

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	99	Skilled (SNF)	135	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	164	60,024	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,482	19,717	9,678	33,877	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		7,850		7,850	12
13	DD 16 OR LESS					13
14	TOTALS	4,482	27,567	9,678	41,727	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.52%

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 03-01-00

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

YES Date 03-01-00 NO

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

YES NO If YES, enter number of beds certified 99 and days of care provided 8,029

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12-31-16 Fiscal Year: 12-31-16

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

Facility Name & ID Number **PRESENCE ST BENEDICT N & R** # **0044784** Report Period Beginning: **1/01/16** Ending: **12/31/16**

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		20,227	657,089	677,316	677,316		677,316			1
2	Food Purchase		267,373		267,373	267,373	(2,400)	264,973			2
3	Housekeeping	174,826	40,807	13,204	228,837	228,837		228,837			3
4	Laundry	85,448	11,383	75	96,906	96,906	(22,541)	74,365			4
5	Heat and Other Utilities			191,677	191,677	191,677	2,741	194,418			5
6	Maintenance	132,781	37,000	110,713	280,494	280,494	9,220	289,714			6
7	Other (specify):* Pastoral	38,881	6,983		45,864	45,864		45,864			7
8	TOTAL General Services	431,936	383,773	972,758	1,788,467	1,788,467	(12,980)	1,775,487			8
	B. Health Care and Programs										
9	Medical Director	33,613			33,613	33,613		33,613			9
10	Nursing and Medical Records	2,849,288	137,672	281,715	3,268,675	3,268,675		3,268,675			10
10a	Therapy	1,080,070	7,020	103,535	1,190,625	1,190,625		1,190,625			10a
11	Activities	150,885	7,836	15,647	174,368	174,368	133	174,501			11
12	Social Services	78,752	2,474		81,226	81,226		81,226			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Shelter	130,518			130,518	130,518		130,518			15
16	TOTAL Health Care and Programs	4,323,126	155,002	400,897	4,879,025	4,879,025	133	4,879,158			16
	C. General Administration										
17	Administrative	341,712	20,774	1,072,103	1,434,589	1,434,589	(89,703)	1,344,886			17
18	Directors Fees										18
19	Professional Services			27,391	27,391	27,391	28,441	55,832			19
20	Dues, Fees, Subscriptions & Promotions			33,275	33,275	33,275	2,679	35,954			20
21	Clerical & General Office Expenses			4,400	4,400	4,400	1,685	6,085			21
22	Employee Benefits & Payroll Taxes			1,215,343	1,215,343	1,215,343	74,035	1,289,378			22
23	Inservice Training & Education			2,146	2,146	2,146	636	2,782			23
24	Travel and Seminar						4,736	4,736			24
25	Other Admin. Staff Transportation			378	378	378		378			25
26	Insurance-Prop.Liab.Malpractice			197,351	197,351	197,351	1,001	198,352			26
27	Other (specify):*										27
28	TOTAL General Administration	341,712	20,774	2,552,387	2,914,873	2,914,873	23,510	2,938,383			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,096,774	559,549	3,926,042	9,582,365	9,582,365	10,663	9,593,028			29

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

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

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

#0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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			455,668	455,668		455,668	50,631	506,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,350	131,350		131,350	(419)	130,931			32
33	Real Estate Taxes			9,160	9,160		9,160		9,160			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,701	24,701		24,701	19,451	44,152			35
36	Other (specify):*											36
37	TOTAL Ownership			620,879	620,879		620,879	69,663	690,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			654,612	654,612		654,612		654,612			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			220,905	220,905		220,905		220,905			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			875,517	875,517		875,517		875,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,096,774	559,549	5,422,438	11,078,761		11,078,761	80,326	11,159,087			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	(3,746)	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	(22,541)	4		8
9	Non-Straightline Depreciation	44,802	30		9
10	Interest and Other Investment Income	(419)	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	(234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,862		\$	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)	62,464		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 62,464		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 80,326		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

PRESENCE ST BENEDICT N & R

ID# 0044784

Report Period Beginning: 1/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	(3,746)	1,346	0	0	0	0	0	0	0	0	0	(2,400)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(22,541)	0	0	0	0	0	0	0	0	0	0	(22,541)	4
5	Heat and Other Utilities	0	2,741	0	0	0	0	0	0	0	0	0	2,741	5
6	Maintenance	0	9,220	0	0	0	0	0	0	0	0	0	9,220	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(26,287)	13,307	0	0	0	0	0	0	0	0	0	(12,980)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	133	0	0	0	0	0	0	0	0	0	133	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	133	0	0	0	0	0	0	0	0	0	133	16
	C. General Administration													
17	Administrative	0	(142,239)	52,536	0	0	0	0	0	0	0	0	(89,703)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,441	0	0	0	0	0	0	0	0	0	28,441	19
20	Fees, Subscriptions & Promotions	(234)	2,913	0	0	0	0	0	0	0	0	0	2,679	20
21	Clerical & General Office Expenses	0	1,685	0	0	0	0	0	0	0	0	0	1,685	21
22	Employee Benefits & Payroll Taxes	0	74,035	0	0	0	0	0	0	0	0	0	74,035	22
23	Inservice Training & Education	0	636	0	0	0	0	0	0	0	0	0	636	23
24	Travel and Seminar	0	4,736	0	0	0	0	0	0	0	0	0	4,736	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,001	0	0	0	0	0	0	0	0	0	1,001	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(234)	(28,792)	52,536	0	23,510	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,521)	(15,352)	52,536	0	10,663	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	44,802	0	5,829	0	0	0	0	0	0	0	0	50,631	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(419)	0	0	0	0	0	0	0	0	0	0	(419)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	19,451	0	0	0	0	0	0	0	0	19,451	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	44,383	0	25,280	0	69,663	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	17,862	(15,352)	77,816	0	80,326	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 Commu
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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%	\$ 1,346	\$	1,346	1
2	V	5 Utilities		Presence Life Connections	100.00%	2,741		2,741	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	9,220		9,220	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	133		133	4
5	V	17 Admin - Misc. Other	427,788	Presence Life Connections	100.00%	4,679		(423,109)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	280,870		280,870	6
7	V	19 Professional Services		Presence Life Connections	100.00%	28,441		28,441	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	2,913		2,913	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	1,685		1,685	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	74,035		74,035	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	636		636	11
12	V	24 Travel		Presence Life Connections	100.00%	4,736		4,736	12
13	V	26 Insurance		Presence Life Connections	100.00%	1,001		1,001	13
14	Total		\$ 427,788			\$ 412,436	\$ *	(15,352)	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%	\$ 5,829	\$ 5,829
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	0	
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	19,451	19,451
19	V	17 Admin Salaries		Presence Health	100.00%	64,081	64,081
20	V	30 Depreciation	162,213	Presence Health	100.00%	162,213	
21	V	17 Admin Consulting, Other	644,844	Presence Health	100.00%	633,299	(11,545)
22	V	39 Ancillary Services - Other	654,612	Presence Senior Services Pharmacy	100.00%	654,612	
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,461,669			\$ 1,539,485	\$ * 77,816

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

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Susan Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral Health	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem Way	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Carlo	Northlake	Independent Living	13
14					Presence Ambulatory Services	Various	Parent	14
15					Resurrection Development	Chicago	Parent	15
16					Presence Healthcare Services	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care Services	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 Retirement	Chicago	Independent Living	24
25					Resurrection University	Chicago	College	25
26					Presence Health Partners	Various	Parent	26
27					Presence Properties Plus	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Estates	Kankakee	Independent Living	29
30								30

Facility Name & ID Number **PRESENCE ST BENEDICT N & R** # **0044784** Report Period Beginning: **1/01/16** Ending: **12/31/16**

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 ST BENEDICT N & R # 0044784 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	9,455,191	33	\$ 29,753	\$ 427,788	\$ 1,346	1	
2	5	Utilities	Management Fee Income	9,455,191	33	60,575	427,788	2,741	2	
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785	427,788	9,220	3	
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934	427,788	133	4	
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412	427,788	4,679	5	
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	427,788	280,870	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607	427,788	28,441	7	
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374	427,788	2,913	8	
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236	427,788	1,685	9	
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354	427,788	74,035	10	
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049	427,788	636	11	
12	24	Travel	Management Fee Income	9,455,191	33	104,676	427,788	4,736	12	
13	26	Insurance	Management Fee Income	9,455,191	33	22,118	427,788	1,001	13	
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835	427,788	5,829	14	
15	32	Interest	Management Fee Income	9,455,191	33	0	427,788	0	15	
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0	427,788	0	16	
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912	427,788	19,451	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,674,560	\$ 6,207,940	\$ 437,716	25	

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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	6,627,442	10	\$ 658,602	\$ 658,602	644,844	\$ 64,081	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		162,213	162,213	2
3	17	Admin Consulting, Other	Operating Expense	6,627,442	10	6,508,786		644,844	633,299	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					\$ 8,825,401	\$ 658,602		\$ 859,593	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending: 12/31/16

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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		\$	\$		654,612	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				\$	\$		654,612	25

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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 2015 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 2016 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:	2011	8	
	2012	9	
	2013	10	
	2014	11	
	2015	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE ST BENEDICT N & R COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

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

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

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

Empty lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

1. Total Amount Incurred: N/A 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 56,961, 2000, \$ 2,910,262, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 56,961, (blank), \$ 2,910,262, 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	99	2000	1991	\$ 5,342,488	\$ 123,433	40	\$ 134,685	\$ 11,252	\$ 2,482,954	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		2000	92,057		7			92,057	9
10	VARIOUS		2001	273,061	15,528	12	15,513	(15)	270,071	10
11	VARIOUS		2002	29,538	1,604	16	1,884	281	27,889	11
12	VARIOUS		2003	8,200	156	15	166	11	7,187	12
13	VARIOUS		2004	12,982	639	15	662	23	9,376	13
14	VARIOUS		2005	191,740	8,391	10	9,242	851	163,754	14
15	VARIOUS		2006	86,586	2,596	10	2,558	(38)	76,988	15
16	VARIOUS		2008	1,284	64	20	64	0	577	16
17	VARIOUS		2012	15,524	667	23	669	2	3,010	17
18										18
19										19
20	REMOVING TOP 2 inch OF ASPHALT		2014	50,900	6,211	8	6,363	151	15,704	20
21	RENOVATIONS FOR CONVERSION OF		2014	50,400	2,465	20	2,520	55	6,227	21
22	REPLACE AIR COOLED CHILLER MOD		2014	125,000	6,141	20	6,250	109	15,480	22
23										23
24	: DEPOSIT TO INSTALL NEW LIGHT		2015	6,477	324	20	983	659	405	24
25	BARIATRIC BED, ELECTRONIC, WID		2015	6,884	459	18	139	(320)	574	25
26	BARIATRIC POWERED ALTERNATING		2015	9,997	542	18	375	(167)	542	26
27										27
28	NEW Bathroom - (ILC) Independent Living		2016	9,350	273	20	234	(39)	273	28
29	: Electrical work for new phone system		2016	3,335	153	20	139	(14)	153	29
30	: INSTALL RESILIENT FLOORING - (ILC) Independent Living		2016	7,494	375	20	375		375	30
31	NEW CARRIER MAKE UP AIR		2016	60,000	250	20	3,000	2,750	250	31
32	New window		2016	3,525	15	20	176	162	15	32
33	GALVANIZED STEEL INSULATD DOOR		2016	3,635	91	20	76	(15)	91	33
34	2ND FLOOR CORRIDOR LED LIGHTS		2016	4,318	173	25	173	0	173	34
35	ILC Roof Replacement		2016	78,623	1,310	20	983	(328)	1,310	35
36										36

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

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

See Page 12A, Line 70 for total

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)	\$ 6,473,397	\$ 171,859		\$ 187,229	\$ 15,370	\$ 3,175,433	70

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	\$ 2,128,859	\$ 107,043	\$ 136,608	\$ 29,565	12	\$ 1,477,265	71
72	Current Year Purchases	15,850	1,032	898	(134)	11	1,032	72
73	Fully Depreciated Assets	433,011	13,522	13,522		7	433,011	73
74	Home Office Allocation		168,042	168,042				74
75	TOTALS	\$ 2,577,720	\$ 289,639	\$ 319,070	\$ 29,431		\$ 1,911,308	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)	\$ 11,961,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 461,498	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 506,299	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,801	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,086,740	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				0			5
6								6
7	TOTAL				\$			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.	/2017	\$ _____
13.	/2018	\$ _____
14.	/2019	\$ _____

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: \$ 44,152 Description: Nursing 1,566; Activities 167; Administration 11,897; Rehabilitation 11,072; Home Office 19,451

(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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a, 1	9578	hrs	\$ 418,657		\$	\$	9,578	\$ 418,657	1
2	Licensed Speech and Language Development Therapist	10a, 1	2135	hrs	94,446				2,135	94,446	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	10780	hrs	465,544				10,780	465,544	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				654,612		654,612	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Director</u>	10a, 1	2104		101,423				2,104	101,423	12
13	Other (specify):										13
14	TOTAL				\$ 1,080,070		\$	\$ 654,612	24,597	\$ 1,734,682	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.

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	\$ 13,093,635	\$	1
2	Cash-Patient Deposits	136,639		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	39,798,115		3
4	Supply Inventory (priced at)	1,624,833		4
5	Short-Term Investments	1,515,071		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,808,186		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 58,976,479	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,314,676		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	236,115,679		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	68,273,740		16
17	Accumulated Depreciation (book methods)	(187,356,794)		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):	2,149,114		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 155,443,930	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 214,420,409	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,011,382	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,457,867		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,069		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,368		32
33	Accrued Interest Payable	5,594		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Third Parties</u>	(1,918,871)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 32,152,409	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	757,059		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	114,984		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 872,043	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 33,024,452	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 181,395,957	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 214,420,409	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	4,169,316	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 180,072,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,721,705	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	515,397	11
12	Expenditures for Specific Purposes	(913,464)	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)	\$ 1,323,638	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)	\$ 181,395,957	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	\$ 10,568,167	1
2	Discounts and Allowances for all Levels	(1,158,976)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,409,191	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,408,685	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,408,685	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,746	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	917,775	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	22,541	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 944,062	23
D. Non-Operating Revenue			
24	Contributions	5,903	24
25	Interest and Other Investment Income***	419	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,322	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	32,206	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,206	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,800,466	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,788,467	31
32	Health Care	4,879,025	32
33	General Administration	2,914,873	33
B. Capital Expense			
34	Ownership	620,879	34
C. Ancillary Expense			
35	Special Cost Centers	654,612	35
36	Provider Participation Fee	220,905	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,078,761	40
41	Income before Income Taxes (line 30 minus line 40)**	1,721,705	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,721,705	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 790,176	44
45	Private Pay - Net Inpatient Revenue	5,931,249	45
46	Medicare - Net Inpatient Revenue	2,350,532	46
47	Other-(specify) <u>Insurance</u>	337,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,409,191	49

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

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

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

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

Facility Name & ID Number **PRESENCE ST BENEDICT N & R**

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	1,858	2,099	\$ 94,360	\$ 44.95	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	34,165	37,930	1,566,003	41.29	3
4	Licensed Practical Nurses	6,899	8,218	220,063	26.78	4
5	CNAs & Orderlies	67,286	75,251	1,095,885	14.56	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	23,067	24,597	1,080,070	43.91	7
8	Rehab/Therapy Aides	147	147	2,798	19.03	8
9	Activity Director	3,731	4,186	100,251	23.95	9
10	Activity Assistants	4,071	4,455	50,634	11.37	10
11	Social Service Workers	3,990	4,229	87,260	20.63	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	5,594	6,157	132,781	21.57	17
18	Housekeepers	11,355	12,933	174,826	13.52	18
19	Laundry	6,070	7,114	85,448	12.01	19
20	Administrator	1,785	2,071	110,752	53.48	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,624	4,989	60,358	12.10	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	240	240	33,613	140.05	27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,747	2,004	48,611	24.26	31
32	Other Health C: Admissions	3,680	4,155	114,180	27.48	32
33	Other(specify) <u>Pastoral</u>	1,456	1,583	38,881	24.56	33
34	TOTAL (lines 1 - 33)	181,765	202,358	\$ 5,096,774 *	\$ 25.19	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			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant	71	4,933	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	2,420	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 7,353		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	196	\$ 13,729	10,3	50
51	Licensed Practical Nurses	0	0	10,3	51
52	Certified Nurse Assistants/Aides	10,690	267,244	10,3	52
53	TOTAL (lines 50 - 52)	10,886	\$ 280,973		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Bernie Ladra	Administrator		\$ 110,752	Workers' Compensation Insurance	\$ 60,772	IDPH License Fee	\$	
Administrative Staff	Office Manager		0	Unemployment Compensation Insurance	16,466	Advertising: Employee Recruitment		
Administrative Staff	Receptionists		60,358	FICA Taxes	353,971	Health Care Worker Background Check		
Administrative Staff	Administrative Asst		0	Employee Health Insurance	503,297	(Indicate # of checks performed 29)		
Administrative Staff	Admissions		114,180	Employee Meals		Patient Background Checks	228	
Administrative Staff	Other Administrative		56,422	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	1,200	
TOTAL (agree to Schedule V, line 17, col. 1)				Home Office Allocation	74,035	Dues & Subscriptions	31,841	
(List each licensed administrator separately.)			\$ 341,712	Dental	15,900	Advertising & Public Relations	234	
B. Administrative - Other				Life Insurance	3,736	Home Office Allocation	2,913	
Description			Amount	Disability Insurance	19,866			
Corp Office Management Fee			\$ 1,072,103	Pension	224,977	Less: Public Relations Expense	()	
				Tuition Reimbursement	10,017	Non-allowable advertising	(234)	
				Other Benefits	6,340	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,072,103	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,289,378	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$	Out-of-State Travel	\$
POLSINELLI PC	Legal		\$ 12,837					
GALLAGHER BASSET SERVICES	Biomed		300					
LIFECYCLE	Aviary Maintenance		854					
PACIFIC INTERPRETERS INC	Interpreter		283				In-State Travel	0
FAST TRAK MEDIVAN TRANSPOR	Transportation		800					
ERIKSSON ENGINEERING ASSOC	Engineering/Survey		1,058					
Brinks Incorporated	Security		1,523				Seminar Expense	
JM Brennan inc	Mechanical		9,736				Home Office Allocation	4,736
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 27,391				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,736

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

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 \$11,975.44
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,865 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. \$ 220,905
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. \$ 3,746
- (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