



Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	43,800	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	43,800	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	1,545	7,426	25,300	34,271	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,545	7,426	25,300	34,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.24%

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 03-01-98

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

YES  Date 03-01-98 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 6,709

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: 12-31-15 Fiscal Year: 12-31-15

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

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR # 0043430 Report Period Beginning: 1/01/15 Ending: 12/31/15

**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
	<b>A. General Services</b>										
1	Dietary		18,531	467,502	486,033	486,033		486,033			1
2	Food Purchase		254,146		254,146	254,146	239	254,385			2
3	Housekeeping	97,272	23,194	979	121,445	121,445		121,445			3
4	Laundry	25,329	2,921	55,972	84,222	84,222		84,222			4
5	Heat and Other Utilities			196,714	196,714	196,714	1,971	198,685			5
6	Maintenance	83,397	22,814	95,875	202,086	202,086	26,401	228,487			6
7	Other (specify):* Patoral Care	40,590	94	23	40,707	40,707		40,707			7
8	<b>TOTAL General Services</b>	246,588	321,700	817,065	1,385,353	1,385,353	28,611	1,413,964			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,400	19,400	19,400		19,400			9
10	Nursing and Medical Records	2,696,830	318,485	100,951	3,116,266	3,116,266		3,116,266			10
10a	Therapy	149,599		660,109	809,708	809,708		809,708			10a
11	Activities	104,781	765	6,997	112,543	112,543	471	113,014			11
12	Social Services	59,849		3,550	63,399	63,399		63,399			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,011,059	319,250	791,007	4,121,316	4,121,316	471	4,121,787			16
	<b>C. General Administration</b>										
17	Administrative	283,015	12,152	788,984	1,084,151	1,084,151	212,539	1,296,690			17
18	Directors Fees										18
19	Professional Services			21,945	21,945	21,945	35,426	57,371			19
20	Dues, Fees, Subscriptions & Promotions			19,291	19,291	19,291	(2,283)	17,008			20
21	Clerical & General Office Expenses			10,470	10,470	10,470	3,501	13,971			21
22	Employee Benefits & Payroll Taxes			941,996	941,996	941,996	107,389	1,049,385			22
23	Inservice Training & Education						986	986			23
24	Travel and Seminar			1,727	1,727	1,727	1,193	2,920			24
25	Other Admin. Staff Transportation			5,762	5,762	5,762		5,762			25
26	Insurance-Prop.Liab.Malpractice			164,077	164,077	164,077	38,501	202,578			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	283,015	12,152	1,954,252	2,249,419	2,249,419	397,252	2,646,671			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,540,662	653,102	3,562,324	7,756,088	7,756,088	426,334	8,182,422			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 &amp; ID Number

PRESENCE PINE VIEW CARE CTR

#0043430

Report Period Beginning:

1/01/15

Ending:

12/31/15

## 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	
	<b>D. Ownership</b>											
30	Depreciation			219,355	219,355		219,355	(40,177)	179,178			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			191,662	191,662		191,662	88,462	280,124			32
33	Real Estate Taxes			125,720	125,720		125,720		125,720			33
34	Rent-Facility & Grounds			628,304	628,304		628,304	37,845	666,149			34
35	Rent-Equipment & Vehicles			94,966	94,966		94,966	672	95,638			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,260,007	1,260,007		1,260,007	86,802	1,346,809			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			404,561	404,561		404,561		404,561			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			233,111	233,111		233,111		233,111			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			637,672	637,672		637,672		637,672			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,540,662	653,102	5,460,003	9,653,767		9,653,767	513,136	10,166,903			45

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

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	(1,041)	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	902	30		9
10	Interest and Other Investment Income	(6,326)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,735)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (9,200)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (9,200)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

PRESENCE PINE VIEW CARE CTR

ID# 0043430

Report Period Beginning: 1/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$	21	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	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	(1,041)	1,280	0	0	0	0	0	0	0	0	0	239	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	1,971	0	0	0	0	0	0	0	0	0	1,971	5
6	Maintenance	0	3,137	23,264	0	0	0	0	0	0	0	0	26,401	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,041)</b>	<b>6,388</b>	<b>23,264</b>	<b>0</b>	<b>28,611</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	471	0	0	0	0	0	0	0	0	0	471	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>471</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>471</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(97,128)	309,667	0	0	0	0	0	0	0	0	212,539	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	35,426	0	0	0	0	0	0	0	0	0	35,426	19
20	Fees, Subscriptions & Promotions	(2,735)	452	0	0	0	0	0	0	0	0	0	(2,283)	20
21	Clerical & General Office Expenses	0	3,501	0	0	0	0	0	0	0	0	0	3,501	21
22	Employee Benefits & Payroll Taxes	0	41,124	66,265	0	0	0	0	0	0	0	0	107,389	22
23	Inservice Training & Education	0	986	0	0	0	0	0	0	0	0	0	986	23
24	Travel and Seminar	0	1,193	0	0	0	0	0	0	0	0	0	1,193	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	38,501	0	0	0	0	0	0	0	0	0	38,501	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,735)</b>	<b>24,055</b>	<b>375,932</b>	<b>0</b>	<b>397,252</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(3,776)</b>	<b>30,914</b>	<b>399,196</b>	<b>0</b>	<b>426,334</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending:

12/31/15

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)	
	<b>D. Ownership</b>													
30	Depreciation	902	0	(41,079)	0	0	0	0	0	0	0	0	(40,177)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,326)	0	94,788	0	0	0	0	0	0	0	0	88,462	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	37,845	0	0	0	0	0	0	0	0	37,845	34
35	Rent-Equipment & Vehicles	0	0	672	0	0	0	0	0	0	0	0	672	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,424)</b>	<b>0</b>	<b>92,226</b>	<b>0</b>	<b>86,802</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(9,200)	30,914	491,422	0	0	0	0	0	0	0	0	513,136	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 Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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%	\$ 1,280	\$ 1,280	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,971	1,971	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	3,137	3,137	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	471	471	4
5	V	17 Admin - Misc. Other	314,144	Presence Life Connections	100.00%	11,831	(302,313)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	205,185	205,185	6
7	V	19 Professional Services		Presence Life Connections	100.00%	35,426	35,426	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	452	452	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	3,501	3,501	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	41,124	41,124	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	986	986	11
12	V	24 Travel		Presence Life Connections	100.00%	1,193	1,193	12
13	V	26 Insurance		Presence Life Connections	100.00%	38,501	38,501	13
14	Total		\$ 314,144			\$ 345,058	\$ * 30,914	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%	\$ 3,685	\$ 3,685
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	18,432	18,432
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	672	672
19	V	17 Admin Salaries		Presence Health	100.00%	109,252	109,252
20	V	22 Employee Benefits		Presence Health	100.00%	66,265	66,265
21	V	30 Depreciation	89,561	Presence Health	100.00%	44,797	(44,764)
22	V	34 Rent Facility		Presence Health	100.00%	19,413	19,413
23	V	17 Admin Consulting,Other	474,840	Presence Health	100.00%	403,091	(71,749)
24	V	17 Information Systems Salaries		Presence Health	100.00%	38,741	38,741
25	V	17 Information Systems - Other		Presence Health	100.00%	138,419	138,419
26	V	17 Admin Salaries		Presence Health	100.00%	32,019	32,019
27	V	17 Information Systems Salaries		Presence Health	100.00%	44,149	44,149
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	23,264	23,264
29	V	17 Admin Consulting,Other		Presence Health	100.00%	18,836	18,836
30	V	32 Admin - Interest Expense		Presence Health	100.00%	94,788	94,788
31	V	39 Ancillary Services - Other	404,561	Presence Senior Services Pharmacy	100.00%	404,561	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 968,962			\$ 1,460,384	\$ * 491,422

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

Facility Name & ID Number

PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy Dowd	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	James Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6	Joseph Hugar	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	John Larson	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8	Sr Marie Mason	BOD			Presence St. Vincent	Freeport	Community Living	8
9	Sallie Miller	BOD			Presence Behavioral H	Broadview	Parent	9
10	Phyllis Nichols	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Lawrence Pankau, MD	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Tim Phillippe	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Thomas Smith	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14		BOD			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 Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Est	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR # 0043430 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	NA								\$	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 PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 7,761,581	27	\$ 31,634		314,144	\$ 1,280	1
2	5	Utilities	Management Fee Income 7,761,581	27	48,706		314,144	1,971	2
3	6	Maintenance - Other	Management Fee Income 7,761,581	27	77,498		314,144	3,137	3
4	11	Activities-Special Events	Management Fee Income 7,761,581	27	11,644		314,144	471	4
5	17	Admin - Misc. Other	Management Fee Income 7,761,581	27	292,301		314,144	11,831	5
6	17	Administrative Salaries	Management Fee Income 7,761,581	27	5,069,517	5,069,517	314,144	205,185	6
7	19	Professional Services	Management Fee Income 7,761,581	27	875,274		314,144	35,426	7
8	20	Dues,Subscriptions	Management Fee Income 7,761,581	27	11,166		314,144	452	8
9	21	Clerical Supplies	Management Fee Income 7,761,581	27	86,492		314,144	3,501	9
10	22	Employee Benefits	Management Fee Income 7,761,581	27	1,016,065		314,144	41,124	10
11	23	Education/Conference	Management Fee Income 7,761,581	27	24,366		314,144	986	11
12	24	Travel	Management Fee Income 7,761,581	27	29,466		314,144	1,193	12
13	26	Insurance	Management Fee Income 7,761,581	27	951,237		314,144	38,501	13
14	30	Depreciation	Management Fee Income 7,761,581	27	91,051		314,144	3,685	14
15	32	Interest	Management Fee Income 7,761,581	27	0		314,144	0	15
16	34	Rent - Facility	Management Fee Income 7,761,581	27	455,407		314,144	18,432	16
17	35	Rent - Equipment	Management Fee Income 7,761,581	27	16,606		314,144	672	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 9,088,430	\$ 5,069,517		\$ 367,847	25

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending: 12/31/15

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	5,977,354	17	\$ 1,375,283	\$ 1,375,283	474,840	\$ 109,252	1
2	22	Employee Benefits	Operating Expense	5,977,354	17	834,149		474,840	66,265	2
3	30	Depreciation	Operating Expense	1,607,196	17	803,889		89,561	44,797	3
4	34	Rent Facility	Operating Expense	5,977,354	17	244,378		474,840	19,413	4
5	17	Admin Consulting,Other	Operating Expense	5,977,354	17	5,074,164		474,840	403,091	5
6	17	Information Systems Salaries	Operating Expense	5,977,354	17	487,675	487,675	474,840	38,741	6
7	17	Information Systems - Other	Operating Expense	5,977,354	17	1,742,443		474,840	138,419	7
8	17	Admin Salaries	Direct Cost	5,977,354	17	403,064	403,064	474,840	32,019	8
9	17	Information Systems Salaries	Direct Cost	5,977,354	17	555,758	555,758	474,840	44,149	9
10	6	Information Systems - Equip Mai	Direct Cost	5,977,354	17	292,852		474,840	23,264	10
11	17	Admin Consulting,Other	Direct Cost	5,977,354	17	237,106		474,840	18,836	11
12	32	Admin - Interest Expense	Direct Cost	5,977,354	17	1,193,207		474,840	94,788	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					\$ 13,243,968	\$ 2,821,780		\$ 1,033,034	25

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 60614  
 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		\$	\$		\$ 404,561	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				\$	\$		\$ 404,561	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	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			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	Home Office Allocation						\$	\$			\$ 94,788	1				
2												2				
3												3				
4												4				
5												5				
	<b>Working Capital</b>															
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 94,788	9				
	<b>B. Non-Facility Related*</b>															
10												10				
11												11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14				
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 94,788	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2014 report.		\$	<b>98,536</b>		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.)		\$	<b>117,388</b>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>18,852</b>		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>106,868</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>125,720</b>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<b>99,829</b>	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<b>102,801</b>	9																
	2012	<b>110,131</b>	10																
	2013	<b>115,554</b>	11																
	2014	<b>117,388</b>	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.**



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        X   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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

# 0043430 Report Period Beginning:

1/01/15 Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: \_\_\_\_\_ 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).

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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				\$	1
2					2
3	TOTALS			\$	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			\$	\$		\$	\$	\$
5									
6									
7									
8									
	<b>Improvement Type**</b>								
9	VARIOUS		2000	42,804	2,119	20	2,119		33,852
10	VARIOUS		2001	4,610		10			4,610
11	VARIOUS		2003	353,632	12,743	11	12,743		327,104
12	VARIOUS		2004	1,964		10			1,964
13	VARIOUS		2005	23,126		10			23,126
14	VARIOUS		2006	47,174	4,165	14	4,165		41,263
15	VARIOUS		2007	53,355	2,980	11	2,980		46,653
16	VARIOUS		2008	39,074	3,190	11	3,190		28,191
17	VARIOUS		2009	47,003	4,722	9	4,722		36,780
18	VARIOUS		2010	105,391	10,663	10	10,663		60,856
19	VARIOUS		2011	83,355	8,599	14	8,599		47,032
20									
21	HVAC ROOF TOP UNIT FOR THE KIT		2012	11,747	783	15	783		2,743
22									
23	SEWAGE EJECTOR PUMP		2013	4,900	490	10	490		1,230
24									
25	NEW FLOOR DINING ROOM PATIENT		2014	43,795	2,920	15	2,920		4,357
26	ROOF		2014	15,000	1,500	10	1,500		3,720
27	SHOWER ROOM		2014	38,500	3,850	10	3,850		5,839
28									
29	HVAC UNITS		2015	207,475	5,928	35	5,928		6,339
30	INSTALL LIGHTING MATERIAL IN HALLWAYS		2015	5,686	227	25	227		190
31	LIGHT FIXTURE INSTALLATION - RECEPTION AREA/BATHRM		2015	5,686	379	15	379		564
32	LIGHTING FIXTURES AND EQUIPMENT FOR RESIDENT ROOMS		2015	11,961	797	15	797		1,049
33	MAIN BOILER		2015	11,000	440	25	440		330
34	PAINTING HERITAGE & PROVIDENCE		2015	10,500	131	80	131		22
35	SEALING OF PARKING LOT		2015	5,750	719	8	719		1,062
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 PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending:

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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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,173,486	\$ 67,347		\$ 67,347	\$	\$ 678,874	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	\$ 749,759	\$ 61,776	\$ 61,776	\$	11	\$ 430,750	71
72	Current Year Purchases	11,560	671	1,573	902	8	671	72
73	Fully Depreciated Assets	481,061				8	481,061	73
74	Home Office Allocation		89,561	89,561				74
75	TOTALS	\$ 1,242,380	\$ 152,008	\$ 152,910	\$ 902		\$ 912,482	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)	\$ 2,415,866	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 219,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 220,257	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 902	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,591,356	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				37,845			5
6								6
7	TOTAL				\$ 37,845			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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \$ 95,638 Description: Administration 4773, Dietary 1914, Nursing 87092, Home Office

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10a, 1&3	3091 hrs	\$ 30,524	4,303	\$ 261,902			7,394	\$ 292,426	1	
2	Licensed Speech and Language Development Therapist	10a, 1&3	358 hrs	12,757	647	41,197			1,005	53,954	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a, 1&3	2877 hrs	69,006	4,276	259,749			7,153	328,755	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39,3	# of prescrpts					404,561		404,561	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <b>DIRECTOR</b>		490	37,312					490	37,312	12	
13	Other (specify):										13	
14	<b>TOTAL</b>			\$ 149,599	9,226	\$ 562,848	\$ 404,561		16,042	\$ 1,117,008	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 PINE VIEW CARE CTR**

# **0043430**

Report Period Beginning: **1/01/15**

Ending:

**12/31/15**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/15** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 15,116,271	\$	1
2	Cash-Patient Deposits	142,276		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	38,985,402		3
4	Supply Inventory (priced at )	1,405,559		4
5	Short-Term Investments	1,530,325		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,822,954		7
8	Accounts Receivable (owners or related parties)	2,119,287		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 61,122,074</b>	<b>\$</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,185,056		12
13	Land	17,252,477		13
14	Buildings, at Historical Cost	235,676,159		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,751,494		16
17	Accumulated Depreciation (book methods)	(179,552,982)		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 (specify):	397,300		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 156,709,504</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 217,831,578</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 13,801,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,484,204		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,921,984		32
33	Accrued Interest Payable	6,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Due to Third Parties</b>	<b>(1,674,742)</b>		<b>36</b>
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 40,542,848</b>	<b>\$</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,286,073		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>Conditional Asset Retirement</b>	<b>99,654</b>		<b>43</b>
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 1,385,727</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 41,928,575</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 175,903,003</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 217,831,578</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,167,735	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	104,540,458	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 177,708,193	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(2,271,642)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,437,836	11
12	Expenditures for Specific Purposes	(971,384)	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)	\$ (1,805,190)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 175,903,003	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,259,671	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,259,671	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,458,320	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,458,320	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,041	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	637,290	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 638,331	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	19,477	24
25	Interest and Other Investment Income***	6,326	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 25,803	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,382,125	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,385,353	31
32	Health Care	4,121,316	32
33	General Administration	2,249,419	33
<b>B. Capital Expense</b>			
34	Ownership	1,260,007	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	404,561	35
36	Provider Participation Fee	233,111	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,653,767	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,271,642)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,271,642)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,671,227	44
45	Private Pay - Net Inpatient Revenue	599,553	45
46	Medicare - Net Inpatient Revenue	1,663,070	46
47	Other-(specify) <u>Insurance</u>	325,821	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,259,671	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 PINE VIEW CARE CTR**

# **0043430**

Report Period Beginning:

**1/01/15**

Ending:

**12/31/15**

**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	1,937	2,173	\$ 84,589	\$ 38.93	1
2	Assistant Director of Nursing	1,893	2,085	73,209	35.11	2
3	Registered Nurses	30,587	32,968	903,914	27.42	3
4	Licensed Practical Nurses	19,433	20,603	504,435	24.48	4
5	CNAs & Orderlies	80,882	86,170	1,068,147	12.40	5
6	CNA Trainees					6
7	Licensed Therapist	6,807	6,816	149,599	21.95	7
8	Rehab/Therapy Aides	2,483	2,892	40,155	13.88	8
9	Activity Director	1,796	2,044	41,450	20.28	9
10	Activity Assistants	6,143	6,478	63,454	9.80	10
11	Social Service Workers	1,817	1,942	39,101	20.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	13,250	14,778	182,406	12.34	17
18	Housekeepers					18
19	Laundry	2,000	2,220	23,794	10.72	19
20	Administrator	1,989	2,090	91,258	43.66	20
21	Assistant Administrator	951	961	16,011	16.66	21
22	Other Administrative	817	854	27,056	31.68	22
23	Office Manager	933	1,069	30,234	28.28	23
24	Clerical	6,898	7,371	118,036	16.01	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	1,378	1,538	23,809	15.48	31
32	Other Health C: Admissions	803	839	19,184	22.87	32
33	Other(specify) <u>Pastoral</u>	1,904	2,063	40,821	19.79	33
34	TOTAL (lines 1 - 33)	184,701	197,954	\$ 3,540,662 *	\$ 17.89	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	19,400	9,3	36
37	Medical Records Consultant	30	2,168	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	53	2,626	11,3	44
45	Social Service Consultant	48	3,247	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	131	\$ 27,441		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	42	\$ 3,141	10,2	50
51	Licensed Practical Nurses	72	3,384	10,2	51
52	Certified Nurse Assistants/Aides	4,446	120,012	10,2	52
53	TOTAL (lines 50 - 52)	4,560	\$ 126,537		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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number PRESENCE PINE VIEW CARE CTR

# 0043430

Report Period Beginning:

1/01/15

Ending:

12/31/15

## 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. LEADING AGE \$5288.10
- (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? 8 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,039 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.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 233,111  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,041
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.