,463		532,200	705	11
12	24	Travel	Management Fee Income 7,895,880	23	62,753		532,200	4,230	12
13	26	Insurance	Management Fee Income 7,895,880	23	(7,150)		532,200	(482)	13
14	30	Depreciation	Management Fee Income 7,895,880	23	33,862		532,200	2,282	14
15	32	Interest	Management Fee Income 7,895,880	23	1,057,182		532,200	71,256	15
16	34	Rent - Facility	Management Fee Income 7,895,880	23	330,990		532,200	22,309	16
17	35	Rent - Equipment	Management Fee Income 7,895,880	23	20,962		532,200	1,413	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,540,845	\$ 3,526,307		\$ 440,867	25

Facility Name & ID Number Presence St Joseph Center

0041871 Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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 NO

Name of Related Organization Presence Health
 Street Address 9223 West St. Francis Road
 City / State / Zip Code Frankfort, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	936,340	10	\$ 991,694	\$ 991,694	74,896	\$ 79,324	1
2	22	Employee Benefits	Operating Expense	936,340	10	523,983		74,896	41,912	2
3	30	Depreciation	Operating Expense	936,340	10	521,887		74,896	41,745	3
4	34	Rent Facility	Operating Expense	936,340	10	216,946		74,896	17,353	4
5	19	Admin Consulting,Other	Operating Expense	936,340	10	411,047		74,896	32,879	5
6	17	Information Systems Salaries	Operating Expense	1,983,972	10	319,617	319,617	158,904	25,599	6
7	22	Information Systems Benefits	Operating Expense	1,983,972	10	293,305		158,904	23,492	7
8	17	Information Systems - Other	Operating Expense	1,983,972	10	201,957		158,904	16,176	8
9	17	Admin Salaries	Direct Cost	936,340	10	262,066	262,066	74,896	20,962	9
10	17	Information Systems Salaries	Direct Cost	1,983,972	10	382,190	382,190	158,904	30,611	10
11	6	Information Systems - Equip Mai	Direct Cost	1,983,972	10	526,191		158,904	42,145	11
12	19	Admin Consulting,Other	Direct Cost	936,340	10	780,014		74,896	62,392	12
13	32	Admin - Interest Expense	Direct Cost	936,340	10	1,662,527		74,896	132,982	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					\$ 7,093,424	\$ 1,955,567		\$ 567,572	25

Facility Name & ID Number Presence St Joseph Center

0041871 Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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 NO

Name of Related Organization Presence Senior Services Pharmacy
 Street Address 670 North Convent Street
 City / State / Zip Code Bourbonnais, Illinois 60914
 Phone Number (815)936-3644
 Fax Number (815)936-3238

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 415,649	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				\$	\$		\$ 415,649	25

Facility Name & ID Number

Presence St Joseph Center

0041871

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Home Office Allocation						\$	\$			\$ 204,238					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$ 204,238					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$ 204,238					

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.)

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 2011 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 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	118,680		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.		\$	118,680		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2007	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2008	_____	9												
	2009	_____	10												
	2010	_____	11												
	2011	_____	12												

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Presence St Joseph Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>To Be Determined</u>	<u></u>	\$ <u>118,680.00</u>	\$ <u>118,680.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>118,680.00</u></u>	\$ <u><u>118,680.00</u></u>

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 51,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1996</u>	<u>\$ 1,400,000</u>	1
2					2
3	TOTALS			\$ 1,400,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120	1996	1996	\$ 2,500,000	\$ 62,500	25	\$ 62,500	\$	\$ 1,031,250
5									
6									
7									
8									
Improvement Type**									
9	VARIOUS	1996							
10	VARIOUS	1997		1,037		7			1,037
11	VARIOUS	1998		3,718		10			3,718
12	VARIOUS	1999		78,698	2,227	12	2,227		64,224
13	VARIOUS	2000		19,599	262	10	262		17,369
14	VARIOUS	2001							
15	VARIOUS	2002		28,187	1,489	13	1,489		24,327
16	VARIOUS	2003		77,509	6,814	11	6,814		68,053
17	VARIOUS	2004		16,330	627	10	627		14,830
18	VARIOUS	2005		93,561	6,947	12	6,947		52,140
19	VARIOUS	2006		34,761	2,322	10	2,322		22,002
20	VARIOUS	2007		154,464	12,080	12	12,080		67,762
21	VARIOUS	2008		219,347	18,468	14	18,468		84,447
22									
23	INSTALL SPRINKER	2009		4185	209	20	209		732
24	COMPRESSOR	2009		5365	447	12	447		1565
25	HOT WATER EXCHANGER, EXPANSION TANK, PUMPS AND	2009		55826	5583	10	5583		19539
26	ASPHALT PARKING LOT	2009		5396	675	8	675		2361
27	CARRIER 10 TON CONDENSING UNIT W/ LOW AMBIENT C	2009		6590	439	15	439		1538
28	GENERATOR LOAD	2009		2649	530	5	530		1854
29	THIRD FLOOR MEN'S BATHROOM/TOILET	2009		17605	1760	10	1760		6162
30	15 SECOND DOOR MAGNETS, TRANSMITTERS, RECEIVER	2009		15440	1544	10	1544		5404
31	CANOPY PROJECT	2009		57918	3861	15	3861		12724
32	DEDUCTION FOR NON-CARE ASSETS	2009		(17,605)	(1,760)	-10	(1,760)		(6,162)
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 CLF HOBAN HALL HOT WATER HEATERS AND INSTALLATI	2010	\$ 2750	\$ 275	10	\$ 275	\$	\$ 688	37
38 PAINTING OF HALLWAYS IN NURSING HOME	2010	3001	600	5	600		1500	38
39 HVAC AIR DAMPER CONTROL MOTORS	2010	7660	1532	5	1532		3830	39
40 PHASE 3 FOR BOILER	2010	5100	255	20	255		638	40
41 HUMIDIFIER SYSTEM - HONEYWELL STEAM W/ DIGITAL	2010	5960	745	8	745		1863	41
42 CULTURE CHANGE	2010	27077	1805	15	1805		4513	42
43 PARKING LOT SEAL	2010	59821	7478	8	7478		18694	43
44 DEDUCTION FOR NON-CARE ASSETS	2010	(2,750)	(275)	-10	(275)		(688)	44
45								45
46								46
47 FIRE CODE SAFETY DOORS SYSTEM	2011	4214	281	15	281		421	47
48 FIRE ALARM & SMOKE DETECTOR WIRING	2011	13175	1318	10	1318		1976	48
49 SECURITY SYSTEM	2011	6350	635	10	635		952	49
50 CARPET	2011	5303	1061	5	1061		1591	50
51 PAINTING	2011	3174	635	5	635		952	51
52 CLF - 4 FIRE DOORS	2011	7260	484	15	484		726	52
53 COVER TO EDGE OF THIRD STORY	2011	4268	427	10	427		640	53
54 B WING COMPRESSOR	2011	4976	166	15	166		166	54
55 DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(484)	-15	(484)		(726)	55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,530,657	\$ 143,961		\$ 143,961	\$	\$ 1,534,611	70

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

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	\$ 1,198,487	\$ 115,354	\$ 115,354	\$	11	\$ 575,383	71
72	Current Year Purchases	13,600	680	1,360	680	10	680	72
73	Fully Depreciated Assets	507,368				5	507,368	73
74	Home Office Allocation		44,027	44,027				74
75	TOTALS	\$ 1,719,455	\$ 160,061	\$ 160,741	\$ 680		\$ 1,083,431	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	Total			\$ 203,524	\$ 19,318	\$ 26,597	\$ 7,279		\$ 134,512	76
77	*See Vehicle Attachment									77
78	for details									78
79										79
80	TOTALS			\$ 203,524	\$ 19,318	\$ 26,597	\$ 7,279		\$ 134,512	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)	\$ 6,853,636	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 323,340	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 331,299	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,959	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,752,554	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 Joseph Center

0041871

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

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	Home Office Allocation				22,309			5
6								6
7	TOTAL				\$ 22,309			7

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: _____ *

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: \$ 9,364

Description: Nursing \$1,786; Administration \$6,165, Home Office \$1,413

(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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	3,405	\$ 191,540	\$	3,405	\$ 191,540	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		75	4,482		75	4,482	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a,3	hrs		3,493	203,204		3,493	203,204	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 prescripts				415,649		415,649	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	6,973	\$ 399,226	\$ 415,649	6,973	\$ 814,875	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 Joseph Center# 0041871Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(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	\$ 13,086,787	\$	1
2	Cash-Patient Deposits	87,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	19,569,971		3
4	Supply Inventory (priced at)	652,763		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,531		6
7	Other Prepaid Expenses	114,653		7
8	Accounts Receivable (owners or related parties)	152,567		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 33,665,575	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,629,961		12
13	Land	6,033,932		13
14	Buildings, at Historical Cost	86,623,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,565,514		16
17	Accumulated Depreciation (book methods)	(62,295,376)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Deferred Comp</u>)	418,087		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 58,975,342	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 92,640,917	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,316,095	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,097,772		28
29	Short-Term Notes Payable	69,804		29
30	Accrued Salaries Payable	3,738,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,523,338		32
33	Accrued Interest Payable	9,580		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	819,992		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,735,600	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	969,488		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	418,087		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	438,744		43
44	<u>Deferred Lease Payable</u>	28,912		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,855,231	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,590,831	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 77,050,086	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 92,640,917	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 71,119,277	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(967,209)	3
4	Adj. To reconcile consolidated equity & consolidated income	3,388,819	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,540,887	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	556,480	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,067,950	11
12	Expenditures for Specific Purposes	(115,231)	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)	\$ 3,509,199	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)	\$ 77,050,086	24 *

* This must agree with page 17, line 47.

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.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 6,659,240	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,659,240	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	797,981	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 797,981	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	1,223	12	
13	Barber and Beauty Care	1,751	13	
14	Non-Patient Meals	57,167	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	360,687	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)	\$ 420,828	23	
D. Non-Operating Revenue				
24	Contributions	379,815	24	
25	Interest and Other Investment Income***	5,975	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 385,790	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Purchase Rebates	297,299	28	
28a	Misc Income/Gain Loss SOFA	11,810	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 309,109	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,572,948	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,361,067	31	
32	Health Care	3,093,156	32	
33	General Administration	2,357,639	33	
B. Capital Expense				
34	Ownership	406,677	34	
C. Ancillary Expense				
35	Special Cost Centers	415,649	35	
36	Provider Participation Fee	382,280	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,016,468	40	
41	Income before Income Taxes (line 30 minus line 40)**	556,480	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 556,480	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,489,405	44
45	Private Pay - Net Inpatient Revenue	1,847,868	45
46	Medicare - Net Inpatient Revenue	825,401	46
47	Other-(specify) <u>Insurance</u>	496,566	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,659,240	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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 Joseph Center

0041871

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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	1,824	2,080	\$ 76,610	\$ 36.83	1
2	Assistant Director of Nursing	1,844	2,080	64,194	30.86	2
3	Registered Nurses	16,980	18,548	486,792	26.24	3
4	Licensed Practical Nurses	22,813	24,813	551,780	22.24	4
5	CNAs & Orderlies	82,701	89,806	1,039,652	11.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,619	6,060	79,296	13.09	8
9	Activity Director	816	944	14,733	15.61	9
10	Activity Assistants	6,010	6,404	63,460	9.91	10
11	Social Service Workers	1,860	2,080	24,333	11.70	11
12	Dietician	414	428	10,846	25.34	12
13	Food Service Supervisor	1,816	2,080	44,446	21.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,227	37,658	362,984	9.64	15
16	Dishwashers					16
17	Maintenance Workers	8,949	9,894	134,694	13.61	17
18	Housekeepers	11,154	12,095	110,712	9.15	18
19	Laundry					19
20	Administrator	1,492	2,080	76,856	36.95	20
21	Assistant Administrator	344	400	12,788	31.97	21
22	Other Administrative	8,015	8,805	133,526	15.16	22
23	Office Manager					23
24	Clerical	5,613	6,197	76,764	12.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Admissions	3,974	4,373	81,210	18.57	32
33	Other(specify) Pastoral	1,263	1,325	31,444	23.73	33
34	TOTAL (lines 1 - 33)	217,728	238,150	\$ 3,477,120 *	\$ 14.60	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	109	\$ 8,135	1,3	35
36	Medical Director	40	12,000	9,3	36
37	Medical Records Consultant	31	2,157	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	8	473	11,3	44
45	Social Service Consultant	8	473	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	\$ 23,238		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Presence St Joseph Center

0041871

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. Life Services Network - \$7146
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,635 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. \$ 382,280
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 57,167
- (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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

D. Vehicle Costs. Attachment*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5
76	plant engineering	2001 MERCURY SABLE	2001	\$ 23,123.22	\$ -
77	plant engineering	1997 DODGE 2500 (3/4 TON) PICKUP TRUCK	1997	24,089.57	-
78	plant engineering	2003 FORD TURTLE TOP VAN	2004	34,275.00	-
79	plant engineering	2006 CHEVY UPLANDER (MAROON)	2007	15,648.72	-
80	plant engineering	2010 FORD SUPREME 12+2 CAPACITY	2010	48,155.00	12,039.00
81	plant engineering	2012 FORD ELDORADO, 14 PASSENGER VEHICLE	2012	58,232.00	7,279.00
82	TOTALS			\$ 203,524	\$ 19,318

Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
\$ -	\$ 0	3	\$ 23,123.22	76
-	0	5	24,089.57	77
-	0	4	34,275.00	78
-	0	4	15,648.72	79
12,039.00	0	4	30,096.88	
14,558.00	7,279	4	7,279.00	
\$ 26,597	\$ 7,279		\$ 134,512	80