

		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: 0041731

Facility Name: PRESENCE ST ANNE CENTER

Address: 4405 HIGHCREST ROAD ROCKFORD 61107
Number City Zip Code

County: WINNEBAGO

Telephone Number: 815-229-1999 Fax # 815-229-1560

HFS ID Number:

Date of Initial License for Current Owners: 10-06-86

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501C3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 ANNE CENTER

0041731 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	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	59	Intermediate/DD	59	21,594	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,514	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	18,942	8,513	20,699	48,154	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,942	8,513	20,699	48,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.50%

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 10-06-86

J. Was the facility purchased or leased after January 1, 1978?
YES X Date 10-06-86 NO

K. Was the facility certified for Medicare during the reporting year?
YES X NO If YES, enter number of beds certified 119 and days of care provided 13,886

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 ST ANNE CENTER # 0041731 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		15,728	792,834	808,562		808,562		808,562			1
2	Food Purchase		366,309		366,309		366,309	(64,808)	301,501			2
3	Housekeeping	120,205	4,556		124,761		124,761		124,761			3
4	Laundry	9,906		149,163	159,069		159,069		159,069			4
5	Heat and Other Utilities			324,209	324,209		324,209	4,133	328,342			5
6	Maintenance	153,761	66,709	140,166	360,636		360,636	17,500	378,136			6
7	Other (specify):* Pastoral	49,810	847	12,186	62,843		62,843		62,843			7
8	TOTAL General Services	333,682	454,149	1,418,558	2,206,389		2,206,389	(43,175)	2,163,214			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	4,293,176	461,441	302,610	5,057,227		5,057,227		5,057,227			10
10a	Therapy	1,299,423	284	423,306	1,723,013		1,723,013		1,723,013			10a
11	Activities	91,008	4,085	8,568	103,661		103,661	200	103,861			11
12	Social Services	127,919		636	128,555		128,555		128,555			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,811,526	465,810	756,120	7,033,456		7,033,456	200	7,033,656			16
	C. General Administration											
17	Administrative	466,199	68,904	1,569,549	2,104,652		2,104,652	(37,227)	2,067,425			17
18	Directors Fees											18
19	Professional Services			29,040	29,040		29,040	42,895	71,935			19
20	Dues, Fees, Subscriptions & Promotions			58,530	58,530		58,530	379	58,909			20
21	Clerical & General Office Expenses			21,529	21,529		21,529	2,541	24,070			21
22	Employee Benefits & Payroll Taxes			1,707,877	1,707,877		1,707,877	133,140	1,841,017			22
23	Inservice Training & Education			355	355		355	959	1,314			23
24	Travel and Seminar			183	183		183	7,143	7,326			24
25	Other Admin. Staff Transportation			3,323	3,323		3,323		3,323			25
26	Insurance-Prop.Liab.Malpractice			237,051	237,051		237,051	1,509	238,560			26
27	Other (specify):*											27
28	TOTAL General Administration	466,199	68,904	3,627,437	4,162,540		4,162,540	151,339	4,313,879			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,611,407	988,863	5,802,115	13,402,385		13,402,385	108,364	13,510,749			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			631,187	631,187		631,187	71,168	702,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,118	192,118		192,118	(14,350)	177,768			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			253,976	253,976		253,976	29,336	283,312			35
36	Other (specify):*											36
37	TOTAL Ownership			1,077,281	1,077,281		1,077,281	86,154	1,163,435			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,223,181	1,223,181		1,223,181		1,223,181			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			302,357	302,357		302,357		302,357			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,525,538	1,525,538		1,525,538		1,525,538			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,611,407	988,863	8,404,934	16,005,204		16,005,204	194,518	16,199,722			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	(66,838)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	62,377	30		9
10	Interest and Other Investment Income	(14,350)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,014)	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)	\$ (22,825)		\$	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)	217,343		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 217,343		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 194,518		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#0041731

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 ANNE CENTER # 0041731 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	(66,838)	2,030	0	0	0	0	0	0	0	0	0	(64,808)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,133	0	0	0	0	0	0	0	0	0	4,133	5
6	Maintenance	0	13,906	3,594	0	0	0	0	0	0	0	0	17,500	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(66,838)	20,069	3,594	0	0	0	0	0	0	0	0	(43,175)	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	200	0	0	0	0	0	0	0	0	0	200	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	200	0	0	0	0	0	0	0	0	0	200	16
	C. General Administration													
17	Administrative	0	(214,527)	177,300	0	0	0	0	0	0	0	0	(37,227)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	42,895	0	0	0	0	0	0	0	0	0	42,895	19
20	Fees, Subscriptions & Promotions	(4,014)	4,393	0	0	0	0	0	0	0	0	0	379	20
21	Clerical & General Office Expenses	0	2,541	0	0	0	0	0	0	0	0	0	2,541	21
22	Employee Benefits & Payroll Taxes	0	111,661	21,479	0	0	0	0	0	0	0	0	133,140	22
23	Inservice Training & Education	0	959	0	0	0	0	0	0	0	0	0	959	23
24	Travel and Seminar	0	7,143	0	0	0	0	0	0	0	0	0	7,143	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	1,509	0	0	0	0	0	0	0	0	0	1,509	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,014)	(43,426)	198,779	0	0	0	0	0	0	0	0	151,339	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(70,852)	(23,157)	202,373	0	0	0	0	0	0	0	0	108,364	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	62,377	0	8,791	0	0	0	0	0	0	0	0	71,168	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,350)	0	0	0	0	0	0	0	0	0	0	(14,350)	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	29,336	0	0	0	0	0	0	0	0	29,336	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	48,027	0	38,127	0	0	0	0	0	0	0	0	86,154	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)	(22,825)	(23,157)	240,500	0	0	0	0	0	0	0	0	194,518	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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Presence Life Connections	100.00%	\$ 2,030	\$ 2,030	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,133	4,133	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	13,906	13,906	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	200	200	4
5	V	17	Admin - Misc. Other	645,198	Presence Life Connections	100.00%	7,057	(638,141)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	423,614	423,614	6
7	V	19	Professional Services		Presence Life Connections	100.00%	42,895	42,895	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	4,393	4,393	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	2,541	2,541	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	111,661	111,661	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	959	959	11
12	V	24	Travel		Presence Life Connections	100.00%	7,143	7,143	12
13	V	26	Insurance		Presence Life Connections	100.00%	1,509	1,509	13
14	Total			\$ 645,198			\$ 622,041	\$ * (23,157)	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%	\$ 8,791	\$ 8,791	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%	29,336	29,336	18
19	V	17	Admin Salaries		Presence Health	100.00%	0		19
20	V	22	Employee Benefits		Presence Health	100.00%	21,479	21,479	20
21	V	30	Depreciation	252,463	Presence Health	100.00%	252,463		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	925,441	Presence Health	100.00%	827,882	(97,559)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	0		24
25	V	17	Information Systems - Other		Presence Health	100.00%	197,737	197,737	25
26	V	17	Admin Salaries		Presence Health	100.00%	0		26
27	V	17	Information Systems Salaries		Presence Health	100.00%	60,705	60,705	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	3,594	3,594	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	16,417	16,417	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	0		30
31	V	39	Ancillary Services - Other	1,223,181	Presence Senior Services Pharmacy	100.00%	1,223,181		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 2,401,085			\$ 2,641,585	\$ * 240,500	39

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

Facility Name & ID Number

PRESENCE ST ANNE CENTER

0041731

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	Michael Gordon	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Susan Enright	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 Way	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

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	<u>PRESENCE</u> ST ANNE CENTER
--------------------------------------	---------------------------------------

0041731

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 Life Connections

Street Address

18927 Hickory Creek Dr, Ste 300

City / State / Zip Code

Mokena, IL 60448

Phone Number

(708-478-7900

Fax Number

(708-478-5387

1	2	3	4	5	6	7	8	9	
Schedule V		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	\$ 645,198	\$ 2,030	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575	645,198	4,133	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785	645,198	13,906	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934	645,198	200	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412	645,198	7,057	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	423,614	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607	645,198	42,895	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374	645,198	4,393	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236	645,198	2,541	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354	645,198	111,661	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049	645,198	959	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676	645,198	7,143	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118	645,198	1,509	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835	645,198	8,791	14
15	32	Interest	Management Fee Income	9,455,191	33	0	645,198	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0	645,198	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912	645,198	29,336	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 9,674,560	\$ 6,207,940	\$ 660,168	25

Ending: 12/31/16

()

Facility Name & ID Number PRESENCE ST ANNE CENTER # 0041731 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		\$	\$		\$ 1,223,181	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				\$	\$		\$ 1,223,181	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						\$					\$ 16,417	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 16,417	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 16,417	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

[illegible]

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 ST ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

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</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000

B. General Construction Type: Exterior BrickFrame SteelNumber 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	NURSING HOME			1984		\$ 639,976	1
2							2
3	TOTALS					\$ 639,976	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1986	1986	\$ 3,516,907	\$ 19,087	63	\$ 55,824	\$ 36,737	\$ 2,890,227	4
5	59		1993	1993	2,722,251	24,603	56	48,612	24,009	1,918,559	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1990		34,784	1,172	31	1,122	(50)	29,802	9
10	VARIOUS		1994		5,000		10			5,000	10
11	VARIOUS		1995		40,225	741	18	752	11	33,923	11
12	VARIOUS		1996		7,038		10			7,038	12
13	VARIOUS		1997		41,666		7			41,666	13
14	VARIOUS		1998		22,342		5			22,342	14
15	VARIOUS		1999		6,927		5			6,927	15
16	VARIOUS		2000		22,910		5			22,910	16
17	VARIOUS		2001		280,006	6,712	6	6,328	(384)	252,041	17
18	VARIOUS		2002		9,766	502	10	456	(46)	9,599	18
19	VARIOUS		2003		31,300		9			31,300	19
20	VARIOUS		2004		41,705	153	7	147	(7)	41,347	20
21	VARIOUS		2005		21,795	291	10	287	(5)	21,104	21
22	VARIOUS		2006		90,920	5,057	12	5,132	75	74,677	22
23	VARIOUS		2007		180,781	14,913	12	15,305	393	159,664	23
24	VARIOUS		2008		163,653	15,183	12	14,926	(257)	133,177	24
25	VARIOUS		2009		36,593	3,187	11	3,309	122	30,100	25
26	VARIOUS		2010		86,688	5,569	10	5,739	170	48,234	26
27	VARIOUS		2011		109,875	8,981	12	9,435	454	52,361	27
28	VARIOUS		2012		77,789	5,850	12	5,924	74	26,139	28
29											29
30											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

Facility Name & ID Number PRESENCE ST ANNE CENTER

0041731

Report Period Beginning:

1/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CANOPY	2013	\$ 73,700	\$ 4,789	15	\$ 4,913	\$ 124	\$ 17,031	37
38	FIRE SPRINKLER REPLACED IN OFF	2013	8,574	343	25	343		1,200	38
39	FLOORING	2013	326,360	32,292	10	32,636	344	113,768	39
40	FURNACE	2013	4,746	321	15	316	(4)	1,113	40
41	INTEGRATED ANTENNAS LED TVS LO	2013	10,737	2,051	5	2,147	97	7,148	41
42	WALLPAPER FRAMING DRYWALL	2013	22,000	2,132	10	2,200	68	7,609	42
43	STEAM TABLE	2013	4,411	451	10	441	(10)	1,557	43
44	STERLING 100 000 BTU 100 DUCT	2013	2,578	258	10	258		902	44
45	GENERATOR	2013	34,537	7,460	5	6,907	(552)	24,591	45
46	WATER HEATER	2013	16,087	1,699	10	1,609	(90)	5,751	46
47	WEST LOUNGE ROOF TOP HVAC	2013	6,081	589	10	608	19	2,103	47
48									48
49	198 GALLON WATER HEATER	2014	6,740	680	10	674	(6)	1,694	49
50	CANOPY FIRE SPRINKLER	2014	3,980	156	25	159	3	553	50
51	DESK TOP WATER PANEL	2014	2,788	529	5	558	29	1,731	51
52	KITCHEN DINING ROOM DOORS	2014	2,570	101	25	103	1	255	52
53	LIFE SAFETY K20 TAGS FIRESTOP	2014	5,540	544	10	554	10	1,371	53
54	OUTER DOOR ALARM	2014	2,740	264	10	274	10	672	54
55	ROOF	2014	260,500	25,807	10	26,050	243	64,800	55
56	SEAL COAT PARKING LO	2014	49,995	6,944	7	7,142	198	17,591	56
57	WALL PAINT FOR F HALL	2014	853	145	5	171	26	563	57
58	WATER SOFTENER	2014	12,000	1,146	10	1,200	54	2,928	58
59									59
60	COMMODOES	2015	1,206	114	10	121	6	293	60
61	FLOOR SCRUBBER	2015	4,169	834	5	834		1,320	61
62	KEYPAD/TIMER/RELAYS FOR FRONT DOOR SECURITY SY	2015	2,850	285	10	285		523	62
63	INSTALLATION OF LIGHT FIXTURES IN RESIDENT ROOM	2015	10,675	534	20	534		979	63
64	RECESSED LIGHTING IN RES. ROOMS AND DINING ROOM	2015	20,871	1,362	15	1,391	29	3,161	64
65	TWO SHOWERS FOR BATHROOMS IN ST. PAUL UNIT	2015	31,000	1,510	20	1,550	40	3,822	65
66	SUBPANEL TO RELOCATE CIRCUITRY	2015	3,786	151	25	151		215	66
67	WATER HEATER	2015	24,150	2,373	10	2,415	42	4,069	67
68	WINDOWS IN RESIDENT ROOMS	2015	16,650	666	25	666		1,055	68
69	WINDOWS AND TRIM	2016	20,578	1,029	20	1,029	(0)	1,029	69
70	TOTAL (lines 4 thru 69)		\$ 8,544,373	\$ 209,559		\$ 271,538	\$ 61,979	\$ 6,149,532	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,582,641	\$136,902	\$139,195	\$2,293	12	\$903,886	71
72	Current Year Purchases	85,040	4,911	4,567	(345)	13	4,911	72
73	Fully Depreciated Assets	809,220	4,764	4,764		8	809,220	73
74	Home Office Allocation		261,254	261,254				74
75	TOTALS	\$2,476,901	\$407,831	\$409,780	\$1,948		\$1,718,016	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	PLANT ENGINEERING	MINI VAN	1998	\$43,500	\$	\$	\$	5	\$43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOV	1999	27,428				3	27,428	77
78	PLANT ENGINEERING	FORD F-250	2014	35,951	10,537	8,988	(1,550)	4	24,536	78
79	PLANT ENGINEERING	2015 FORD STARCRAFT VAN	2015	48,201	12,050	12,050		4	21,088	79
80	TOTALS			\$155,080	\$22,588	\$21,038	\$(1,550)		\$116,551	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)	\$11,816,329	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$639,978	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$702,355	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$62,377	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,984,099	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: \$283,312
- Description: Nursing 236,762; Admin 12,611; Rehabilitation 4,603; Home Office 29,336
- (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	11246	hrs	\$	407,516		\$	11,246	\$	407,516	1			
2	Licensed Speech and Language Development Therapist	10a, 1	4208	hrs		159,969			4,208		159,969	2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	10a, 1	16666	hrs		630,585			16,666		630,585	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				1,223,181			1,223,181	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
11	Academic Education			hrs								11			
12	Other (specify): <u>Director</u>	10a, 1	2110			101,423			2,110		101,423	12			
13	Other (specify): _____											13			
14	TOTAL				\$	1,299,493		\$		\$	1,223,181	34,230	\$	2,522,674	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	6,410,415	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 182,313,418	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(519,394)	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)	\$ (917,461)	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 ANNE CENTER

0041731

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	\$ 14,748,073	1
2	Discounts and Allowances for all Levels	(5,039,932)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,708,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,958,454	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,958,454	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	66,838	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,736,369	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,803,207	23
	D. Non-Operating Revenue		
24	Contributions	1,613	24
25	Interest and Other Investment Income***	14,350	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,963	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	45	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,485,810	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,206,389	31
32	Health Care	7,033,456	32
33	General Administration	4,162,540	33
	B. Capital Expense		
34	Ownership	1,077,281	34
	C. Ancillary Expense		
35	Special Cost Centers	1,223,181	35
36	Provider Participation Fee	302,357	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,005,204	40
41	Income before Income Taxes (line 30 minus line 40)**	(519,394)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (519,394)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,177,963	44
45	Private Pay - Net Inpatient Revenue	455,689	45
46	Medicare - Net Inpatient Revenue	1,132,239	46
47	Other-(specify) <u>Insurance</u>	508,594	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,274,485	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	1,900	2,090	\$ 104,183	\$ 49.85	1
2	Assistant Director of Nursing	1,955	2,082	76,616	36.80	2
3	Registered Nurses	40,601	43,479	1,424,421	32.76	3
4	Licensed Practical Nurses	46,410	49,808	1,425,540	28.62	4
5	CNAs & Orderlies	84,111	91,546	1,262,891	13.80	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	32,324	34,230	1,299,321	37.96	7
8	Rehab/Therapy Aides	1,013	1,108	13,446	12.14	8
9	Activity Director	1,910	2,121	36,955	17.42	9
10	Activity Assistants	5,304	5,563	64,554	11.60	10
11	Social Service Workers	5,640	6,491	127,919	19.71	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	7,777	9,176	153,761	16.76	17
18	Housekeepers	9,915	10,684	120,205	11.25	18
19	Laundry	937	937	9,906	10.57	19
20	Administrator	1,616	1,821	90,531	49.71	20
21	Assistant Administrator	161	194	5,454	28.11	21
22	Other Administrative	1,480	1,919	39,815	20.75	22
23	Office Manager	1,919	2,085	49,998	23.98	23
24	Clerical	5,946	6,605	97,700	14.79	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	0	0	0		31
32	Other Health Care Admissions	5,882	6,359	158,381	24.91	32
33	Other(specify) Pastoral	2,339	2,443	49,810	20.39	33
34	TOTAL (lines 1 - 33)	259,140	280,741	\$ 6,611,407 *	\$ 23.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	21,000	9,3	36
37	Medical Records Consultant	32	2,184	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,019	61,158	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4,633	277,995	10a,3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,942	11,3	44
45	Social Service Consultant	8	536	12,3	45
46	Other(specify) MDS	524	61,787	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	6,270	\$ 427,602		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	321	\$ 22,480	10,3	50
51	Licensed Practical Nurses	56	2,520	10,3	51
52	Certified Nurse Assistants/Aides	3,985	99,628	10,3	52
53	TOTAL (lines 50 - 52)	4,362	\$ 124,628		53

STATE OF ILLINOIS

Facility Name & ID NumberPRESENCE ST ANNE CENTER# 0041731Report Period Beginning:1/01/16Ending:12/31/16Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Administrator		\$ 90,531
Administrative Staff	Office Manager		49,998
Administrative Staff	Receptionists		24,168
Administrative Staff	Administrative Asst		5,454
Administrative Staff	Admissions		158,381
Administrative Staff	Other Administrative		137,667
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 466,199

B. Administrative - Other

Description	Amount
Corp Office Management Fee	\$ 1,569,549
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 1,569,549

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	\$ 0
Collections	Various	508
Shredding/Storage	Various	0
Survey & Analytical Tools	Various	0
Ground Charge	Various	6,069
Biomed	Various	150
Outsourced Services	Various	22,313
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 29,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 84,710
Unemployment Compensation Insurance	22,896
FICA Taxes	475,735
Employee Health Insurance	701,233
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	133,140
Dental	22,090
Life Insurance	5,182
Disability Insurance	27,660
Pension	312,171
Tuition Reimbursement	20,146
Other Benefits	36,054
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,841,017

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 95)	
Patient Background Checks	559
Employee Recruitment	18,249
Dues & Subscriptions	36,267
Advertising & Public Relations	4,014
Home Office Allocation	4,393
Less: Public Relations Expense	()
Non-allowable advertising	(4,014)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 58,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	183
Seminar Expense	
Home Office Allocation	7,143
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,326

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

XX. GENERAL INFORMATION:

- | | |
|---|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. <u>LEADING AGE \$9,275.01</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>13</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>19,204</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? <u>YES</u> <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>302,357</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>YES</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>NONE</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>66,838</u></p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>NO</u>
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
 c. What percent of all travel expense relates to transportation of nurses and patients? <u>N/A</u>
 d. Have vehicle usage logs been maintained? <u>N/A</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
 g. Does the facility transport residents to and from day training? <u>NO</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>YES</u>
 Firm Name: <u>KPMG</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(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. <u>YES</u>
 Attach invoices and a summary of services for all architect and appraisal fees</p> |
|---|---|