

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861 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	154	Skilled (SNF)	154	27,874	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	154	TOTALS	154	27,874	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	6,244	2,823	10,601	19,668	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,244	2,823	10,601	19,668	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.56%

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 09-01-90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12-01-97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 154 and days of care provided 7,958

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 VILLA FRANCISCAN # 0042861 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		577	354,963	355,540	355,540		355,540			1
2	Food Purchase		133,818		133,818	133,818	(936)	132,882			2
3	Housekeeping	117,705	606		118,311	118,311		118,311			3
4	Laundry	12,756		52,985	65,741	65,741		65,741			4
5	Heat and Other Utilities			138,347	138,347	138,347	463	138,810			5
6	Maintenance	75,235	23,412	59,751	158,398	158,398	32,638	191,036			6
7	Other (specify):* Pastoral	24,633		1,583	26,216	26,216		26,216			7
8	TOTAL General Services	230,329	158,413	607,629	996,371	996,371	32,165	1,028,536			8
	B. Health Care and Programs										
9	Medical Director	9,857		9,000	18,857	18,857		18,857			9
10	Nursing and Medical Records	2,148,483	348,272	284,142	2,780,897	2,780,897		2,780,897			10
10a	Therapy	859,873	11,583	6,028	877,484	877,484		877,484			10a
11	Activities	74,897	3,735	16,470	95,102	95,102	38	95,140			11
12	Social Services	66,250	1,700	1,876	69,826	69,826		69,826			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,159,360	365,290	317,516	3,842,166	3,842,166	38	3,842,204			16
	C. General Administration										
17	Administrative	186,280	16,394	481,047	683,721	683,721	(205,632)	478,089			17
18	Directors Fees										18
19	Professional Services			17,168	17,168	17,168	13,295	30,463			19
20	Dues, Fees, Subscriptions & Promotions			19,016	19,016	19,016	683	19,699			20
21	Clerical & General Office Expenses			24,430	24,430	24,430	56	24,486			21
22	Employee Benefits & Payroll Taxes			873,780	873,780	873,780	18,625	892,405			22
23	Inservice Training & Education			2,872	2,872	2,872	949	3,821			23
24	Travel and Seminar						3,161	3,161			24
25	Other Admin. Staff Transportation			126	126	126		126			25
26	Insurance-Prop.Liab.Malpractice			234,063	234,063	234,063	1,732	235,795			26
27	Other (specify):*										27
28	TOTAL General Administration	186,280	16,394	1,652,502	1,855,176	1,855,176	(167,131)	1,688,045			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,575,969	540,097	2,577,647	6,693,713	6,693,713	(134,928)	6,558,785			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			135,760	135,760		135,760	60,387	196,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,032	37,032		37,032	(26,525)	10,507			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							20,379	20,379			34
35	Rent-Equipment & Vehicles			78,979	78,979		78,979	664	79,643			35
36	Other (specify):*											36
37	TOTAL Ownership			251,771	251,771		251,771	54,905	306,676			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			984,027	984,027		984,027		984,027			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,377	117,377		117,377		117,377			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,101,404	1,101,404		1,101,404		1,101,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,575,969	540,097	3,930,822	8,046,888		8,046,888	(80,023)	7,966,865			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,495)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	56,713	30		9
10	Interest and Other Investment Income	(27,690)	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	(1,491)	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)	\$ 26,037		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 26,037		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

ID# 0042861

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 VILLA FRANCISCAN

0042861

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	(1,495)	559	0	0	0	0	0	0	0	0	0	(936)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	463	0	0	0	0	0	0	0	0	0	463	5
6	Maintenance	0	6,041	26,597	0	0	0	0	0	0	0	0	32,638	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,495)	7,063	26,597	0	32,165	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	38	0	0	0	0	0	0	0	0	0	38	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	38	0	0	0	0	0	0	0	0	0	38	16
	C. General Administration													
17	Administrative	0	(165,071)	(40,561)	0	0	0	0	0	0	0	0	(205,632)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,295	0	0	0	0	0	0	0	0	0	13,295	19
20	Fees, Subscriptions & Promotions	(1,491)	2,174	0	0	0	0	0	0	0	0	0	683	20
21	Clerical & General Office Expenses	0	56	0	0	0	0	0	0	0	0	0	56	21
22	Employee Benefits & Payroll Taxes	0	6,395	12,230	0	0	0	0	0	0	0	0	18,625	22
23	Inservice Training & Education	0	949	0	0	0	0	0	0	0	0	0	949	23
24	Travel and Seminar	0	3,161	0	0	0	0	0	0	0	0	0	3,161	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,732	0	0	0	0	0	0	0	0	0	1,732	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,491)	(137,309)	(28,331)	0	(167,131)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,986)	(130,208)	(1,734)	0	(134,928)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE VILLA FRANCISCAN # 0042861 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	56,713	0	3,674	0	0	0	0	0	0	0	0	60,387	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(27,690)	0	1,165	0	0	0	0	0	0	0	0	(26,525)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	20,379	0	0	0	0	0	0	0	0	20,379	34
35	Rent-Equipment & Vehicles	0	0	664	0	0	0	0	0	0	0	0	664	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	29,023	0	25,882	0	54,905	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)	26,037	(130,208)	24,148	0	(80,023)	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 Heritage Village	Kankakee	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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%	\$ 559	\$	559	1
2	V	5 Utilities		Presence Life Connections	100.00%	463		463	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	6,041		6,041	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	38		38	4
5	V	17 Admin - Misc. Other	269,812	Presence Life Connections	100.00%	60		(269,752)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	104,681		104,681	6
7	V	19 Professional Services		Presence Life Connections	100.00%	13,295		13,295	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	2,174		2,174	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	56		56	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	6,395		6,395	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	949		949	11
12	V	24 Travel		Presence Life Connections	100.00%	3,161		3,161	12
13	V	26 Insurance		Presence Life Connections	100.00%	1,732		1,732	13
14	Total		\$ 269,812			\$ 139,604	\$ *	(130,208)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 3,609	\$	3,609	15
16	V	32 Interest		Presence Life Connections	100.00%	0			16
17	V	34 Rent - Facility		Presence Life Connections	100.00%	20,379		20,379	17
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	664		664	18
19	V	17 Admin Salaries		Presence Health	100.00%	98,792		98,792	19
20	V	22 Employee Benefits		Presence Health	100.00%	12,230		12,230	20
21	V	30 Depreciation	40,397	Presence Health	100.00%	40,462		65	21
22	V	34 Rent Facility		Presence Health	100.00%	0			22
23	V	17 Admin Consulting,Other	211,235	Presence Health	100.00%	58,711		(152,524)	23
24	V	17 Information Systems Salaries		Presence Health	100.00%	13,171		13,171	24
25	V	17 Information Systems - Other		Presence Health	100.00%	0			25
26	V	17 Admin Salaries		Presence Health	100.00%	0			26
27	V	17 Information Systems Salaries		Presence Health	100.00%	0			27
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	26,597		26,597	28
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0			29
30	V	32 Admin - Interest Expense	37,032	Presence Health	100.00%	38,197		1,165	30
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	0			31
32	V	39 Ancillary Services - Other	984,027	Presence Senior Services Pharmacy	100.00%	984,027			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,272,691			\$ 1,296,839	\$ *	24,148	39

* 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 Maryhaven Nursing & Rehab Center	Glenview	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Nazarethville	Des Plaines	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Wendell Provost	BOD	Presence Resurrection Life Center	Chicago	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Life Connect	Mokena	Management Comp	4
5			Presence St Benedict Nursing & Rehab Center	Niles	Presence Senior Service	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 VILLA FRANCISCAN # 0042861 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 VILLA FRANCISCAN

0042861

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	\$	269,812	\$ 559	1
2	5	Utilities	Management Fee Income 3,730,918	27	6,400		269,812	463	2
3	6	Maintenance - Other	Management Fee Income 3,730,918	27	83,534		269,812	6,041	3
4	11	Activities-Special Events	Management Fee Income 3,730,918	27	532		269,812	38	4
5	17	Admin - Misc. Other	Management Fee Income 3,730,918	27	825		269,812	60	5
6	17	Administrative Salaries	Management Fee Income 3,730,918	27	1,447,508	1,447,508	269,812	104,681	6
7	19	Professional Services	Management Fee Income 3,730,918	27	183,838		269,812	13,295	7
8	20	Dues,Subscriptions	Management Fee Income 3,730,918	27	30,056		269,812	2,174	8
9	21	Clerical Supplies	Management Fee Income 3,730,918	27	772		269,812	56	9
10	22	Employee Benefits	Management Fee Income 3,730,918	27	88,426		269,812	6,395	10
11	23	Education/Conference	Management Fee Income 3,730,918	27	13,119		269,812	949	11
12	24	Travel	Management Fee Income 3,730,918	27	43,709		269,812	3,161	12
13	26	Insurance	Management Fee Income 3,730,918	27	23,947		269,812	1,732	13
14	30	Depreciation	Management Fee Income 3,730,918	27	49,905		269,812	3,609	14
15	32	Interest	Management Fee Income 3,730,918	27	0		269,812	0	15
16	34	Rent - Facility	Management Fee Income 3,730,918	27	281,793		269,812	20,379	16
17	35	Rent - Equipment	Management Fee Income 3,730,918	27	9,183		269,812	664	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,271,274	\$ 1,447,508		\$ 164,256	25

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

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	211,235	\$ 98,792	1
2	22	Employee Benefits	Operating Expense	2,845,399	27	164,743		211,235	12,230	2
3	30	Depreciation	Direct Cost	539,434	27	540,297		40,397	40,462	3
4	34	Rent Facility	Operating Expense	2,845,399	27			211,235		4
5	17	Admin Consulting,Other	Operating Expense	2,845,399	27	790,856		211,235	58,711	5
6	17	Information Systems Salaries	Operating Expense	2,845,399	27	177,420	177,420	211,235	13,171	6
7	17	Information Systems - Other	Operating Expense	2,845,399	27			211,235		7
8	17	Admin Salaries	Operating Expense	2,845,399	27			211,235		8
9	17	Information Systems Salaries	Operating Expense	2,845,399	27			211,235		9
10	6	Information Systems - Equip Main	Operating Expense	2,845,399	27	358,267		211,235	26,597	10
11	17	Admin Consulting,Other	Operating Expense	2,845,399	27			211,235		11
12	32	Admin - Interest Expense	Direct Cost	641,674	27	661,853		37,032	38,197	12
13	17	Admin Int Inc Offset	Operating Expense	2,845,399	27			211,235		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		\$ 288,160	25

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

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 670 North Convent Street
 City / State / Zip Code Bourbonnais, Illinois 60914
 Phone Number (815)936-3644
 Fax Number (815)936-3238

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		\$	\$		\$ 984,027	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				\$	\$		\$ 984,027	25

Facility Name & ID Number

PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

1/01/18

Ending:

6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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 VILLA FRANCISCAN COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0042861

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		\$ <u> </u>	\$ <u> </u>

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 VILLA FRANCISCAN

0042861 Report Period Beginning:

1/01/18 Ending:

6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick 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, 1990, \$ 285,994, 1. Row 2: (blank), 2. Row 3: TOTALS, 1,990, \$ 285,994, 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	154		1990	1990	\$ 6,475,673	\$ 36,920	30	\$ 17,699	\$ (19,221)	\$ 5,784,346	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1992		29,187		20			29,187	9
10	VARIOUS		1993		6,242		20			6,242	10
11	VARIOUS		1994		21,786		20			21,786	11
12	VARIOUS		1995		79,452	299	17	1,063	765	66,777	12
13	VARIOUS		1996		41,526		10			41,526	13
14	VARIOUS		1997		17,775		10			17,775	14
15	VARIOUS		1998		9,029		5			9,029	15
16	VARIOUS		1999		4,936		7			4,936	16
17	VARIOUS		2000		53,879		6			53,879	17
18	VARIOUS		2001		8,708		5			8,708	18
19	VARIOUS		2002		3,150		10			3,150	19
20	VARIOUS		2003		23,864	30	11	96	66	23,454	20
21	VARIOUS		2004		136,435	1,111	11	3,467	2,356	125,012	21
22	VARIOUS		2005		45,815	64	11	200	136	44,984	22
23	VARIOUS		2006		596,144	2,387	13	7,203	4,816	283,920	23
24	VARIOUS		2007		98,492	1,038	13	3,195	2,157	72,557	24
25	VARIOUS		2008		11,614	153	13	370	217	8,743	25
26	VARIOUS		2009		100,683	1,274	15	4,099	2,825	72,486	26
27	VARIOUS		2010		180,957	2,229	11	6,829	4,600	130,706	27
28	VARIOUS		2011		119,924	1,890	12	5,761	3,871	80,222	28
29	VARIOUS		2012		85,350	726	20	2,134	1,408	25,806	29
30	ARCHITECT SERVICES CONVERT SEM		2014		278,934	1,162	40	3,487	2,324	27,893	30
31	BOILER		2014		9,600	107	15	320	213	2,560	31
32	CONSTRUCTION CONVERT SEMI PRIV		2014		2,829,183	11,788	40	35,365	23,577	282,918	32
33	IDPH PLAN REVIEW CONVERT SEMI		2014		9,600	40	40	120	80	960	33
34	RECEPTION CASEWORK CABINET BUI		2014		16,290	187	15	543	356	4,423	34
35	SITE SURVEY CONVERT SEMI PRIVA		2014		950	4	40	12	8	95	35
36	SUBSURFACE GEOTECHNICAL ENGINE		2014		11,540	48	40	144	96	1,154	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 VILLA FRANCISCAN

0042861

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DOOR RESTRICTOR FOR ELEVATOR	2015	\$ 6,032	\$ 50	20	\$ 151	\$ 101	\$ 1,030	37
38	GENERATOR	2015	3,481	23	25	70	47	429	38
39	SOLID STATE STARTER FOR ELEVAT	2015	7,813	65	20	195	130	1,335	39
40	WATER HEATER	2015	5,928	99	10	296	197	1,828	40
41	COMMODES	2015	1,206	19	10	60	41	467	41
42									42
43	CONSTRUCTN CNVRT SEMI TO PVT - Flooring, Walls, Showe	2016	75,361	837	15	2,512	1,675	10,048	43
44	ROOF REPLACEMENT	2016	98,236	819	20	2,456	1,637	12,280	44
45	New wall/corner protection - Cambridge Unit	2016	14,921	124	20	373	249	1,865	45
46	INTERIOR PAINTING - Domiano & Cambridge Units	2016	6,000	100	10	300	200	1,500	46
47	New wall and corner protection - Domiano Unit	2016	7,290	61	20	182	121	911	47
48	Carpet and tile replacement - Domiano Units & Bathrooms	2016	12,986	216	10	649	433	2,381	48
49	PROVIDE/INSTALL TEKNOFLOR - Domiano Unit	2016	11,193	93	20	280	187	1,399	49
50	DIELECTRIC UNION REPLACEMENT - Domiano Unit Bathro	2016	28,000	233	20	700	467	3,500	50
51	SIDEWALK/ PARKING LOT REPAIR,	2016	10,314	86	20	258	172	1,289	51
52									52
53	CHILLER	2017	164,712	1,373	20	4,118	2,745	7,549	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)		\$ 11,760,192	\$ 65,654		\$ 104,707	\$ 39,053	\$ 7,283,045	70

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

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

Report Period Beginning:

1/01/18

Ending:

6/30/18

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	\$ 1,053,362	\$ 28,379	\$ 45,160	\$ 16,781	13	\$ 616,611	71
72	Current Year Purchases	15,170	506	505	(1)	10	505	72
73	Fully Depreciated Assets	1,088,912	823	1,704	881	8	1,088,912	73
74	Home Office Allocation		44,071	44,071				74
75	TOTALS	\$ 2,157,444	\$ 73,779	\$ 91,440	\$ 17,661		\$ 1,706,028	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)	\$ 14,203,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 196,147	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56,714	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,989,073	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: \$ 78,979 Description: Nursing 70,894; Admin 7,053; Dietary 1,032; Home Office

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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	9305 hrs	\$ 352,115		\$	\$	9,305	\$ 352,115	1
2	Licensed Speech and Language Development Therapist	10a, 1	976 hrs	43,429				976	43,429	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	10243 hrs	413,407				10,243	413,407	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				984,027		984,027	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	50,922				1,034	50,922	12
13	Other (specify): _____									13
14	TOTAL			\$ 859,873		\$	\$ 984,027	21,558	\$ 1,843,900	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.

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	1,296	137,312	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,836,985	19,421,139	3
4	Supply Inventory (priced at)	20,390	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)	\$ 1,858,671	\$ 31,736,098	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		11,625,810	12
13	Land	285,994	40,692,981	13
14	Buildings, at Historical Cost	11,760,192	87,808,948	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,157,444	5,809,806	16
17	Accumulated Depreciation (book methods)	(8,989,075)	(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)	\$ 5,214,555	\$ 146,086,133	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,073,226	\$ 177,822,231	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (326,208)	\$ 2,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	380,569	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	Due to Third Parties		518,742	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 54,361	\$ 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	Conditional Asset Retirement			43
44	General Reserve		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)	\$ 54,361	\$ 68,287,688	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,018,865	\$ 109,534,543	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,073,226	\$ 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	(173,169,472)	4
5	Adj to Rollback Consolidated Fixed Asset Re-valuation	1,982,234	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,831,890	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(813,100)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	75	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)	\$ (813,025)	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)	\$ 7,018,865	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,880,102	1
2	Discounts and Allowances for all Levels	(2,138,086)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,742,016	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,107,189	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,107,189	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,495	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,364,975	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,366,470	23
D. Non-Operating Revenue			
24	Contributions	75	24
25	Interest and Other Investment Income***	27,690	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,765	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(9,652)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (9,652)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,233,788	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	996,371	31
32	Health Care	3,842,166	32
33	General Administration	1,855,176	33
B. Capital Expense			
34	Ownership	251,771	34
C. Ancillary Expense			
35	Special Cost Centers	984,027	35
36	Provider Participation Fee	117,377	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,046,888	40
41	Income before Income Taxes (line 30 minus line 40)**	(813,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (813,100)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,019,690	44
45	Private Pay - Net Inpatient Revenue	346,532	45
46	Medicare - Net Inpatient Revenue	1,828,286	46
47	Other-(specify)	547,508	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,742,016	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 VILLA FRANCISCAN**

0042861

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	434	558	\$ 32,662	\$ 58.53	1
2	Assistant Director of Nursing	933	1,041	40,803	39.20	2
3	Registered Nurses	32,708	34,869	1,273,059	36.51	3
4	Licensed Practical Nurses	3,258	3,677	109,851	29.88	4
5	CNAs & Orderlies	41,943	44,899	649,575	14.47	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	18,975	21,558	859,873	39.89	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	921	1,029	20,074	19.51	9
10	Activity Assistants	3,757	4,003	53,786	13.44	10
11	Social Service Workers	2,511	3,099	64,403	20.78	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,759	4,208	75,235	17.88	17
18	Housekeepers	8,970	9,651	117,705	12.20	18
19	Laundry	989	1,022	12,756	12.48	19
20	Administrator	903	1,034	69,831	67.53	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,809	2,066	39,758	19.24	23
24	Clerical	3,085	3,217	47,083	14.64	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	100	100	19,940	199.40	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	958	1,019	17,003	16.69	31
32	Other Health C: Admissions	2,446	2,693	47,939	17.80	32
33	Other(specify) Pastoral	978	1,034	24,633	23.82	33
34	TOTAL (lines 1 - 33)	129,437	140,777	\$ 3,575,969 *	\$ 25.40	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	9,000	9,3	36
37	Medical Records Consultant	17	1,229	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,302	11,3	44
45	Social Service Consultant	28	1,876	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 13,407		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	655	\$ 42,854	10,3	50
51	Licensed Practical Nurses	1,157	49,735	10,3	51
52	Certified Nurse Assistants/Aides	1,983	47,091	10,3	52
53	TOTAL (lines 50 - 52)	3,795	\$ 139,680		53

Facility Name & ID Number PRESENCE VILLA FRANCISCAN

0042861

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. 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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,227 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. \$ 117,377
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. \$ 1,495
- (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