



Facility Name & ID Number PRESENCE RESURRECTION NURSING AND REHAB CENTER

# 0044362 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	298	Skilled (SNF)	298	53,938	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	298	TOTALS	298	53,938	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	19,031	4,903	10,061	33,995	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,031	4,903	10,061	33,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.03%

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 03-26-98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 03-26-98 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 298 and days of care provided 7,420

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 NURSING A** # **0044362** 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
	<b>A. General Services</b>										
1	Dietary		45,487	487,845	533,332	533,332		533,332			1
2	Food Purchase		233,116		233,116	233,116	(788)	232,328			2
3	Housekeeping	179,180	39,776	118	219,074	219,074		219,074			3
4	Laundry	85,873	14,960	667	101,500	101,500	(6,804)	94,696			4
5	Heat and Other Utilities			208,824	208,824	208,824	670	209,494			5
6	Maintenance	54,402		121,209	175,611	175,611	47,208	222,819			6
7	Other (specify):* <b>Pastoral</b>	55,227	21	4,207	59,455	59,455		59,455			7
8	<b>TOTAL General Services</b>	374,682	333,360	822,870	1,530,912	1,530,912	40,286	1,571,198			8
	<b>B. Health Care and Programs</b>										
9	Medical Director	10,500		2,100	12,600	12,600		12,600			9
10	Nursing and Medical Records	3,349,244	237,209	68,609	3,655,062	3,655,062		3,655,062			10
10a	Therapy	909,434	10,866	2,335	922,635	922,635		922,635			10a
11	Activities	93,610	1,435	1,922	96,967	96,967	56	97,023			11
12	Social Services	78,346		16,770	95,116	95,116		95,116			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,441,134	249,510	91,736	4,782,380	4,782,380	56	4,782,436			16
	<b>C. General Administration</b>										
17	Administrative	255,988	13,463	695,978	965,429	965,429	(451,405)	514,024			17
18	Directors Fees										18
19	Professional Services			33,443	33,443	33,443	19,241	52,684			19
20	Dues, Fees, Subscriptions & Promotions			20,224	20,224	20,224	(884)	19,340			20
21	Clerical & General Office Expenses			9,661	9,661	9,661	81	9,742			21
22	Employee Benefits & Payroll Taxes			1,189,219	1,189,219	1,189,219	26,942	1,216,161			22
23	Inservice Training & Education			1,650	1,650	1,650	1,373	3,023			23
24	Travel and Seminar			81	81	81	4,575	4,656			24
25	Other Admin. Staff Transportation			956	956	956		956			25
26	Insurance-Prop.Liab.Malpractice			364,437	364,437	364,437	2,506	366,943			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	255,988	13,463	2,315,649	2,585,100	2,585,100	(397,571)	2,187,529			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,071,804	596,333	3,230,255	8,898,392	8,898,392	(357,229)	8,541,163			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	
	<b>D. Ownership</b>											
30	Depreciation			211,270	211,270		211,270	3,909	215,179			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,693	42,693		42,693	(28,866)	13,827			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							29,493	29,493			34
35	Rent-Equipment & Vehicles			20,995	20,995		20,995	961	21,956			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			274,958	274,958		274,958	5,497	280,455			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			915,873	915,873		915,873		915,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,567	245,567		245,567		245,567			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			1,161,440	1,161,440		1,161,440		1,161,440			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	5,071,804	596,333	4,666,653	10,334,790		10,334,790	(351,732)	9,983,058			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,597)	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	(6,804)	4		8
9	Non-Straightline Depreciation	(1,404)	30		9
10	Interest and Other Investment Income	(30,209)	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	(4,030)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (44,044)		\$	30

<b>BHF USE ONLY</b>							
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(153,844)	17	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (153,844)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (197,888)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
 PRESENCE RESURRECTION NURSING AND REHAB CENTER

ID# 0044362

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PRESENCE RESURRECTION NURSING AND REHAB CI

# 0044362

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	(1,597)	809	0	0	0	0	0	0	0	0	0	(788)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,804)	0	0	0	0	0	0	0	0	0	0	(6,804)	4
5	Heat and Other Utilities	0	670	0	0	0	0	0	0	0	0	0	670	5
6	Maintenance	0	8,743	38,465	0	0	0	0	0	0	0	0	47,208	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,401)</b>	<b>10,222</b>	<b>38,465</b>	<b>0</b>	<b>40,286</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	56	0	0	0	0	0	0	0	0	0	56	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>56</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>56</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(153,844)	(238,900)	(58,661)	0	0	0	0	0	0	0	0	(451,405)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,241	0	0	0	0	0	0	0	0	0	19,241	19
20	Fees, Subscriptions & Promotions	(4,030)	3,146	0	0	0	0	0	0	0	0	0	(884)	20
21	Clerical & General Office Expenses	0	81	0	0	0	0	0	0	0	0	0	81	21
22	Employee Benefits & Payroll Taxes	0	9,255	17,687	0	0	0	0	0	0	0	0	26,942	22
23	Inservice Training & Education	0	1,373	0	0	0	0	0	0	0	0	0	1,373	23
24	Travel and Seminar	0	4,575	0	0	0	0	0	0	0	0	0	4,575	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	2,506	0	0	0	0	0	0	0	0	0	2,506	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(157,874)</b>	<b>(198,723)</b>	<b>(40,974)</b>	<b>0</b>	<b>(397,571)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(166,275)</b>	<b>(188,445)</b>	<b>(2,509)</b>	<b>0</b>	<b>(357,229)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE RESURRECTION NURSING AND REHAB C # 0044362 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,404)	0	5,313	0	0	0	0	0	0	0	0	3,909	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,209)	0	1,343	0	0	0	0	0	0	0	0	(28,866)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	29,493	0	0	0	0	0	0	0	0	29,493	34
35	Rent-Equipment & Vehicles	0	0	961	0	0	0	0	0	0	0	0	961	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(31,613)</b>	<b>0</b>	<b>37,110</b>	<b>0</b>	<b>5,497</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>(197,888)</b>	<b>(188,445)</b>	<b>34,601</b>	<b>0</b>	<b>(351,732)</b>	<b>45</b>							

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 809	\$	809	1
2	V	5 Utilities		Presence Life Connections	100.00%	670		670	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	8,743		8,743	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	56		56	4
5	V	17 Admin - Misc. Other	390,485	Presence Life Connections	100.00%	86		(390,399)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	151,499		151,499	6
7	V	19 Professional Services		Presence Life Connections	100.00%	19,241		19,241	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	3,146		3,146	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	81		81	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	9,255		9,255	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	1,373		1,373	11
12	V	24 Travel		Presence Life Connections	100.00%	4,575		4,575	12
13	V	26 Insurance		Presence Life Connections	100.00%	2,506		2,506	13
14	Total		\$ 390,485			\$ 202,040	\$ *	(188,445)	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%	\$ 5,223	\$ 5,223
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	29,493	29,493
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	961	961
19	V	17 Admin Salaries		Presence Health	100.00%	142,875	142,875
20	V	22 Employee Benefits		Presence Health	100.00%	17,687	17,687
21	V	30 Depreciation	56,059	Presence Health	100.00%	56,149	90
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	305,493	Presence Health	100.00%	84,909	(220,584)
24	V	17 Information Systems Salaries		Presence Health	100.00%	19,048	19,048
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%	38,465	38,465
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	42,693	Presence Health	100.00%	44,036	1,343
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	0	
32	V	39 Ancillary Services - Other	915,873	Presence Senior Services Pharmacy	100.00%	915,873	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,320,118			\$ 1,354,719	\$ * 34,601

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

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 Life Center	Chicago	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 NURSING # 0044362 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 NURSING AND REHAB ( # 0044362 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 3,730,918	27	\$ 7,727	\$	390,485	\$ 809	1
2	5	Utilities	Management Fee Income 3,730,918	27	6,400		390,485	670	2
3	6	Maintenance - Other	Management Fee Income 3,730,918	27	83,534		390,485	8,743	3
4	11	Activities-Special Events	Management Fee Income 3,730,918	27	532		390,485	56	4
5	17	Admin - Misc. Other	Management Fee Income 3,730,918	27	825		390,485	86	5
6	17	Administrative Salaries	Management Fee Income 3,730,918	27	1,447,508	1,447,508	390,485	151,499	6
7	19	Professional Services	Management Fee Income 3,730,918	27	183,838		390,485	19,241	7
8	20	Dues,Subscriptions	Management Fee Income 3,730,918	27	30,056		390,485	3,146	8
9	21	Clerical Supplies	Management Fee Income 3,730,918	27	772		390,485	81	9
10	22	Employee Benefits	Management Fee Income 3,730,918	27	88,426		390,485	9,255	10
11	23	Education/Conference	Management Fee Income 3,730,918	27	13,119		390,485	1,373	11
12	24	Travel	Management Fee Income 3,730,918	27	43,709		390,485	4,575	12
13	26	Insurance	Management Fee Income 3,730,918	27	23,947		390,485	2,506	13
14	30	Depreciation	Management Fee Income 3,730,918	27	49,905		390,485	5,223	14
15	32	Interest	Management Fee Income 3,730,918	27	0		390,485	0	15
16	34	Rent - Facility	Management Fee Income 3,730,918	27	281,793		390,485	29,493	16
17	35	Rent - Equipment	Management Fee Income 3,730,918	27	9,183		390,485	961	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,271,274	\$ 1,447,508		\$ 237,717	25

Facility Name & ID Number PRESENCE RESURRECTION NURSING AND REHAB C # 0044362 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

Name of Related Organization Presence Health  
 Street Address 100 North River Road  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number ( 815-806-2327  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	2,845,399	27	\$ 1,330,754	\$ 1,330,754	305,493	\$ 142,875	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		305,493	17,687	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		56,059	56,149	3
4	34	Rent Facility	Operating Expense	2,845,399	27			305,493		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		305,493	84,909	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	305,493	19,048	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			305,493		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			305,493		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			305,493		9
10	6	Information Systems - Equip Main	Operating Expense	2,845,399	27	358,267		305,493	38,465	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			305,493		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		42,693	44,036	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			305,493		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		\$ 403,169	25

Facility Name & ID Number PRESENCE RESURRECTION NURSING AND REHAB ( # 0044362 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 DesPlaines, 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		\$	\$		\$ 915,873	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				\$	\$		\$ 915,873	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>																			
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>																			
15	<b>TOTALS (line 9+line14)</b>																			

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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			<b>FOR BHF USE ONLY</b>
	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 NURSING AND REHAB C COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044362

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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior BRICK & BLOCK Frame STEEL Number of Stories 3+GROUND

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: N/A 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 126,500, 1983, \$ 580,293, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 126,500, (blank), \$ 580,293, 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	298		1983	\$ 6,273,000	\$ 81,852	30	\$	\$(81,852)	\$ 6,273,000	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1983	4,300		20			4,300	9
10	VARIOUS		1984	3,546		20			3,546	10
11	VARIOUS		1987	6,400		10			6,400	11
12	VARIOUS		1989	2,730		12			2,730	12
13	VARIOUS		1990	111,676		16			111,676	13
14	VARIOUS		1991	37,261		18			37,261	14
15	VARIOUS		1992	79,585		14			79,585	15
16	VARIOUS		1993	105,120		16			105,120	16
17	VARIOUS		1994	220,823		13			220,823	17
18	VARIOUS		1995	536,887		11			536,887	18
19	VARIOUS		1996	98,018	476	11		(476)	98,018	19
20	VARIOUS		1997	1,117,276	5,000	13		(5,000)	1,117,276	20
21	VARIOUS		1998	66,417		12			66,417	21
22	VARIOUS		1999	2,005		15			2,005	22
23	VARIOUS		2000	315,247		15			315,247	23
24	VARIOUS		2001	1,281,785		15			1,281,785	24
25	VARIOUS		2002	15,604		13			15,604	25
26	VARIOUS		2003	8,285	19	13	52	33	8,253	26
27	VARIOUS		2005	7,780		9			7,780	27
28	VARIOUS		2006	117,071	1,060	11	995	(65)	103,224	28
29	VARIOUS		2007	33,690	221	15	640	419	26,986	29
30	VARIOUS		2012	553,118	7,405	15	18,281	10,876	219,061	30
31	VARIOUS		2013	736,166	8,233	15	24,539	16,306	246,137	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CONSTRUCTION TO REPLACE FLOORING FOR 1 A WING 3	2014	\$ 95,931	\$ 787	20	\$ 2,398	\$ 1,611	\$ 19,015	37
38	CONSTRUCTION OF MOCK DIALYSIS ROOM IN BASEMEN	2015	46,197	385	20	1,155	770	7,507	38
39	CONSTRUCTION TO EXPAND HALLWAYS TO 1 A WING 3 H	2015	48,016	390	20	1,200	810	9,458	39
40	ASPHALT OVERLAY OF PARKING LOT	2015	68,372	2,568	10	3,419	851	18,802	40
41	3RD FLOOR LCD DUTY STATION CALL LIGHT	2016	68,020	756	15	2,267	1,511	11,337	41
42	NEW FAN COIL	2016	47,500	396	20	1,188	792	5,938	42
43									43
44	NEW HOT WATER BOLIER	2017	289,340	2,562	25	6,019	3,456	8,981	44
45	ELVATOR CYLINDER	2017	32,275	268	20	806	538	1,614	45
46	ASPHALT & CONCRETE - Sidewalk & Parking Lot Bonaventur	2017	16,444	618	10	822	204	959	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)		\$ 12,445,885	\$ 112,996		\$ 63,781	\$ (49,215)	\$ 10,972,731	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	\$ 2,087,188	\$ 40,062	\$ 85,758	\$ 45,696	13	\$ 1,267,605	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,368,418	2,153	4,268	2,115	9	1,368,418	73
74	Home Office Allocation		61,372	61,372				74
75	TOTALS	\$ 3,455,606	\$ 103,587	\$ 151,398	\$ 47,811		\$ 2,636,023	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)	\$ 16,481,784	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 216,583	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 215,179	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,404)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,608,754	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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 20,995 Description: Nursing 2,084; Admin 18,912; Home Office

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a, 1	8487	hrs	\$ 336,826		\$	\$	8,487	\$ 336,826	1
2	Licensed Speech and Language Development Therapist	10a, 1	1160	hrs	49,896				1,160	49,896	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	11496	hrs	470,622				11,496	470,622	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				915,873		915,873	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		52,090				1,034	52,090	12
13	Other (specify): _____										13
14	<b>TOTAL</b>				\$ 909,434		\$	\$ 915,873	22,177	\$ 1,825,307	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 NURSING AND REHAB C# 0044362** 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 6,532,327	1
2	Cash-Patient Deposits	26,473	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,438,243	19,421,139	3
4	Supply Inventory (priced at )	48,554	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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,513,270	\$ 31,736,098	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	580,293	40,692,981	13
14	Buildings, at Historical Cost	12,445,884	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,455,606	5,809,806	16
17	Accumulated Depreciation (book methods)	(13,608,753)	(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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,873,030	\$ 146,086,133	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,386,300	\$ 177,822,231	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ (216,445)	\$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	394,913	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Third Parties</u>		518,742	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 178,468	\$ 24,480,013	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		586,063	39
40	Mortgage Payable			40
41	Bonds Payable		40,821,612	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>			43
44	<u>General Reserve</u>		2,400,000	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 43,807,675	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 178,468	\$ 68,287,688	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,207,832	\$ 109,534,543	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,386,300	\$ 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	(167,171,878)	4
5	Adj to Rollback Consolidated Fixed Asset Re-valuation	(6,860,183)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,987,067	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	220,765	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		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)	\$ 220,765	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,207,832	24 *

\* This must agree with page 17, line 47.

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

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

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,115,946	1
2	Discounts and Allowances for all Levels	(3,302,195)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,813,751	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,331,422	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,331,422	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,597	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,368,901	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	6,804	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,377,302	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	30,209	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30,209	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	2,871	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,871	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,555,555	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,530,912	31
32	Health Care	4,782,380	32
33	General Administration	2,585,100	33
<b>B. Capital Expense</b>			
34	Ownership	274,958	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	915,873	35
36	Provider Participation Fee	245,567	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,334,790	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	220,765	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 220,765	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,930,613	44
45	Private Pay - Net Inpatient Revenue	1,199,068	45
46	Medicare - Net Inpatient Revenue	2,118,434	46
47	Other-(specify) <u>Insurance</u>	565,636	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,813,751	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 NURSING AND REHAB C**

# **0044362**

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	893	1,037	\$ 55,890	\$ 53.90	1
2	Assistant Director of Nursing	922	1,034	51,215	49.53	2
3	Registered Nurses	46,859	51,757	2,009,336	38.82	3
4	Licensed Practical Nurses	1,750	2,004	53,304	26.60	4
5	CNAs & Orderlies	60,357	67,093	1,048,682	15.63	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	20,210	22,177	909,434	41.01	7
8	Rehab/Therapy Aides	2	2	94	47.00	8
9	Activity Director	864	1,003	34,548	34.44	9
10	Activity Assistants	4,022	4,528	59,062	13.04	10
11	Social Service Workers	3,592	3,754	78,346	20.87	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	1,946	2,425	55,604	22.93	17
18	Housekeepers	10,595	12,184	179,180	14.71	18
19	Laundry	6,066	6,752	85,873	12.72	19
20	Administrator	854	1,034	71,673	69.32	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,229	1,361	29,860	21.94	22
23	Office Manager	918	1,036	22,450	21.67	23
24	Clerical	5,838	6,611	108,536	16.42	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	180	180	30,329	168.49	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	1,962	2,065	44,185	21.40	31
32	Other Health Care(specify)	3,710	4,110	88,976	21.65	32
33	Other(specify)	1,894	2,140	55,227	25.81	33
34	TOTAL (lines 1 - 33)	174,663	194,287	\$ 5,071,804 *	\$ 26.10	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	2,100	9,3	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	257	10,577	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	257	\$ 12,677		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	0	0	10,3	52
53	TOTAL (lines 50 - 52)		\$		53



Facility Name &amp; ID Number PRESENCE RESURRECTION NURSING AND REHAB CENTER

# 0044362

Report Period Beginning:

1/01/18

Ending: 6/30/18

**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. 10910
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47,460 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. \$ 245,567  
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. \$ 1,597
- (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