

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER

0044354 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	122	Skilled (SNF)	122	22,082	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	6,335	3
4		Intermediate/DD			4
5	5	Sheltered Care (SC)	5	905	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	29,322	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	10,955	6,852	9,754	27,561	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,955	6,852	9,754	27,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.99%

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 03-01-00

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 122 and days of care provided 7,947

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: 6-30-18 Fiscal Year: 6-30-18

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENT # 0044354 Report Period Beginning: 1/01/18 Ending: 6/30/18

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		(1,537)	391,856	390,319	390,319		390,319			1
2	Food Purchase		180,405		180,405	180,405	(1,697)	178,708			2
3	Housekeeping	86,712	23,336		110,048	110,048		110,048			3
4	Laundry	26,115	85,062		111,177	111,177	(9,707)	101,470			4
5	Heat and Other Utilities			106,592	106,592	106,592	615	107,207			5
6	Maintenance	52,908	13,111	122,767	188,786	188,786	35,215	224,001			6
7	Other (specify):* Pastoral	83,164	902	10,867	94,933	94,933		94,933			7
8	TOTAL General Services	248,899	301,279	632,082	1,182,260	1,182,260	24,426	1,206,686			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,448,404	160,911	118,338	2,727,653	2,727,653		2,727,653			10
10a	Therapy	768,507	7,020	449	775,976	775,976		775,976			10a
11	Activities	65,695	920	295	66,910	66,910	51	66,961			11
12	Social Services	67,370	379		67,749	67,749		67,749			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,349,976	169,230	119,082	3,638,288	3,638,288	51	3,638,339			16
	C. General Administration										
17	Administrative	216,154	10,786	574,637	801,577	801,577	(401,957)	399,620			17
18	Directors Fees										18
19	Professional Services			21,108	21,108	21,108	17,677	38,785			19
20	Dues, Fees, Subscriptions & Promotions			18,544	18,544	18,544	2,890	21,434			20
21	Clerical & General Office Expenses			11,458	11,458	11,458	74	11,532			21
22	Employee Benefits & Payroll Taxes			854,597	854,597	854,597	21,003	875,600			22
23	Inservice Training & Education			1,657	1,657	1,657	1,261	2,918			23
24	Travel and Seminar						4,203	4,203			24
25	Other Admin. Staff Transportation			1,635	1,635	1,635		1,635			25
26	Insurance-Prop.Liab.Malpractice			94,452	94,452	94,452	2,303	96,755			26
27	Other (specify):*										27
28	TOTAL General Administration	216,154	10,786	1,578,088	1,805,028	1,805,028	(352,546)	1,452,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,815,029	481,295	2,329,252	6,625,576	6,625,576	(328,069)	6,297,507			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.

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			158,479	158,479		158,479	27,169	185,648			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,121	33,121		33,121	(19,332)	13,789			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							27,096	27,096			34
35	Rent-Equipment & Vehicles			18,154	18,154		18,154	883	19,037			35
36	Other (specify):*											36
37	TOTAL Ownership			209,754	209,754		209,754	35,816	245,570			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			742,282	742,282		742,282		742,282			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,111	164,111		164,111		164,111			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			906,393	906,393		906,393		906,393			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,815,029	481,295	3,445,399	7,741,723		7,741,723	(292,253)	7,449,470			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	(2,440)	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	(9,707)	4		8
9	Non-Straightline Depreciation	22,310	30		9
10	Interest and Other Investment Income	(20,374)	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		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)	\$ (10,211)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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)	(141,021)	17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (141,021)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (151,232)		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

ID# 0044354

Report Period Beginning: 1/01/18

Ending: 6/30/18

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 RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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	(2,440)	743	0	0	0	0	0	0	0	0	0	(1,697)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9,707)	0	0	0	0	0	0	0	0	0	0	(9,707)	4
5	Heat and Other Utilities	0	615	0	0	0	0	0	0	0	0	0	615	5
6	Maintenance	0	8,032	27,183	0	0	0	0	0	0	0	0	35,215	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,147)	9,390	27,183	0	24,426	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	51	0	0	0	0	0	0	0	0	0	51	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	51	0	0	0	0	0	0	0	0	0	51	16
	C. General Administration													
17	Administrative	(141,021)	(219,481)	(41,455)	0	0	0	0	0	0	0	0	(401,957)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,677	0	0	0	0	0	0	0	0	0	17,677	19
20	Fees, Subscriptions & Promotions	0	2,890	0	0	0	0	0	0	0	0	0	2,890	20
21	Clerical & General Office Expenses	0	74	0	0	0	0	0	0	0	0	0	74	21
22	Employee Benefits & Payroll Taxes	0	8,503	12,500	0	0	0	0	0	0	0	0	21,003	22
23	Inservice Training & Education	0	1,261	0	0	0	0	0	0	0	0	0	1,261	23
24	Travel and Seminar	0	4,203	0	0	0	0	0	0	0	0	0	4,203	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	2,303	0	0	0	0	0	0	0	0	0	2,303	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(141,021)	(182,570)	(28,955)	0	(352,546)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(153,168)	(173,129)	(1,772)	0	(328,069)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER# 0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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	22,310	0	4,859	0	0	0	0	0	0	0	0	27,169	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,374)	0	1,042	0	0	0	0	0	0	0	0	(19,332)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	27,096	0	0	0	0	0	0	0	0	27,096	34
35	Rent-Equipment & Vehicles	0	0	883	0	0	0	0	0	0	0	0	883	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,936	0	33,880	0	35,816	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)	(151,232)	(173,129)	32,108	0	(292,253)	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%	\$ 743	\$	743	1
2	V	5 Utilities		Presence Life Connections	100.00%	615		615	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	8,032		8,032	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	51		51	4
5	V	17 Admin - Misc. Other	358,745	Presence Life Connections	100.00%	79		(358,666)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	139,185		139,185	6
7	V	19 Professional Services		Presence Life Connections	100.00%	17,677		17,677	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	2,890		2,890	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	74		74	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	8,503		8,503	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	1,261		1,261	11
12	V	24 Travel		Presence Life Connections	100.00%	4,203		4,203	12
13	V	26 Insurance		Presence Life Connections	100.00%	2,303		2,303	13
14	Total		\$ 358,745			\$ 185,616	\$ *	(173,129)	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%	\$ 4,799	\$ 4,799
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	27,096	27,096
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	883	883
19	V	17 Admin Salaries		Presence Health	100.00%	100,970	100,970
20	V	22 Employee Benefits		Presence Health	100.00%	12,500	12,500
21	V	30 Depreciation	37,715	Presence Health	100.00%	37,775	60
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	215,892	Presence Health	100.00%	60,005	(155,887)
24	V	17 Information Systems Salaries		Presence Health	100.00%	13,462	13,462
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%	27,183	27,183
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	33,121	Presence Health	100.00%	34,163	1,042
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	0	
32	V	39 Ancillary Services - Other	742,282	Presence Senior Services Pharmacy	100.00%	742,282	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,029,010			\$ 1,061,118	\$ * 32,108

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

Facility Name & ID Number

PRESENCE RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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 Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Sue 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 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	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 Estate	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENT # 0044354 Report Period Beginning: 1/01/18 Ending: 6/30/18

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 RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 1/01/18 Ending: 6/30/18

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	3,730,918	27	\$ 7,727	\$ 358,745	\$ 743	1	
2	5	Utilities	Management Fee Income	3,730,918	27	6,400	358,745	615	2	
3	6	Maintenance - Other	Management Fee Income	3,730,918	27	83,534	358,745	8,032	3	
4	11	Activities-Special Events	Management Fee Income	3,730,918	27	532	358,745	51	4	
5	17	Admin - Misc. Other	Management Fee Income	3,730,918	27	825	358,745	79	5	
6	17	Administrative Salaries	Management Fee Income	3,730,918	27	1,447,508	1,447,508	358,745	139,185	6
7	19	Professional Services	Management Fee Income	3,730,918	27	183,838	358,745	17,677	7	
8	20	Dues,Subscriptions	Management Fee Income	3,730,918	27	30,056	358,745	2,890	8	
9	21	Clerical Supplies	Management Fee Income	3,730,918	27	772	358,745	74	9	
10	22	Employee Benefits	Management Fee Income	3,730,918	27	88,426	358,745	8,503	10	
11	23	Education/Conference	Management Fee Income	3,730,918	27	13,119	358,745	1,261	11	
12	24	Travel	Management Fee Income	3,730,918	27	43,709	358,745	4,203	12	
13	26	Insurance	Management Fee Income	3,730,918	27	23,947	358,745	2,303	13	
14	30	Depreciation	Management Fee Income	3,730,918	27	49,905	358,745	4,799	14	
15	32	Interest	Management Fee Income	3,730,918	27	0	358,745	0	15	
16	34	Rent - Facility	Management Fee Income	3,730,918	27	281,793	358,745	27,096	16	
17	35	Rent - Equipment	Management Fee Income	3,730,918	27	9,183	358,745	883	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,271,274	\$ 1,447,508	\$ 218,394	25	

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending: 6/30/18

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	2,845,399	27	\$ 1,330,754	\$ 1,330,754	215,892	\$ 100,970	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		215,892	12,500	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		37,715	37,775	3
4	34	Rent Facility	Operating Expense	2,845,399	27			215,892		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		215,892	60,005	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	215,892	13,462	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			215,892		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			215,892		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			215,892		9
10	6	Information Systems - Equip Main	Operating Expense	2,845,399	27	358,267		215,892	27,183	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			215,892		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		33,121	34,163	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			215,892		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					\$ 4,024,190	\$ 1,508,174		\$ 286,058	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 1/01/18 Ending: 6/30/18

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 Senior Services Pharmacy
 Street Address 100 North River Road
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (847-410-4900
 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		\$	\$		\$ 742,282	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				\$	\$		\$ 742,282	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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																				
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

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 2017 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 2018 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:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE RESURRECTION LIFE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044354

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 2016 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 2016.

(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,000 B. General Construction Type: Exterior Brick/Concrete Frame 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. [X] (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).

Blank 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: 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, 281,600, 1996, \$ 3,600,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 281,600, (blank), \$ 3,600,000, 3.

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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	159	1998		\$ 11,729,482	\$ 83,304	40	\$ 63,814	\$ (19,490)	\$ 9,719,191
5									
6									
7									
8									
	Improvement Type**								
9	VARIOUS	1999		76,653	524	12		(524)	76,653
10	VARIOUS	2000		131,067		11			131,067
11	VARIOUS	2001		17,210		11			17,210
12	VARIOUS	2002		24,356	153	12	458	305	21,148
13	VARIOUS	2003		25,777	69	9	172	103	25,777
14	VARIOUS	2004		21,803	813	13	655	(159)	21,148
15	VARIOUS	2005		6,444		8			6,444
16	VARIOUS	2006		62,098	5	18	16	11	59,904
17	VARIOUS	2008		1,401	12	20	35	23	667
18	VARIOUS	2012		24,172	370		1,122	752	13,410
19									
20	LYNXSPRING TRIDIUM	2015		15,340	128	20	384	256	2,109
21									
22	PLUMBING DCW BOOSTER	2016		4,251	35	20	106	71	531
23									
24	ASPHALT NEW PARKING LOT	2017		46,043	1,726	10	2,302	576	2,686
25	FIRE PUMP & TRANSFER SWITCH	2017		27,650	230	20	691	461	1,959
26									
27	Annunciator panel	2018		13,311	202	20	202		202
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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)	\$ 12,227,058	\$ 87,571		\$ 69,957	\$ (17,614)	\$ 10,100,106	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,781,258	\$ 32,591	\$ 72,869	\$ 40,278	14	\$ 931,741	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,413,262	191	450	259	10	1,413,262	73
74	Home Office Allocation		42,574	42,574				74
75	TOTALS	\$ 3,194,520	\$ 75,356	\$ 115,893	\$ 40,537		\$ 2,345,003	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)	\$ 19,021,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,850	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,923	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,445,109	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								5
6								6
7	TOTAL				\$			7

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: \$ 18,154 Description: Nursing 5,834; Admin 10,575; Dietary 259; Environmental Services 54; Rehab 1,371; Spiritual 60; Home O
(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

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. _____/2018 \$ _____

13. _____/2019 \$ _____

14. _____/2020 \$ _____

* 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	7307	hrs	\$ 284,548		\$	7,307	\$ 284,548	1
2	Licensed Speech and Language Development Therapist	10a, 1	1301	hrs	55,915			1,301	55,915	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a, 1	8789	hrs	375,642			8,789	375,642	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			742,282		742,282	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Director</u>	10a, 1	1034		52,402			1,034	52,402	12
13	Other (specify): _____									13
14	TOTAL				\$ 768,507		\$ 742,282	18,431	\$ 1,510,789	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER

0044354

Report Period Beginning: 1/01/18

Ending:

6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/18

(last day of reporting year)

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	\$	\$ 6,532,327	1
2	Cash-Patient Deposits	5,279	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,651,930	19,421,139	3
4	Supply Inventory (priced at)	36,613	1,498,530	4
5	Short-Term Investments		122,907	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		153,437	7
8	Accounts Receivable (owners or related parties)		3,870,446	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,693,822	\$ 31,736,098	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	3,600,000	40,692,981	13
14	Buildings, at Historical Cost	12,227,058	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,194,520	5,809,806	16
17	Accumulated Depreciation (book methods)	(12,445,108)	(2,612,112)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		3,822	21
22	Other Long-Term Assets (specify):		2,756,878	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,576,470	\$ 146,086,133	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,270,292	\$ 177,822,231	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ (144,829)	\$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	330,928	20,902,273	28
29	Short-Term Notes Payable		581,779	29
30	Accrued Salaries Payable		3,490	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		298,218	32
33	Accrued Interest Payable		4,518	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Third Parties</u>		518,742	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 186,099	\$ 24,480,013	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		586,063	39
40	Mortgage Payable			40
41	Bonds Payable		40,821,612	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>			43
44	<u>General Reserve</u>		2,400,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 43,807,675	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 186,099	\$ 68,287,688	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,084,193	\$ 109,534,543	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,270,292	\$ 177,822,231	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 179,019,128	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	(170,006,394)	4
5	Adj to Rollback Consolidated Fixed Asset Re-valuation	(7,004,715)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,008,019	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,937,565	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	2,213,940	11
12	Expenditures for Specific Purposes	(75,331)	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)	\$ 6,076,174	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)	\$ 8,084,193	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PRESENCE RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 1/01/18

Ending: 6/30/18

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,397,444	1
2	Discounts and Allowances for all Levels	(3,099,751)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,297,693	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,954,295	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,954,295	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	2,440	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,085,915	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	9,707	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,098,062	23
D. Non-Operating Revenue			
24	Contributions	2,289,270	24
25	Interest and Other Investment Income***	20,374	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,309,644	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	19,594	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,679,288	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,182,260	31
32	Health Care	3,638,288	32
33	General Administration	1,805,028	33
B. Capital Expense			
34	Ownership	209,754	34
C. Ancillary Expense			
35	Special Cost Centers	742,282	35
36	Provider Participation Fee	164,111	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,741,723	40
41	Income before Income Taxes (line 30 minus line 40)**	3,937,565	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,937,565	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,532,242	44
45	Private Pay - Net Inpatient Revenue	2,147,060	45
46	Medicare - Net Inpatient Revenue	2,273,571	46
47	Other-(specify) <u>Insurance</u>	344,820	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,297,693	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 RESURRECTION LIFE CENTER**

0044354

Report Period Beginning:

1/01/18

Ending:

6/30/18

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	986	1,034	\$ 52,086	\$ 50.37	1
2	Assistant Director of Nursing	895	1,034	47,138	45.59	2
3	Registered Nurses	29,267	32,805	1,266,431	38.60	3
4	Licensed Practical Nurses	5,107	5,959	175,136	29.39	4
5	CNAs & Orderlies	52,254	57,884	880,793	15.22	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	17,210	18,431	768,506	41.70	7
8	Rehab/Therapy Aides	27	27	1,325	49.07	8
9	Activity Director	889	1,035	24,932	24.09	9
10	Activity Assistants	3,565	3,704	46,484	12.55	10
11	Social Service Workers	2,826	3,067	67,370	21.97	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	1,898	2,093	52,908	25.28	17
18	Housekeepers	6,303	6,874	86,712	12.61	18
19	Laundry	1,720	1,976	26,115	13.22	19
20	Administrator	858	1,034	86,510	83.67	20
21	Assistant Administrator	130	146	4,102	28.10	21
22	Other Administrative	886	1,042	22,297	21.40	22
23	Office Manager	931	1,049	24,530	23.38	23
24	Clerical	1,519	1,783	20,626	11.57	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	20	20	3,076	153.80	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	990	1,134	25,338	22.34	31
32	Other Health Care(specify)	1,878	2,096	49,450	23.59	32
33	Other(specify)	1,783	1,981	83,164	41.98	33
34	TOTAL (lines 1 - 33)	131,942	146,208	\$ 3,815,029 *	\$ 26.09	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			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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. 8107.5
- (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. \$ 30,674 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. \$ 164,111
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,440
- (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