

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0044768</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>PRESENCE MARYHAVEN NSG & REH</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1700 EAST LAKE AVE</u> <u>GLENVIEW</u> <u>60025</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>847-729-1300</u> Fax # <u>847-729-9620</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MICHAEL R. GORDON</u></td></tr><tr><td>(Title) <u>CFO, VICE PRESIDENT OF FINANCE</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL R. GORDON</u>	(Title) <u>CFO, VICE PRESIDENT OF FINANCE</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>											
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	(Type or Print Name) <u>MICHAEL R. GORDON</u>																								
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Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>03-01-00</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501C3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501C3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>GEORGE VIEU</u> Telephone Number: <u>708-478-7943</u>																									
Email Address: _____																									

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	135	Skilled (SNF)	135	49,410	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	135	TOTALS	135	49,410	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,590	13,453	8,122	38,165	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,590	13,453	8,122	38,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.24%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO X

I. On what date did you start providing long term care at this location?
Date started 03-01-00

J. Was the facility purchased or leased after January 1, 1978?
YES X Date 03-01-00 NO

K. Was the facility certified for Medicare during the reporting year?
YES X NO If YES, enter number of beds certified 135 and days of care provided 5,948

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		12,213	640,247	652,460		652,460		652,460			1
2	Food Purchase		217,333		217,333		217,333	(668)	216,665			2
3	Housekeeping	159,449	36,844	6,615	202,908		202,908		202,908			3
4	Laundry	87,247	17,970		105,217		105,217	(50,554)	54,663			4
5	Heat and Other Utilities			169,461	169,461		169,461	2,789	172,250			5
6	Maintenance	100,995	63,474	111,670	276,139		276,139	9,383	285,522			6
7	Other (specify):* Pastoral	43,664	487	7,275	51,426		51,426		51,426			7
8	TOTAL General Services	391,355	348,321	935,268	1,674,944		1,674,944	(39,050)	1,635,894			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,378,562	147,968	96,588	3,623,118		3,623,118		3,623,118			10
10a	Therapy	915,292	8,312	35,877	959,481		959,481		959,481			10a
11	Activities	113,714	6,552	2,168	122,434		122,434	135	122,569			11
12	Social Services	71,936		5,821	77,757		77,757		77,757			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,479,504	162,832	158,454	4,800,790		4,800,790	135	4,800,925			16
	C. General Administration											
17	Administrative	278,946	12,373	1,086,058	1,377,377		1,377,377	(91,654)	1,285,723			17
18	Directors Fees											18
19	Professional Services			6,632	6,632		6,632	28,944	35,576			19
20	Dues, Fees, Subscriptions & Promotions			48,313	48,313		48,313	1,600	49,913			20
21	Clerical & General Office Expenses			27,007	27,007		27,007	1,715	28,722			21
22	Employee Benefits & Payroll Taxes			1,230,761	1,230,761		1,230,761	75,346	1,306,107			22
23	Inservice Training & Education			589	589		589	647	1,236			23
24	Travel and Seminar			3,854	3,854		3,854	4,820	8,674			24
25	Other Admin. Staff Transportation			702	702		702		702			25
26	Insurance-Prop.Liab.Malpractice			198,572	198,572		198,572	1,018	199,590			26
27	Other (specify):*											27
28	TOTAL General Administration	278,946	12,373	2,602,488	2,893,807		2,893,807	22,436	2,916,243			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,149,805	523,526	3,696,210	9,369,541		9,369,541	(16,479)	9,353,062			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			533,302	533,302		533,302	64,455	597,757			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,021	143,021		143,021	(866)	142,155			32
33	Real Estate Taxes			297,999	297,999		297,999		297,999			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			53,503	53,503		53,503	19,795	73,298			35
36	Other (specify):*											36
37	TOTAL Ownership			1,027,825	1,027,825		1,027,825	83,384	1,111,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			686,074	686,074		686,074		686,074			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			274,552	274,552		274,552		274,552			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			960,626	960,626		960,626		960,626			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,149,805	523,526	5,684,661	11,357,992		11,357,992	66,905	11,424,897			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,038)	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	(50,554)	4		8
9	Non-Straightline Depreciation	58,523	30		9
10	Interest and Other Investment Income	(866)	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	(1,364)	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)	\$ 3,701		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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)	63,204		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 63,204		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 66,905		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044768

Report Period Beginning:1/01/16

Ending:12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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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 MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,038)	1,370	0	0	0	0	0	0	0	0	0	(668)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(50,554)	0	0	0	0	0	0	0	0	0	0	(50,554)	4
5	Heat and Other Utilities	0	2,789	0	0	0	0	0	0	0	0	0	2,789	5
6	Maintenance	0	9,383	0	0	0	0	0	0	0	0	0	9,383	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(52,592)	13,542	0	0	0	0	0	0	0	0	0	(39,050)	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	135	0	0	0	0	0	0	0	0	0	135	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	135	0	0	0	0	0	0	0	0	0	135	16
	C. General Administration													
17	Administrative	0	(144,757)	53,103	0	0	0	0	0	0	0	0	(91,654)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,944	0	0	0	0	0	0	0	0	0	28,944	19
20	Fees, Subscriptions & Promotions	(1,364)	2,964	0	0	0	0	0	0	0	0	0	1,600	20
21	Clerical & General Office Expenses	0	1,715	0	0	0	0	0	0	0	0	0	1,715	21
22	Employee Benefits & Payroll Taxes	0	75,346	0	0	0	0	0	0	0	0	0	75,346	22
23	Inservice Training & Education	0	647	0	0	0	0	0	0	0	0	0	647	23
24	Travel and Seminar	0	4,820	0	0	0	0	0	0	0	0	0	4,820	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	1,018	0	0	0	0	0	0	0	0	0	1,018	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,364)	(29,303)	53,103	0	0	0	0	0	0	0	0	22,436	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(53,956)	(15,626)	53,103	0	0	0	0	0	0	0	0	(16,479)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	58,523	0	5,932	0	0	0	0	0	0	0	0	64,455	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(866)	0	0	0	0	0	0	0	0	0	0	(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	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	19,795	0	0	0	0	0	0	0	0	19,795	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	57,657	0	25,727	0	0	0	0	0	0	0	0	83,384	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)	3,701	(15,626)	78,830	0	0	0	0	0	0	0	0	66,905	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Commu
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	2	Food	\$	Presence Life Connections	100.00%	\$ 1,370	\$ 1,370	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,789	2,789	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	9,383	9,383	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	135	135	4
5	V	17	Admin - Misc. Other	435,363	Presence Life Connections	100.00%	4,762	(430,601)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	285,844	285,844	6
7	V	19	Professional Services		Presence Life Connections	100.00%	28,944	28,944	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,964	2,964	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,715	1,715	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	75,346	75,346	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	647	647	11
12	V	24	Travel		Presence Life Connections	100.00%	4,820	4,820	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,018	1,018	13
14	Total			\$ 435,363			\$ 419,737	\$ * (15,626)	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%	\$ 5,932	\$ 5,932	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	0		17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	19,795	19,795	18
19	V	17	Admin Salaries		Presence Health	100.00%	64,773	64,773	19
20	V	30	Depreciation	177,947	Presence Health	100.00%	177,947		20
21	V	17	Admin Consulting,Other	651,802	Presence Health	100.00%	640,132	(11,670)	21
22	V	39	Ancillary Services - Other	1,852,216	Presence Senior Services Pharmacy	100.00%	1,852,216		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,681,965			\$ 2,760,795	\$ * 78,830	39

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

Facility Name & ID Number

PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning:

1/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Susan Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral Health	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem 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 Services	Various	Parent	14
15					Resurrection Development	Chicago	Parent	15
16					Presence Healthcare Services	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care Services	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retirement	Chicago	Independent Living	24
25					Resurrection University	Chicago	College	25
26					Presence Health Partners	Various	Parent	26
27					Presence Properties Plus	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Estate	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number	PRESENCE MARYHAVEN NSG & REH	#	0044768	Report Period Beginning:	1/01/16	Ending:	12/31/16
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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	2	Food	Management Fee Income	9,455,191	33	\$ 29,753	\$	435,363	\$ 1,370	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575		435,363	2,789	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785		435,363	9,383	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934		435,363	135	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412		435,363	4,762	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	435,363	285,844	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607		435,363	28,944	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374		435,363	2,964	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236		435,363	1,715	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354		435,363	75,346	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049		435,363	647	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676		435,363	4,820	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118		435,363	1,018	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835		435,363	5,932	14
15	32	Interest	Management Fee Income	9,455,191	33	0		435,363	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0		435,363	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912		435,363	19,795	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 9,674,560	\$ 6,207,940		\$ 445,464	25

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization 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	6,627,442	10	\$ 658,602	\$ 658,602	651,802	\$ 64,773	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		177,947	177,947	2
3	17	Admin Consulting,Other	Operating Expense	6,627,442	10	6,508,786		651,802	640,132	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 8,825,401	\$ 658,602		\$ 882,852	25

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH # 0044768 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			\$	\$		\$ 686,074	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					\$	\$		\$ 686,074	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE MARYHAVEN NSG & REH COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044768

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

A. Square Feet: 83,762

B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	83,762	2000	\$ 2,935,798	1
2					2
3	TOTALS	83,762		\$ 2,935,798	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	135		2000	1961	\$ 5,932,922	\$ 120,189	40	\$ 148,015	\$ 27,826	\$ 3,098,469	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	126,735		10			126,735	9
10	VARIOUS			2001	251,673	14,519	15	14,499	(20)	249,245	10
11	VARIOUS			2002	1,434,032	59,516	11	57,764	(1,752)	1,425,529	11
12	VARIOUS			2003	1,428	98	15	95	(3)	1,241	12
13	VARIOUS			2004	1,760	112	15	117	5	1,518	13
14	VARIOUS			2005	61,382	624	9	685	61	58,812	14
15	VARIOUS			2006	107,161	2,371	11	2,527	156	98,583	15
16	VARIOUS			2007	2,310		8			2,310	16
17	VARIOUS			2008	73,448	3,531	20	3,672	141	32,864	17
18	VARIOUS			2012	44,500	7,497	6	7,802	305	34,703	18
19											19
20											20
21	Nurse Call Light System			2015	59,990	3,999	30	3,999	0	4,563	21
22	Call Light System East Wing			2015	84,900	4,135	20	4,245	110	10,466	22
23	Exterior Signage			2015	7,434	465	20	372	(93)	465	23
24	New Carpet - East Wing			2015	29,800	5,960	10	5,960		11,130	24
25	New Doors - East, West, & Glenn Wings			2015	10,210	408	25	408		681	25
26	Milwork West Hallway			2015	48,150	2,408	20	2,408		4,614	26
27	New Flooring - East, West, & Glenn Wings			2015	62,000	12,400	5	12,400		23,767	27
28											28
29	Trane Fan Coil Units			2016	19,994	250	40	167	(83)	250	29
30	Fire Hydrant			2016	8,910	223	20	186	(37)	223	30
31											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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$8,368,740	\$238,705		\$265,321	\$26,616	\$5,186,167	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	\$2,249,718	\$109,535	\$141,658	\$32,123	13	\$1,578,687	71
72	Current Year Purchases	82,619	3,587	3,467	(120)	18	3,587	72
73	Fully Depreciated Assets	696,561	3,528	3,432	(96)	10	696,561	73
74	Home Office Allocation		183,879	183,879				74
75	TOTALS	\$3,028,898	\$300,529	\$332,436	\$31,907		\$2,278,835	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	14,333,436
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	539,234
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	597,757
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	58,523
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	7,465,002

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				0			5
6								6
7	TOTAL				\$			7

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: \$73,298
- Description: Nursing 27,185; Admin 18,322; Rehabilitation 7,997; Home Office 19,795
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	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	7145	hrs	\$ 313,791		\$	7,145	\$ 313,791	1
2	Licensed Speech and Language Development Therapist	10a, 1	3455	hrs	154,184			3,455	154,184	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a, 1	7908	hrs	350,100			7,908	350,100	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 prescrpts			686,074		686,074	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Director</u>	10a, 1	2104		97,216			2,104	97,216	12
13	Other (specify): <u></u>									13
14	TOTAL				\$ 915,291		\$ 686,074	20,612	\$ 1,601,365	14

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

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,093,635	\$	1
2	Cash-Patient Deposits	136,639		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	39,798,115		3
4	Supply Inventory (priced at)	1,624,833		4
5	Short-Term Investments	1,515,071		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,808,186		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 58,976,479	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,314,676		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	236,115,679		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	68,273,740		16
17	Accumulated Depreciation (book methods)	(187,356,794)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	2,149,114		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 155,443,930	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 214,420,409	\$	25

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	5,778,344	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 181,681,347	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	112,677	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	515,397	11
12	Expenditures for Specific Purposes	(913,464)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (285,390)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 181,395,957	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PRESENCE MARYHAVEN NSG & REH

0044768

Report Period Beginning: 1/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,174,449	1
2	Discounts and Allowances for all Levels	(1,946,481)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,227,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,122,601	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,122,601	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,038	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,060,103	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	50,554	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,112,695	23
	D. Non-Operating Revenue		
24	Contributions	2,271	24
25	Interest and Other Investment Income***	866	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,137	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	4,268	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,268	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,470,669	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,674,944	31
32	Health Care	4,800,790	32
33	General Administration	2,893,807	33
	B. Capital Expense		
34	Ownership	1,027,825	34
	C. Ancillary Expense		
35	Special Cost Centers	686,074	35
36	Provider Participation Fee	274,552	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,357,992	40
41	Income before Income Taxes (line 30 minus line 40)**	112,677	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 112,677	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,531,955	44
45	Private Pay - Net Inpatient Revenue	3,588,820	45
46	Medicare - Net Inpatient Revenue	1,642,299	46
47	Other-(specify) <u>Insurance</u>	464,894	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,227,968	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,404	1,724	\$ 91,069	\$ 52.82	1
2	Assistant Director of Nursing	1,714	1,831	73,309	40.04	2
3	Registered Nurses	44,453	48,889	1,961,770	40.13	3
4	Licensed Practical Nurses	5,576	6,127	169,403	27.65	4
5	CNAs & Orderlies	66,906	74,689	1,072,557	14.36	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	19,180	20,612	915,291	44.41	7
8	Rehab/Therapy Aides	933	1,026	10,662	10.39	8
9	Activity Director	1,894	2,099	43,465	20.71	9
10	Activity Assistants	5,830	6,382	71,286	11.17	10
11	Social Service Workers	2,311	2,805	71,936	25.65	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	3,810	4,208	100,995	24.00	17
18	Housekeepers	10,664	12,522	159,450	12.73	18
19	Laundry	6,145	7,242	87,248	12.05	19
20	Administrator	1,927	2,101	81,786	38.93	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	16	16	429	26.81	22
23	Office Manager	1,676	1,942	40,424	20.82	23
24	Clerical	4,073	4,405	58,901	13.37	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,633	1,841	32,212	17.50	31
32	Other Health Care Admissions	2,232	2,365	63,948	27.04	32
33	Other(specify) Pastoral	1,472	1,582	43,664	27.60	33
34	TOTAL (lines 1 - 33)	183,849	204,408	\$ 5,149,805 *	\$ 25.19	34

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	16,500	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	23	1,368	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	229	9,244	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	252	\$ 27,112		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	309	\$ 21,239	10,3	50
51	Licensed Practical Nurses	799	35,963	10,3	51
52	Certified Nurse Assistants/Aides	3,505	35,052	10,3	52
53	TOTAL (lines 50 - 52)	4,613	\$ 92,254		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0044768

Report Period Beginning:

1/01/16

Ending:

Page 22

12/31/16

- (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?
If YES, give association name and amount. LEADING AGE \$9,723.33
- (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?
What was the average life used for new equipment added during this period? YES
15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,079 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. \$ 274,552
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,038
- (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