

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	176	Skilled (SNF)	176	64,240	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	176	TOTALS	176	64,240	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	15,507	7,773	21,124	44,404	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,507	7,773	21,124	44,404	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.12%

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 09/01/90

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

YES Date 12/01/97 NO

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

YES NO If YES, enter number of beds certified 176 and days of care provided 19,055

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

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	474,013	36,412	23,133	533,558		533,558		533,558	1	
2	Food Purchase		326,980		326,980		326,980	(4,674)	322,306	2	
3	Housekeeping	246,788	36,208	132	283,128		283,128		283,128	3	
4	Laundry	24,412	569	144,565	169,546		169,546		169,546	4	
5	Heat and Other Utilities			229,164	229,164		229,164	4,249	233,413	5	
6	Maintenance	161,541	45,449	74,659	281,649		281,649	63,332	344,981	6	
7	Other (specify):* Pastoral Care	40,861	1,000	3,134	44,995		44,995		44,995	7	
8	TOTAL General Services	947,615	446,618	474,787	1,869,020		1,869,020	62,907	1,931,927	8	
	B. Health Care and Programs										
9	Medical Director			26,438	26,438		26,438		26,438	9	
10	Nursing and Medical Records	4,789,860	455,998	35,655	5,281,513		5,281,513	(64,812)	5,216,701	10	
10a	Therapy			1,604,409	1,604,409		1,604,409		1,604,409	10a	
11	Activities	192,450	4,956	34,155	231,561		231,561	(22,773)	208,788	11	
12	Social Services	161,451	1,624	384	163,459		163,459		163,459	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	5,143,761	462,578	1,701,041	7,307,380		7,307,380	(87,585)	7,219,795	16	
	C. General Administration										
17	Administrative	381,745	34,652	1,216,924	1,633,321		1,633,321	(338,626)	1,294,695	17	
18	Directors Fees									18	
19	Professional Services			4,506	4,506		4,506	16,498	21,004	19	
20	Dues, Fees, Subscriptions & Promotions			14,490	14,490		14,490	10,836	25,326	20	
21	Clerical & General Office Expenses			32,013	32,013		32,013	(16,551)	15,462	21	
22	Employee Benefits & Payroll Taxes			1,620,677	1,620,677		1,620,677	188,871	1,809,548	22	
23	Inservice Training & Education							1,261	1,261	23	
24	Travel and Seminar			876	876		876	3,933	4,809	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			228,781	228,781		228,781	281	229,062	26	
27	Other (specify):*									27	
28	TOTAL General Administration	381,745	34,652	3,118,267	3,534,664		3,534,664	(133,497)	3,401,167	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,473,121	943,848	5,294,095	12,711,064		12,711,064	(158,175)	12,552,889	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 VILLA FRANCISCAN

#0042861

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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			488,829	488,829		488,829	(3,175)	485,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			329,954	329,954		329,954	194,804	524,758			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							63,717	63,717			34
35	Rent-Equipment & Vehicles			164,704	164,704		164,704	1,707	166,411			35
36	Other (specify):*											36
37	TOTAL Ownership			983,487	983,487		983,487	257,053	1,240,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,732,981		1,732,981		1,732,981	(994,406)	738,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			255,994	255,994		255,994		255,994			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,732,981	255,994	1,988,975		1,988,975	(994,406)	994,569			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,473,121	2,676,829	6,533,576	15,683,526		15,683,526	(895,528)	14,787,998			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 FRANCISCAN

0042861

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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	(6,569)	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	8,397	30		9
10	Interest and Other Investment Income	(28,727)	32		10
11	Discounts, Allowances, Rebates & Refunds	(994,406)	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				17
18	Fines and Penalties	(12,500)	21		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	(405)	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	(355,617)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,389,827)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,389,827)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

PRESENCE VILLA FRANCISCANID# 0042861Report Period Beginning: 01/01/2013Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEVELOPMENT MISC	\$ (8,662)	21	1
2	BEAUTY AND BARBER	(24,046)	11	2
3	RADIOLOGY AND XRAY	(64,812)	10	3
4	Merger Related Home Office Allocation	(258,097)	17	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		(355,617)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	(6,569)	1,895	0	0	0	0	0	0	0	0	0	(4,674)	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	4,249	0	0	0	0	0	0	0	0	0	4,249	5
6	Maintenance	0	1,723	61,609	0	0	0	0	0	0	0	0	63,332	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,569)	7,867	61,609	0	62,907	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	(64,812)	0	0	0	0	0	0	0	0	0	0	(64,812)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(24,046)	1,273	0	0	0	0	0	0	0	0	0	(22,773)	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	(88,858)	1,273	0	0	0	0	0	0	0	0	0	(87,585)	16
	C. General Administration													
17	Administrative	(258,097)	70,815	(151,344)	0	0	0	0	0	0	0	0	(338,626)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,498	0	0	0	0	0	0	0	0	0	16,498	19
20	Fees, Subscriptions & Promotions	(405)	11,241	0	0	0	0	0	0	0	0	0	10,836	20
21	Clerical & General Office Expenses	(21,162)	4,611	0	0	0	0	0	0	0	0	0	(16,551)	21
22	Employee Benefits & Payroll Taxes	0	49,252	139,619	0	0	0	0	0	0	0	0	188,871	22
23	Inservice Training & Education	0	1,261	0	0	0	0	0	0	0	0	0	1,261	23
24	Travel and Seminar	0	3,933	0	0	0	0	0	0	0	0	0	3,933	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	281	0	0	0	0	0	0	0	0	0	281	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(279,664)	157,892	(11,725)	0	(133,497)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(375,091)	167,032	49,884	0	(158,175)	29							

STATE OF ILLINOIS

Facility Name & ID Number PRESENCE VILLA FRANCISCAN# 0042861

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	8,397	0	(11,572)	0	0	0	0	0	0	0	0	(3,175)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,727)	0	223,531	0	0	0	0	0	0	0	0	194,804	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	63,717	0	0	0	0	0	0	0	0	63,717	34
35	Rent-Equipment & Vehicles	0	0	1,707	0	0	0	0	0	0	0	0	1,707	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,330)	0	277,383	0	257,053	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(994,406)	0	0	0	0	0	0	0	0	0	0	(994,406)	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	(994,406)	0	0	0	0	0	0	0	0	0	0	(994,406)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,389,827)	167,032	327,267	0	0	0	0	0	0	0	0	(895,528)	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	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)	
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 1,895	\$ 1,895	1
2	V	5 Utilities		Presence Life Connections	100.00%	4,249	4,249	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	1,723	1,723	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	1,273	1,273	4
5	V	17 Admin - Misc. Other	445,236	Presence Life Connections	100.00%	256,914	(188,322)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	259,137	259,137	6
7	V	19 Professional Services		Presence Life Connections	100.00%	16,498	16,498	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	11,241	11,241	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	4,611	4,611	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	49,252	49,252	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	1,261	1,261	11
12	V	24 Travel		Presence Life Connections	100.00%	3,933	3,933	12
13	V	26 Insurance		Presence Life Connections	100.00%	281	281	13
14	Total		\$ 445,236			\$ 612,268	\$ * 167,032	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%	\$ 3,143	\$ 3,143
16	V	32 Interest		Presence Life Connections	100.00%	5	5
17	V	34 Rent - Facility		Presence Life Connections	100.00%	20,892	20,892
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	1,707	1,707
19	V	17 Admin Salaries		Presence Health	100.00%	171,088	171,088
20	V	22 Employee Benefits		Presence Health	100.00%	139,619	139,619
21	V	30 Depreciation	83,459	Presence Health	100.00%	68,744	(14,715)
22	V	34 Rent Facility		Presence Health	100.00%	42,825	42,825
23	V	17 Admin Consulting,Other	771,688	Presence Health	100.00%	75,789	(695,899)
24	V	17 Information Systems Salaries		Presence Health	100.00%	51,274	51,274
25	V	17 Information Systems - Other		Presence Health	100.00%	201,375	201,375
26	V	17 Admin Salaries		Presence Health	100.00%	48,110	48,110
27	V	17 Information Systems Salaries		Presence Health	100.00%	72,232	72,232
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	61,609	61,609
29	V	17 Admin Consulting,Other		Presence Health	100.00%	476	476
30	V	32 Admin - Interest Expense		Presence Health	100.00%	223,526	223,526
31	V	39 Ancillary Services - Other	1,732,981	Presence Senior Services Pharmacy	100.00%	1,732,981	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,588,128			\$ 2,915,395	\$ * 327,267

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

Facility Name & ID Number

PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

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	JO-ANN COSTANTINO	BOD						1
2	NANCY T. DOWD	BOD						2
3	FLORIDA FREEMAN	BOD						3
4	PATRICIA GOMEZ	BOD						4
5	JAMES C. HAGEN	BOD						5
6	LUCIA JONES	BOD						6
7	TERESA (TESS) KWIATKOWSKI	BOD						7
8	CONNIE S. MARCH	BOD						8
9	SR. MARIE MASON	BOD						9
10	SALLIE MILLER	BOD						10
11	PHYLLIS NICHOLS	BOD						11
12	LAWRENCE R. PANKAU	BOD						12
13	PAUL SKIEM	BOD						13
14	THOMAS E. SMITH	BOD						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

Facility Name & ID Number PRESENCE VILLA FRANCISCAN # 0042861 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	N/A								\$	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 FRANCISCAN

0042861 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 18927 Hickory Creek Dr, Ste 300
 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 7,173,919	29	\$ 30,538		445,236	\$ 1,895	1
2	5	Utilities	Management Fee Income 7,173,919	29	68,461		445,236	4,249	2
3	6	Maintenance - Other	Management Fee Income 7,173,919	29	27,769		445,236	1,723	3
4	11	Activities-Special Events	Management Fee Income 7,173,919	29	20,505		445,236	1,273	4
5	17	Admin - Misc. Other	Management Fee Income 7,173,919	29	4,139,560		445,236	256,914	5
6	17	Administrative Salaries	Management Fee Income 7,173,919	29	4,175,380	4,175,380	445,236	259,137	6
7	19	Professional Services	Management Fee Income 7,173,919	29	265,828		445,236	16,498	7
8	20	Dues,Subscriptions	Management Fee Income 7,173,919	29	181,120		445,236	11,241	8
9	21	Clerical Supplies	Management Fee Income 7,173,919	29	74,289		445,236	4,611	9
10	22	Employee Benefits	Management Fee Income 7,173,919	29	793,578		445,236	49,252	10
11	23	Education/Conference	Management Fee Income 7,173,919	29	20,317		445,236	1,261	11
12	24	Travel	Management Fee Income 7,173,919	29	63,365		445,236	3,933	12
13	26	Insurance	Management Fee Income 7,173,919	29	4,528		445,236	281	13
14	30	Depreciation	Management Fee Income 7,173,919	29	50,634		445,236	3,143	14
15	32	Interest	Management Fee Income 7,173,919	29	87		445,236	5	15
16	34	Rent - Facility	Management Fee Income 7,173,919	29	336,621		445,236	20,892	16
17	35	Rent - Equipment	Management Fee Income 7,173,919	29	27,511		445,236	1,707	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 10,280,091	\$ 4,175,380		\$ 638,015	25

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 100 North River Road
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (815)806-2327
 Fax Number

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	4,947,793	17	\$ 1,096,956	\$ 1,096,956	771,688	\$ 171,088	1
2	22	Employee Benefits	Operating Expense	4,947,793	17	895,186	771,688	771,688	139,619	2
3	30	Depreciation	Operating Expense	535,127	17	440,774	83,459	83,459	68,744	3
4	34	Rent Facility	Operating Expense	4,947,793	17	274,581	771,688	771,688	42,825	4
5	17	Admin Consulting,Other	Operating Expense	4,947,793	17	485,930	771,688	771,688	75,789	5
6	17	Information Systems Salaries	Operating Expense	4,947,793	17	328,752	328,752	771,688	51,274	6
7	17	Information Systems - Other	Operating Expense	4,947,793	17	1,291,143	771,688	771,688	201,375	7
8	17	Admin Salaries	Direct Cost	4,947,793	17	308,463	308,463	771,688	48,110	8
9	17	Information Systems Salaries	Direct Cost	4,947,793	17	463,127	463,127	771,688	72,232	9
10	6	Information Systems - Equip Mai	Direct Cost	4,947,793	17	395,016	771,688	771,688	61,609	10
11	17	Admin Consulting,Other	Direct Cost	4,947,793	17	3,054	771,688	771,688	476	11
12	32	Admin - Interest Expense	Direct Cost	4,947,793	17	1,433,168	771,688	771,688	223,526	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					\$ 7,416,150	\$ 2,197,298		\$ 1,156,667	25

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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		\$	\$		\$ 1,732,981	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				\$	\$		\$ 1,732,981	25

Facility Name & ID Number

PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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						\$	\$			\$ 223,531					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$ 223,531					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$ 223,531					

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 2012 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 2013 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:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE VILLA FRANCISCAN COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0042861

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 2012 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 2012.

	(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.	_____	_____	\$ _____	\$ _____
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Home</u>		<u>1990</u>	<u>\$ 285,994</u>	1
2					2
3	TOTALS			\$ 285,994	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	176	1990	1990	\$ 6,521,709	\$ 171,373	25	\$ 171,373	\$	\$ 5,697,977
5									
6									
7									
8									
Improvement Type**									
9	VARIOUS		1991	2,510		20			2,510
10	VARIOUS		1992	55,495		19			55,495
11	VARIOUS		1993	22,368	363	17	363		22,368
12	VARIOUS		1994	21,786	810	20	810		21,358
13	VARIOUS		1995	79,452	2,529	17	2,529		57,396
14	VARIOUS		1996	41,526	769	10	769		39,157
15	VARIOUS		1997	17,775	169	10	169		17,380
16	VARIOUS		1998	9,029		5			9,029
17	VARIOUS		1999	4,936		7			4,936
18	VARIOUS		2000	53,879		6			53,879
19	VARIOUS		2001	8,708		5			8,708
20	VARIOUS		2002	3,150		10			3,150
21	VARIOUS		2003	22,477	1,194	9	1,194		21,921
22	VARIOUS		2004	137,822	7,565	12	7,565		94,845
23	VARIOUS		2005	45,815	4,382	11	4,382		37,358
24	VARIOUS		2006	593,705	30,589	12	30,589		228,380
25	VARIOUS		2007	100,931	6,655	11	6,655		45,694
26	VARIOUS		2008	11,614	869	13	869		4,780
27	VARIOUS		2009	100,683	8,198	15	8,198		36,891
28									
29									
30									
31									
32									
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

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SEALING PARKING LOT	2010	\$ 5,500	\$ 1,100	5	\$ 1,100	\$	\$ 3,850	37
38	VINYL FLOORING REPLACEMENT IN BATHROOM AND RE	2010	33,562	3,356	10	3,356		11,747	38
39	ELECTRICAL CONVERSION OF KITCHEN EQUIPMENT	2010	10,435	522	20	522		1,826	39
40	ACCESS CONTROL SYSTEM UPGRADE	2010	12,044	2,409	5	2,409		8,431	40
41	PARTIAL RE-ROOF & FLASHING	2010	44,900	4,490	10	4,490		15,715	41
42	MASONRY WORK ABOVE ON MAIN ENTRANCE	2010	3,425	343	10	343		1,199	42
43	OMNI WATCH SYSTEM	2010	19,160	1,916	10	1,916		6,706	43
44	BATHROOM FLOOR TILE	2010	34,107	1,705	20	1,705		5,969	44
45	REPAIR LEAK ON 1/2 OF CHILLER	2010	4,553	650	7	650		2,277	45
46	WANDERGUARD SYSTEM	2010	5,910	591	10	591		2,068	46
47	PAINT WALLS/NEW KITCHEN COUNTER	2010	7,362	736	10	736		2,577	47
48									48
49	FIRE ALARM UPGRADE SYSTEM	2011	95,843	9,584	10	9,584		23,961	49
50	SECURITY SYSTEM	2011	9,956	996	10	996		2,489	50
51	BTU GAS FIRE MAKE UP AIR UNIT	2011	14,125	942	15	942		2,354	51
52									52
53	NEW DOORS FOR MAIN ENTRANCE INT & EXT, EMPLOYE	2012	85,350	4,268	20	4,268		6,401	53
54									54
55	N/A	2013							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)		\$ 8,241,602	\$ 269,073		\$ 269,073	\$	\$ 6,560,782	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	\$ 1,307,261	\$ 127,900	\$ 127,900	\$	11	\$ 841,165	71
72	Current Year Purchases	170,067	8,397	16,794	8,397	10	8,397	72
73	Fully Depreciated Assets	597,271				8	597,271	73
74	Home Office Allocation		71,887	71,887				74
75	TOTALS	\$ 2,074,599	\$ 208,184	\$ 216,581	\$ 8,397		\$ 1,446,833	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)	\$ 10,602,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 477,257	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 485,654	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,397	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,007,615	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.

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				63,717			5
6								6
7	TOTAL				\$ 63,717			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 166,411 Description: Nursing \$150,003, Dietary \$2519, Administration \$12182, Home office \$1707

(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 FRANCISCAN # 0042861 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
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.)

<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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	\$	12,126	\$ 709,399	\$	12,126	\$ 709,399	1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,268	74,167		1,268	74,167	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a, 3	hrs		14,017	820,843		14,017	820,843	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				1,732,981		1,732,981	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			\$	27,411	\$ 1,604,409	\$ 1,732,981	27,411	\$ 3,337,390	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 FRANCISCAN**# **0042861**Report Period Beginning: **01/01/2013**Ending: **12/31/2013****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013** (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	\$ 13,661,975	\$	1
2	Cash-Patient Deposits	68,270		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	15,696,287		3
4	Supply Inventory (priced at)	800,313		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	385,660		7
8	Accounts Receivable (owners or related parties)	147,435		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 30,759,940	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,299,457		12
13	Land	4,046,124		13
14	Buildings, at Historical Cost	99,124,432		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	23,581,218		16
17	Accumulated Depreciation (book methods)	(69,655,808)		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>)	333,555		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,728,978	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 100,488,918	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 8,064,524	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,175,855		28
29	Short-Term Notes Payable	73,289		29
30	Accrued Salaries Payable	3,854,754		30
31	Accrued Taxes Payable (excluding real estate taxes)	164,651		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,706,940		32
33	Accrued Interest Payable	10,831		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	8,866,479		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 23,917,323	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	894,135		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	510,572		42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>	438,744		43
44	<u>Deferred Lease Payable</u>	32,265		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,875,716	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,793,039	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 74,695,879	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 100,488,918	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 77,050,086	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(4,370,200)	3
4	Adj. To reconcile consolidated equity & consolidated income	2,085,987	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,765,873	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(327,145)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	496,473	11
12	Expenditures for Specific Purposes	(239,322)	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)	\$ (69,994)	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)	\$ 74,695,879	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	\$ 8,603,531	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,603,531	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,368,964	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,368,964	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	24,046	13
14	Non-Patient Meals	6,569	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,073,054	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	64,812	20
21	Other Medical Services		21
22	Laundry	15,730	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,184,211	23
D. Non-Operating Revenue			
24	Contributions	36,255	24
25	Interest and Other Investment Income***	28,727	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,982	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	994,406	28
28a	Other Misc Income	140,287	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,134,693	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,356,381	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,869,020	31
32	Health Care	7,307,380	32
33	General Administration	3,534,664	33
B. Capital Expense			
34	Ownership	983,487	34
C. Ancillary Expense			
35	Special Cost Centers	1,732,981	35
36	Provider Participation Fee	255,994	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,683,526	40
41	Income before Income Taxes (line 30 minus line 40)**	(327,145)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (327,145)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,183,345	44
45	Private Pay - Net Inpatient Revenue	1,624,413	45
46	Medicare - Net Inpatient Revenue	4,286,991	46
47	Other-(specify) <u>Insurance</u>	508,782	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,603,531	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 VILLA FRANCISCAN**

0042861

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	1,960	2,080	\$ 92,317	\$ 44.38	1
2	Assistant Director of Nursing	1,660	2,080	82,875	39.84	2
3	Registered Nurses	56,110	60,558	2,017,718	33.32	3
4	Licensed Practical Nurses	23,139	24,972	672,324	26.92	4
5	CNAs & Orderlies	108,163	112,656	1,658,531	14.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,614	4,006	51,509	12.86	8
9	Activity Director	1,836	2,080	49,778	23.93	9
10	Activity Assistants	11,756	12,844	146,691	11.42	10
11	Social Service Workers	7,757	8,421	162,045	19.24	11
12	Dietician	3,572	4,120	97,075	23.56	12
13	Food Service Supervisor	1,808	2,080	51,895	24.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,296	30,893	330,412	10.70	15
16	Dishwashers					16
17	Maintenance Workers	8,269	9,016	159,749	17.72	17
18	Housekeepers	20,567	22,304	246,158	11.04	18
19	Laundry	1,841	2,115	24,503	11.59	19
20	Administrator	1,832	2,080	96,668	46.48	20
21	Assistant Administrator					21
22	Other Administrative	7,127	7,534	115,253	15.30	22
23	Office Manager	1,668	2,077	46,293	22.29	23
24	Clerical	8,799	9,606	177,826	18.51	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	1,857	2,045	29,406	14.38	31
32	Other Health Care(specify)	5,580	6,104	123,532	20.24	32
33	Other(specify)	1,668	1,869	40,563	21.70	33
34	TOTAL (lines 1 - 33)	308,879	331,540	\$ 6,473,121 *	\$ 19.52	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	136	\$ 9,706	1,3	35
36	Medical Director	Monthly	26,438	9,3	36
37	Medical Records Consultant	33	2,268	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	416	11,3	44
45	Social Service Consultant	6	384	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	183	\$ 39,212		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Melissa Adams	Administrator		\$ 96,668	Workers' Compensation Insurance	\$ 21,758	IDPH License Fee	\$	
Administrative Staff	Office Manager		46,293	Unemployment Compensation Insurance	240,350	Advertising: Employee Recruitment		
Administrative Staff	Human Resource		40,851	FICA Taxes	475,010	Health Care Worker Background Check		
Administrative Staff	Receptionist		74,401	Employee Health Insurance	678,030	(Indicate # of checks performed <u>35</u>)		
Administrative Staff	Admissions		123,532	Employee Meals		Patient Background Checks <u>700</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment		
				Pension	163,996	Dues & Subscription	14,025	
				Life Insurance	3,183	Advertisiosg & Public Relations	465	
				Employee Recognition				
				Disability Insurance	32,476	Home Office Allocation	11,241	
				Other Benefit Expense	5,874	Less: Public Relations Expense (
				Home Office Allocation	188,871	Non-allowable advertising	(405)	
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 381,745	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,809,548	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,326	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corp Office Management Fee			\$ 1,216,924	N/A		\$	Out-of-State Travel	\$
							In-State Travel	876
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,216,924				Seminar Expense	
C. Professional Services							Home Office Allocation	3,933
Vendor/Payee	Type		Amount				Entertainment Expense (
Legal			\$ 438				(agree to Sch. V, line 24, col. 8)	
Survey & Analytical Tools			3,120				TOTAL	\$ 4,809
Outsourced Services			873					
Collection Fee			75					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,506	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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 VILLA FRANCISCAN

0042861

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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 \$9330
- (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. \$ 60,912 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. \$ 255,994
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. \$ 6,569
- (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.