

		FOR BHF USE					

LL1

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: 0044784

Facility Name: PRESENCE ST BENEDICT N & R

Address: 6930 WEST TOUHY AVE NILES 60714
Number City Zip Code

County: COOK

Telephone Number: 847-647-0003 Fax # 847-647-1936

HFS ID Number:

Date of Initial License for Current Owners: 03-01-00

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501C3	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.	☐	
		☐	Limited Liability Co.	☐	
		☐	Trust	☐	
		☐	Other	☐	

In the event there are further questions about this report, please contact:
Name: GEORGE VIEU Telephone Number: 708-478-7943
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/16 to 12/31/16 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.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) MICHAEL R. GORDON
(Title) CFO, VICE PRESIDENT OF FINANCE

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number PRESENCE ST BENEDICT N & R

0044784 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	99	Skilled (SNF)	135	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	128	TOTALS	164	60,024	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,482	19,717	9,678	33,877	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		7,850		7,850	12
13	DD 16 OR LESS					13
14	TOTALS	4,482	27,567	9,678	41,727	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.52%

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 99 and days of care provided 8,029

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL X 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 ST BENEDICT N & R # 0044784 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		20,227	657,089	677,316		677,316		677,316			1
2	Food Purchase		267,373		267,373		267,373	(2,400)	264,973			2
3	Housekeeping	174,826	40,807	13,204	228,837		228,837		228,837			3
4	Laundry	85,448	11,383	75	96,906		96,906	(22,541)	74,365			4
5	Heat and Other Utilities			191,677	191,677		191,677	2,741	194,418			5
6	Maintenance	132,781	37,000	110,713	280,494		280,494	9,220	289,714			6
7	Other (specify):* Pastoral	38,881	6,983		45,864		45,864		45,864			7
8	TOTAL General Services	431,936	383,773	972,758	1,788,467		1,788,467	(12,980)	1,775,487			8
	B. Health Care and Programs											
9	Medical Director	33,613			33,613		33,613		33,613			9
10	Nursing and Medical Records	2,849,288	137,672	281,715	3,268,675		3,268,675		3,268,675			10
10a	Therapy	1,080,070	7,020	103,535	1,190,625		1,190,625		1,190,625			10a
11	Activities	150,885	7,836	15,647	174,368		174,368	133	174,501			11
12	Social Services	78,752	2,474		81,226		81,226		81,226			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Shelter	130,518			130,518		130,518		130,518			15
16	TOTAL Health Care and Programs	4,323,126	155,002	400,897	4,879,025		4,879,025	133	4,879,158			16
	C. General Administration											
17	Administrative	341,712	20,774	1,072,103	1,434,589		1,434,589	(89,703)	1,344,886			17
18	Directors Fees											18
19	Professional Services			27,391	27,391		27,391	28,441	55,832			19
20	Dues, Fees, Subscriptions & Promotions			33,275	33,275		33,275	2,679	35,954			20
21	Clerical & General Office Expenses			4,400	4,400		4,400	1,685	6,085			21
22	Employee Benefits & Payroll Taxes			1,215,343	1,215,343		1,215,343	74,035	1,289,378			22
23	Inservice Training & Education			2,146	2,146		2,146	636	2,782			23
24	Travel and Seminar							4,736	4,736			24
25	Other Admin. Staff Transportation			378	378		378		378			25
26	Insurance-Prop.Liab.Malpractice			197,351	197,351		197,351	1,001	198,352			26
27	Other (specify):*											27
28	TOTAL General Administration	341,712	20,774	2,552,387	2,914,873		2,914,873	23,510	2,938,383			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,096,774	559,549	3,926,042	9,582,365		9,582,365	10,663	9,593,028			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			455,668	455,668		455,668	50,631	506,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,350	131,350		131,350	(419)	130,931			32
33	Real Estate Taxes			9,160	9,160		9,160		9,160			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,701	24,701		24,701	19,451	44,152			35
36	Other (specify):*											36
37	TOTAL Ownership			620,879	620,879		620,879	69,663	690,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			654,612	654,612		654,612		654,612			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			220,905	220,905		220,905		220,905			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			875,517	875,517		875,517		875,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,096,774	559,549	5,422,438	11,078,761		11,078,761	80,326	11,159,087			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	(3,746)	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	(22,541)	4		8
9	Non-Straightline Depreciation	44,802	30		9
10	Interest and Other Investment Income	(419)	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	(234)	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)	\$ 17,862		\$	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)	62,464		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 62,464		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 80,326		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#0044784

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
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 ST BENEDICT N & R # 0044784 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	(3,746)	1,346	0	0	0	0	0	0	0	0	0	(2,400)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(22,541)	0	0	0	0	0	0	0	0	0	0	(22,541)	4
5	Heat and Other Utilities	0	2,741	0	0	0	0	0	0	0	0	0	2,741	5
6	Maintenance	0	9,220	0	0	0	0	0	0	0	0	0	9,220	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(26,287)	13,307	0	0	0	0	0	0	0	0	0	(12,980)	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	133	0	0	0	0	0	0	0	0	0	133	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	133	0	0	0	0	0	0	0	0	0	133	16
	C. General Administration													
17	Administrative	0	(142,239)	52,536	0	0	0	0	0	0	0	0	(89,703)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,441	0	0	0	0	0	0	0	0	0	28,441	19
20	Fees, Subscriptions & Promotions	(234)	2,913	0	0	0	0	0	0	0	0	0	2,679	20
21	Clerical & General Office Expenses	0	1,685	0	0	0	0	0	0	0	0	0	1,685	21
22	Employee Benefits & Payroll Taxes	0	74,035	0	0	0	0	0	0	0	0	0	74,035	22
23	Inservice Training & Education	0	636	0	0	0	0	0	0	0	0	0	636	23
24	Travel and Seminar	0	4,736	0	0	0	0	0	0	0	0	0	4,736	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	1,001	0	0	0	0	0	0	0	0	0	1,001	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(234)	(28,792)	52,536	0	0	0	0	0	0	0	0	23,510	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(26,521)	(15,352)	52,536	0	0	0	0	0	0	0	0	10,663	29

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	44,802	0	5,829	0	0	0	0	0	0	0	0	50,631	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(419)	0	0	0	0	0	0	0	0	0	0	(419)	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	19,451	0	0	0	0	0	0	0	0	19,451	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	44,383	0	25,280	0	0	0	0	0	0	0	0	69,663	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)	17,862	(15,352)	77,816	0	0	0	0	0	0	0	0	80,326	45

VII. RELATED PARTIES

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

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

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Presence Life Connections	100.00%	\$ 1,346	\$ 1,346	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,741	2,741	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	9,220	9,220	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	133	133	4
5	V	17	Admin - Misc. Other	427,788	Presence Life Connections	100.00%	4,679	(423,109)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	280,870	280,870	6
7	V	19	Professional Services		Presence Life Connections	100.00%	28,441	28,441	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,913	2,913	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,685	1,685	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	74,035	74,035	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	636	636	11
12	V	24	Travel		Presence Life Connections	100.00%	4,736	4,736	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,001	1,001	13
14	Total			\$ 427,788			\$ 412,436	\$ * (15,352)	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%	\$ 5,829	\$ 5,829	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%	19,451	19,451	18
19	V	17	Admin Salaries		Presence Health	100.00%	64,081	64,081	19
20	V	30	Depreciation	162,213	Presence Health	100.00%	162,213		20
21	V	17	Admin Consulting, Other	644,844	Presence Health	100.00%	633,299	(11,545)	21
22	V	39	Ancillary Services - Other	654,612	Presence Senior Services Pharmacy	100.00%	654,612		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			\$ 1,461,669			\$ 1,539,485	\$ * 77,816	39

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

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

0044784

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	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

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

Ending: 12/31/16

(708-478-5387

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Admin Salaries	Operating Expense	6,627,442	10	\$ 658,602	\$ 658,602	644,844	\$ 64,081	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		162,213	162,213	2
3	17	Admin Consulting,Other	Operating Expense	6,627,442	10	6,508,786		644,844	633,299	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		\$ 859,593	25

Facility Name & ID Number PRESENCE ST BENEDICT N & R # 0044784 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			\$	\$		\$ 654,612	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					\$	\$		\$ 654,612	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.

A. Square Feet: 56,961

B. General Construction Type: Exterior BrickFrame MetalNumber of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	56,961	2000	\$ 2,910,262	1
2					2
3	TOTALS	56,961		\$ 2,910,262	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	99		2000	1991	\$ 5,342,488	\$ 123,433	40	\$ 134,685	\$ 11,252	\$ 2,482,954
5										
6										
7										
8										
	Improvement Type**									
9	VARIOUS		2000		92,057		7			92,057
10	VARIOUS		2001		273,061	15,528	12	15,513	(15)	270,071
11	VARIOUS		2002		29,538	1,604	16	1,884	281	27,889
12	VARIOUS		2003		8,200	156	15	166	11	7,187
13	VARIOUS		2004		12,982	639	15	662	23	9,376
14	VARIOUS		2005		191,740	8,391	10	9,242	851	163,754
15	VARIOUS		2006		86,586	2,596	10	2,558	(38)	76,988
16	VARIOUS		2008		1,284	64	20	64	0	577
17	VARIOUS		2012		15,524	667	23	669	2	3,010
18										
19										
20	REMOVING TOP 2 inch OF ASPHALT		2014		50,900	6,211	8	6,363	151	15,704
21	RENOVATIONS FOR CONVERSION OF		2014		50,400	2,465	20	2,520	55	6,227
22	REPLACE AIR COOLED CHILLER MOD		2014		125,000	6,141	20	6,250	109	15,480
23										
24	: DEPOSIT TO INSTALL NEW LIGHT		2015		6,477	324	20	983	659	405
25	BARIATRIC BED, ELECTRONIC, WID		2015		6,884	459	18	139	(320)	574
26	BARIATRIC POWERED ALTERNATING		2015		9,997	542	18	375	(167)	542
27										
28	NEW Bathroom - (ILC) Independent Living		2016		9,350	273	20	234	(39)	273
29	: Electrical work for new phone system		2016		3,335	153	20	139	(14)	153
30	: INSTALL RESILIENT FLOORING - (ILC) Independent Living		2016		7,494	375	20	375		375
31	NEW CARRIER MAKE UP AIR		2016		60,000	250	20	3,000	2,750	250
32	New window		2016		3,525	15	20	176	162	15
33	GALVANIZED STEEL INSULATD DOOR		2016		3,635	91	20	76	(15)	91
34	2ND FLOOR CORRIDOR LED LIGHTS		2016		4,318	173	25	173	0	173
35	ILC Roof Replacement		2016		78,623	1,310	20	983	(328)	1,310
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)		\$6,473,397	\$171,859		\$187,229	\$15,370	\$3,175,433	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	\$2,128,859	\$107,043	\$136,608	\$29,565	12	\$1,477,265	71
72	Current Year Purchases	15,850	1,032	898	(134)	11	1,032	72
73	Fully Depreciated Assets	433,011	13,522	13,522		7	433,011	73
74	Home Office Allocation		168,042	168,042				74
75	TOTALS	\$2,577,720	\$289,639	\$319,070	\$29,431		\$1,911,308	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	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)	\$11,961,379	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$461,498	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$506,299	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$44,801	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,086,740	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	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: \$44,152
- Description: Nursing 1,566; Activities 167; Administration 11,897; Rehabilitation 11,072; Home Office 19,451
(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

C. CONTRACTUAL INCOME

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)	\$			

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	9578	hrs	\$	418,657		\$	9,578	\$	418,657	1			
2	Licensed Speech and Language Development Therapist	10a, 1	2135	hrs		94,446			2,135		94,446	2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	10a, 1	10780	hrs		465,544			10,780		465,544	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				654,612			654,612	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			101,423			2,104		101,423	12			
13	Other (specify): _____											13			
14	TOTAL				\$	1,080,070		\$		\$	654,612	24,597	\$	1,734,682	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 Operating	2 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 Operating	2 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	4,169,316	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 180,072,319	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,721,705	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)	\$ 1,323,638	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 ST BENEDICT N & R

0044784

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	\$ 10,568,167	1
2	Discounts and Allowances for all Levels	(1,158,976)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,409,191	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,408,685	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,408,685	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	3,746	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	917,775	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	22,541	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 944,062	23
	D. Non-Operating Revenue		
24	Contributions	5,903	24
25	Interest and Other Investment Income***	419	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,322	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	32,206	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32,206	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,800,466	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,788,467	31
32	Health Care	4,879,025	32
33	General Administration	2,914,873	33
	B. Capital Expense		
34	Ownership	620,879	34
	C. Ancillary Expense		
35	Special Cost Centers	654,612	35
36	Provider Participation Fee	220,905	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,078,761	40
41	Income before Income Taxes (line 30 minus line 40)**	1,721,705	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,721,705	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 790,176	44
45	Private Pay - Net Inpatient Revenue	5,931,249	45
46	Medicare - Net Inpatient Revenue	2,350,532	46
47	Other-(specify) <u>Insurance</u>	337,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,409,191	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	1,858	2,099	\$ 94,360	\$ 44.95	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	34,165	37,930	1,566,003	41.29	3
4	Licensed Practical Nurses	6,899	8,218	220,063	26.78	4
5	CNAs & Orderlies	67,286	75,251	1,095,885	14.56	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	23,067	24,597	1,080,070	43.91	7
8	Rehab/Therapy Aides	147	147	2,798	19.03	8
9	Activity Director	3,731	4,186	100,251	23.95	9
10	Activity Assistants	4,071	4,455	50,634	11.37	10
11	Social Service Workers	3,990	4,229	87,260	20.63	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	5,594	6,157	132,781	21.57	17
18	Housekeepers	11,355	12,933	174,826	13.52	18
19	Laundry	6,070	7,114	85,448	12.01	19
20	Administrator	1,785	2,071	110,752	53.48	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	4,624	4,989	60,358	12.10	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	240	240	33,613	140.05	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	1,747	2,004	48,611	24.26	31
32	Other Health Care Admissions	3,680	4,155	114,180	27.48	32
33	Other(specify) Pastoral	1,456	1,583	38,881	24.56	33
34	TOTAL (lines 1 - 33)	181,765	202,358	\$ 5,096,774 *	\$ 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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	71	4,933	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	44	2,420	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 7,353		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	196	\$ 13,729	10,3	50
51	Licensed Practical Nurses	0	0	10,3	51
52	Certified Nurse Assistants/Aides	10,690	267,244	10,3	52
53	TOTAL (lines 50 - 52)	10,886	\$ 280,973		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

PRESENCE ST BENEDICT N & R

0044784

Report Period Beginning:

1/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bernie Ladra	Administrator		\$ 110,752
Administrative Staff	Office Manager		0
Administrative Staff	Receptionists		60,358
Administrative Staff	Administrative Asst		0
Administrative Staff	Admissions		114,180
Administrative Staff	Other Administrative		56,422
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 341,712

B. Administrative - Other

Description	Amount
Corp Office Management Fee	\$ 1,072,103
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 1,072,103

C. Professional Services

Vendor/Payee	Type	Amount
POLSINELLI PC	Legal	\$ 12,837
GALLAGHER BASSET SERVICES	Biomed	300
LIFECYCLE	Aviary Maintenance	854
PACIFIC INTERPRETERS INC	Interpreter	283
FAST TRAK MEDIVAN TRANSPOR	Transportation	800
ERIKSSON ENGINEERING ASSOC	Engineering/Survey	1,058
Brinks Incorporated	Security	1,523
JM Brennan inc	Mechanical	9,736
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 27,391

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 60,772
Unemployment Compensation Insurance	16,466
FICA Taxes	353,971
Employee Health Insurance	503,297
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	74,035
Dental	15,900
Life Insurance	3,736
Disability Insurance	19,866
Pension	224,977
Tuition Reimbursement	10,017
Other Benefits	6,340
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,289,378

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 29)	
Patient Background Checks	228
Employee Recruitment	1,200
Dues & Subscriptions	31,841
Advertising & Public Relations	234
Home Office Allocation	2,913
Less: Public Relations Expense	()
Non-allowable advertising	(234)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	0
Seminar Expense	
Home Office Allocation	4,736
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,736

* Attach copy of IMRF notifications

**See instructions.

(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