

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430 Report Period Beginning: 1/01/17 Ending: 12/31/17

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,212	8,921	6,389	29,522	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,212	8,921	6,389	29,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.40%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A-NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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 4,737

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: 12-31-17 Fiscal Year: 12-31-17

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

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR # 0043430 Report Period Beginning: 1/01/17 Ending: 12/31/17

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		2,480	496,804	499,284	499,284		499,284			1
2	Food Purchase		207,171		207,171	207,171	(680)	206,491			2
3	Housekeeping	99,220			99,220	99,220		99,220			3
4	Laundry	26,236		54,381	80,617	80,617		80,617			4
5	Heat and Other Utilities			150,335	150,335	150,335	1,537	151,872			5
6	Maintenance	84,953	24,042	117,658	226,653	226,653	80,632	307,285			6
7	Other (specify):* Pastoral	53,868			53,868	53,868		53,868			7
8	TOTAL General Services	264,277	233,693	819,178	1,317,148	1,317,148	81,489	1,398,637			8
	B. Health Care and Programs										
9	Medical Director			19,230	19,230	19,230		19,230			9
10	Nursing and Medical Records	2,503,273	185,134	560,729	3,249,136	3,249,136		3,249,136			10
10a	Therapy	434,653	10,988		445,641	445,641		445,641			10a
11	Activities	71,242	80	6,046	77,368	77,368	36	77,404			11
12	Social Services	70,316		442	70,758	70,758		70,758			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,079,484	196,202	586,447	3,862,133	3,862,133	36	3,862,169			16
	C. General Administration										
17	Administrative	253,917	9,517	787,181	1,050,615	1,050,615	(192,354)	858,261			17
18	Directors Fees										18
19	Professional Services			41,852	41,852	41,852	15,119	56,971			19
20	Dues, Fees, Subscriptions & Promotions			56,754	56,754	56,754	2,293	59,047			20
21	Clerical & General Office Expenses			16,817	16,817	16,817	653	17,470			21
22	Employee Benefits & Payroll Taxes			903,878	903,878	903,878	63,345	967,223			22
23	Inservice Training & Education			125	125	125	517	642			23
24	Travel and Seminar			3,496	3,496	3,496	3,033	6,529			24
25	Other Admin. Staff Transportation			2,459	2,459	2,459		2,459			25
26	Insurance-Prop.Liab.Malpractice			241,294	241,294	241,294	4,551	245,845			26
27	Other (specify):*										27
28	TOTAL General Administration	253,917	9,517	2,053,856	2,317,290	2,317,290	(102,843)	2,214,447			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,597,678	439,412	3,459,481	7,496,571	7,496,571	(21,318)	7,475,253			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 PINE VIEW CARE CTR

#0043430

Report Period Beginning:

1/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			487,367	487,367		487,367	(205,955)	281,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,265	66,265		66,265	(31,757)	34,508			32
33	Real Estate Taxes			108,138	108,138		108,138		108,138			33
34	Rent-Facility & Grounds			629,583	629,583		629,583		629,583			34
35	Rent-Equipment & Vehicles			85,016	85,016		85,016	14,424	99,440			35
36	Other (specify):*											36
37	TOTAL Ownership			1,376,369	1,376,369		1,376,369	(223,288)	1,153,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			751,888	751,888		751,888		751,888			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,933	218,933		218,933		218,933			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			970,821	970,821		970,821		970,821			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,597,678	439,412	5,806,671	9,843,761		9,843,761	(244,606)	9,599,155			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	(1,558)	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		4		8
9	Non-Straightline Depreciation	(211,099)	30		9
10	Interest and Other Investment Income	(31,757)	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	(192)	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)	\$ (244,606)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (244,606)		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	
							52

PRESENCE PINE VIEW CARE CTR

ID# 0043430

Report Period Beginning: 1/01/17

Ending: 12/31/17

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 PINE VIEW CARE CTR

0043430

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	(1,558)	878	0	0	0	0	0	0	0	0	0	(680)	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	1,537	0	0	0	0	0	0	0	0	0	1,537	5
6	Maintenance	0	7,111	73,521	0	0	0	0	0	0	0	0	80,632	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,558)	9,526	73,521	0	81,489	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	36	0	0	0	0	0	0	0	0	0	36	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	36	0	0	0	0	0	0	0	0	0	36	16
	C. General Administration													
17	Administrative	0	(63,091)	(129,263)	0	0	0	0	0	0	0	0	(192,354)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,119	0	0	0	0	0	0	0	0	0	15,119	19
20	Fees, Subscriptions & Promotions	(192)	2,485	0	0	0	0	0	0	0	0	0	2,293	20
21	Clerical & General Office Expenses	0	653	0	0	0	0	0	0	0	0	0	653	21
22	Employee Benefits & Payroll Taxes	0	7,603	55,742	0	0	0	0	0	0	0	0	63,345	22
23	Inservice Training & Education	0	517	0	0	0	0	0	0	0	0	0	517	23
24	Travel and Seminar	0	3,033	0	0	0	0	0	0	0	0	0	3,033	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	4,551	0	0	0	0	0	0	0	0	0	4,551	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(192)	(29,130)	(73,521)	0	(102,843)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,750)	(19,568)	0	0	0	0	0	0	0	0	0	(21,318)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR # 0043430 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(211,099)	0	5,144	0	0	0	0	0	0	0	0	(205,955)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,757)	0	0	0	0	0	0	0	0	0	0	(31,757)	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	14,424	0	0	0	0	0	0	0	0	14,424	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(242,856)	0	19,568	0	(223,288)	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)	(244,606)	(19,568)	19,568	0	(244,606)	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 Cor Mariae Center	Rockford	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence St. Joseph Center	Freeport	Presence Fox Knoll	Aurora	Retirement Commu
		Presence McAuley Manor	Aurora	Presence Health	Chicago	Parent Company
		Presence St. Anne Center	Rockford	Presence Home Care	Various	Home Health
		Presence Villa Franciscan	Joliet	Presence Care @ Hom	Various	Home Equipment
		Presence Heritage Village	Kankakee	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%	\$ 878	\$	878	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,537		1,537	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	7,111		7,111	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	36		36	4
5	V	17 Admin - Misc. Other	228,638	Presence Life Connections	100.00%	(37)		(228,675)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	165,584		165,584	6
7	V	19 Professional Services		Presence Life Connections	100.00%	15,119		15,119	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	2,485		2,485	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	653		653	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	7,603		7,603	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	517		517	11
12	V	24 Travel		Presence Life Connections	100.00%	3,033		3,033	12
13	V	26 Insurance		Presence Life Connections	100.00%	4,551		4,551	13
14	Total		\$ 228,638			\$ 209,070	\$ *	(19,568)	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%	\$ 5,144	\$ 5,144
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%	14,424	14,424
19	V	17 Admin Salaries		Presence Health	100.00%	309,605	309,605
20	V	22 Employee Benefits		Presence Health	100.00%	55,742	55,742
21	V	30 Depreciation	159,014	Presence Health	100.00%	159,014	
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	558,543	Presence Health	100.00%	183,526	(375,017)
24	V	17 Information Systems Salaries		Presence Health	100.00%	0	
25	V	17 Information Systems - Other		Presence Health	100.00%	0	
26	V	17 Admin Salaries		Presence Health	100.00%	0	
27	V	17 Information Systems Salaries		Presence Health	100.00%	0	
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	73,521	73,521
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	66,265	Presence Health	100.00%	66,265	
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	(63,851)	(63,851)
32	V	39 Ancillary Services - Other	751,888	Presence Senior Services Pharmacy	100.00%	751,888	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,535,710			\$ 1,555,278	\$ * 19,568

* 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:

1/01/17

Ending: 12/31/17

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Mike Gordon	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Nazarethville	Des Plaines	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Wendell Provost	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life Connect	Mokena	Management Comp	4
5			Presence St Benedict Nursing & Rehab Center	Niles	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			A Merkle C Knipprath Nursing Home	Clifton	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8					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 W	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	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 PINE VIEW CARE CTR # 0043430 Report Period Beginning: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430

Report Period Beginning:

1/01/17

Ending: 12/31/17

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 Presence Life Connections
 Street Address 18927 Hickory Creek Dr, Ste 300
 City / State / Zip Code Mokena, IL 60448
 Phone Number (708-478-7900
 Fax Number (708-478-5387

1	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	5,620,989	33	\$ 21,575	\$ 228,638	\$ 878	1	
2	5	Utilities	Management Fee Income	5,620,989	33	37,782	228,638	1,537	2	
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812	228,638	7,111	3	
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894	228,638	36	4	
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)	228,638	(37)	5	
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	228,638	165,584	6
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695	228,638	15,119	7	
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085	228,638	2,485	8	
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056	228,638	653	9	
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921	228,638	7,603	10	
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708	228,638	517	11	
12	24	Travel	Management Fee Income	5,620,989	33	74,575	228,638	3,033	12	
13	26	Insurance	Management Fee Income	5,620,989	33	111,873	228,638	4,551	13	
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474	228,638	5,144	14	
15	32	Interest	Management Fee Income	5,620,989	33	0	228,638	0	15	
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0	228,638	0	16	
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619	228,638	14,424	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 5,620,989	\$ 4,070,831	\$ 228,638	25	

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430

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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 Presence Health
 Street Address 100 North River Road
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (815-806-2327
 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	17	Admin Salaries	Operating Expense	13,936,478	35	\$ 7,725,094	\$ 7,725,094	558,543	\$ 309,605	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		558,543	55,742	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		159,014	159,014	3
4	34	Rent Facility	Operating Expense	13,936,478	35			558,543		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		558,543	183,526	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			558,543		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			558,543		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			558,543		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			558,543		9
10	6	Information Systems - Equip Maint	Operating Expense	13,936,478	35	1,834,459		558,543	73,521	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			558,543		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		66,265	66,265	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		558,543	(63,851)	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					\$ 20,673,348	\$ 7,725,094		\$ 783,822	25

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430

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1/01/17

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VIII. ALLOCATION OF INDIRECT COSTS

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

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 751,888	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				\$	\$		\$ 751,888	25

Facility Name & ID Number

PRESENCE PINE VIEW CARE CTR

0043430

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1/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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 2016 report.		\$	111,191	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.)		\$	111,283	2
3. Under or (over) accrual (line 2 minus line 1).		\$	92	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	108,046	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.		\$	108,138	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	110,131	8	
	2013	115,554	9	
	2014	117,388	10	
	2015	114,335	11	
	2016	111,283	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

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).

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			\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		2000	42,804	3,225	20	2,140	(1,085)	39,195	9
10	VARIOUS		2001	4,610		10			4,610	10
11	VARIOUS		2003	353,632	12,743	11	12,560	(183)	352,591	11
12	VARIOUS		2004	1,964		10			1,964	12
13	VARIOUS		2005	23,126		10			23,126	13
14	VARIOUS		2006	47,174	1,458	14	622	(836)	45,253	14
15	VARIOUS		2007	53,355	2,309	11	1,685	(624)	51,942	15
16	VARIOUS		2008	39,074	4,318	11	2,646	(1,672)	35,480	16
17	VARIOUS		2009	47,003	4,609	9	4,433	(176)	46,111	17
18	VARIOUS		2010	105,391	16,389	10	11,107	(5,282)	87,909	18
19	VARIOUS		2011	83,355	11,763	14	2,975	(8,788)	66,196	19
20	VARIOUS		2012	11,747	3,327	15	783	(2,544)	6,859	20
21	VARIOUS		2013	4,900	1,344	10	490	(854)	3,081	21
22										22
23	NEW FLOOR DINING ROOM PATIENT		2014	43,795	14,611	15	2,920	(11,691)	21,819	23
24	ROOF		2014	15,000	4,142	10	1,500	(2,642)	9,272	24
25	SHOWER ROOM		2014	38,500	11,996	10	3,850	(8,146)	21,875	25
26										26
27	HVAC UNITS		2015	207,475	75,056	35	5,928	(69,128)	87,311	27
28	INSTALL LIGHTING MATERIAL IN HALLWAYS		2015	5,686	2,047	25	227	(1,820)	2,464	28
29	LIGHT FIXTURE INSTALLATION - RECEPTION AREA/BATHRM		2015	5,686	1,898	15	379	(1,519)	2,828	29
30	LIGHTING FIXTURES AND EQUIPMENT FOR RESIDENT ROOMS		2015	11,961	4,043	15	797	(3,246)	5,872	30
31	MAIN BOILER		2015	11,000	3,974	25	440	(3,534)	4,744	31
32	PAINTING HERITAGE & PROVIDENCE		2015	10,500	3,921	80	131	(3,790)	4,074	32
33	SEALING OF PARKING LOT		2015	5,750	1,716	8	719	(997)	3,448	33
34										34
35	NEW ASPHALT & CONCRETE - PARKING LOT & SIDEWALK		2017	35,001	292	10	292		292	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430

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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)	\$ 1,208,487	\$ 185,181		\$ 56,624	\$ (128,557)	\$ 928,316	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	\$ 675,890	\$ 138,765	\$ 56,223	\$ (82,542)	13	\$ 436,440	71
72	Current Year Purchases	11,717	252	252		12	56,476	72
73	Fully Depreciated Assets	633,471	4,155	4,155		8	633,471	73
74	Home Office Allocation		164,158	164,158				74
75	TOTALS	\$ 1,321,078	\$ 307,330	\$ 224,788	\$ (82,542)		\$ 1,126,387	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)	\$ 2,529,565	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 492,511	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 281,412	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (211,099)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,054,703	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:	<u>Building</u>			\$ <u>629,583</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>629,583</u>			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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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: \$ 99,440 Description: Nursing 73,117; Rehabilitation 359; Admin 11,540; Home Office 14,424

(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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 1	4317	hrs	\$ 169,051		\$	4,317	\$ 169,051	1
2	Licensed Speech and Language Development Therapist	10a, 1	288	hrs	12,295			288	12,295	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a, 1	6422	hrs	246,985			6,422	246,985	4
5	Physician Care			visits						5
6	Dental Care			visits						6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy			# of prescrpts			751,888		751,888	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39,3		hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Director</u>	10a, 1	152		6,322			152	6,322	12
13	Other (specify):									13
14	TOTAL				\$ 434,653		\$ 751,888	11,179	\$ 1,186,541	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,899,845	\$	1
2	Cash-Patient Deposits	144,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	32,268,677		3
4	Supply Inventory (priced at)	1,411,420		4
5	Short-Term Investments	116,835		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	13,801,325		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 53,642,932	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	11,514,361		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	248,853,412		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	58,926,661		16
17	Accumulated Depreciation (book methods)	(193,707,894)		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):	2,788,546		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 151,322,601	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 204,965,533	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,918,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,250,139		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,490		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	587,749		32
33	Accrued Interest Payable	4,849		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Third Parties</u>	(2,518,894)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 25,270,159	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	629,027		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	47,219		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 676,246	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,946,405	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 179,019,128	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 204,965,533	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 181,395,957	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	(546,881)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 180,849,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,849,009)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,390,900	11
12	Expenditures for Specific Purposes	(1,371,839)	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)	\$ (1,829,948)	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)	\$ 179,019,128	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,593,129	1
2	Discounts and Allowances for all Levels	(2,918,837)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,674,292	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,348,464	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,348,464	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	1,558	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	938,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 940,004	23
D. Non-Operating Revenue			
24	Contributions	4,965	24
25	Interest and Other Investment Income***	31,757	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,722	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(4,730)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,730)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,994,752	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,317,148	31
32	Health Care	3,862,133	32
33	General Administration	2,317,290	33
B. Capital Expense			
34	Ownership	1,376,369	34
C. Ancillary Expense			
35	Special Cost Centers	751,888	35
36	Provider Participation Fee	218,933	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,843,761	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,849,009)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,849,009)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,135,715	44
45	Private Pay - Net Inpatient Revenue	2,070,850	45
46	Medicare - Net Inpatient Revenue	1,141,355	46
47	Other-(specify) <u>Insurance</u>	326,372	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,674,292	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 PINE VIEW CARE CTR**

0043430

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	1,640	1,800	\$ 83,643	\$ 46.47	1
2	Assistant Director of Nursing	1,432	1,544	59,711	38.67	2
3	Registered Nurses	19,703	22,213	784,760	35.33	3
4	Licensed Practical Nurses	14,749	16,102	530,395	32.94	4
5	CNAs & Orderlies	53,365	57,798	966,464	16.72	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	10,218	11,178	434,653	38.88	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	5,776	6,125	72,091	11.77	10
11	Social Service Workers	1,874	2,128	56,000	26.32	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	3,701	4,077	84,953	20.84	17
18	Housekeepers	8,347	8,906	99,220	11.14	18
19	Laundry	1,933	2,168	26,236	12.10	19
20	Administrator	1,136	1,184	55,578	46.94	20
21	Assistant Administrator	160	160	4,411	27.57	21
22	Other Administrative	0	0	0		22
23	Office Manager	1,832	2,092	57,351	27.41	23
24	Clerical	5,900	6,259	111,618	17.83	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		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	1,866	1,996	32,543	16.30	31
32	Other Health Care(specify)	3,649	4,025	84,183	20.92	32
33	Other(specify)	1,896	2,080	53,868	25.90	33
34	TOTAL (lines 1 - 33)	139,177	151,835	\$ 3,597,678 *	\$ 23.69	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	19,230	9,3	36
37	Medical Records Consultant	31	2,116	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	52	2,756	11,3	44
45	Social Service Consultant	7	442	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	90	\$ 24,544		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,263	\$ 216,037	10,3	50
51	Licensed Practical Nurses	1,347	58,255	10,3	51
52	Certified Nurse Assistants/Aides	7,769	183,602	10,3	52
53	TOTAL (lines 50 - 52)	12,379	\$ 457,894		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	
Amrit Jacob	Administrator		\$ 55,578	Workers' Compensation Insurance	\$ 62,756	IDPH License Fee	\$	
Administrative Staff	Office Manager		57,531	Unemployment Compensation Insurance	5,140	Advertising: Employee Recruitment		
Administrative Staff	Receptionists		51,443	FICA Taxes	261,070	Health Care Worker Background Check		
Administrative Staff	Admissions		84,183	Employee Health Insurance	371,416	(Indicate # of checks performed 28)		
Administrative Staff	Administrative Asst		4,411	Employee Meals		Patient Background Checks	207	
Administrative Staff	Other Administrative		771	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment		
TOTAL (agree to Schedule V, line 17, col. 1)				Home Office Allocation	63,345	Dues & Subscriptions	56,562	
(List each licensed administrator separately.)			\$ 253,917	Dental	11,343	Advertising & Public Relations	192	
B. Administrative - Other				Life Insurance	2,488	Home Office Allocation	2,485	
Description			Amount	Disability Insurance	14,016			
Corp Office Management Fee			\$ 787,181	Pension	182,528	Less: Public Relations Expense	()	
				Tuition Reimbursement	8,953	Non-allowable advertising	(192)	
				Other Benefits	(15,832)	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 787,181	TOTAL (agree to Schedule V, line 22, col.8)		\$ 967,223	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					
BIOMETRIC IMPRESSIONS CORP	Fingerprinting		\$ 766	N/A		\$	Out-of-State Travel	\$
ELGIN MEDI TRANSPORT	Transportation services		280					
IRON MOUNTAIN	Storage		3,229					
LIVING DESIGN INC	Aviary Service		1,130				In-State Travel	3,496
MONAHAN LAW GROUP LLC	Legal		22,269					
ON HOLD CONCEPTS INC	Music Service		315					
PACIFIC INTERPRETERS INC	Over the phone interpreting		208				Seminar Expense	
POLSINELLI PC	Legal		5,705				Home Office Allocation	3,033
SCHAEFER GREENHOUSES INC	Internal Beautification		4,300					
SERENITY AQUARIUM AND AVIA	Aquarium service		1,815					
TOWN AND COUNTRY GARDENS	Internal Beautification		1,835				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 41,852				\$ 6,529	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE PINE VIEW CARE CTR

0043430

Report Period Beginning:

1/01/17

Ending:

12/31/17

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. 8385
- (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? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,576 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. \$ 218,933
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. \$ 1,558
- (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