

		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: 0044792

Facility Name: PRESENCE VILLA SCALABRINI NR

Address: 480 NORTH WOLF ROAD NORTHLAKE 60164
Number City Zip Code

County: COOK

Telephone Number: 708-562-0040 Fax # 708-562-5180

HFS ID Number:

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

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 VILLA SCALABRINI NR

0044792 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	171	Skilled (SNF)	171	62,586	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,598	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	42,021	18,049	15,771	75,841	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,021	18,049	15,771	75,841	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.90%

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 171 and days of care provided 12,759

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 VILLA SCALABRINI NR # 0044792 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		57,854	882,275	940,129		940,129		940,129			1
2	Food Purchase		519,315		519,315		519,315	14,885	534,200			2
3	Housekeeping	302,090	95,301		397,391		397,391		397,391			3
4	Laundry	139,416	137,201	815	277,432		277,432	(11,208)	266,224			4
5	Heat and Other Utilities			385,671	385,671		385,671	5,569	391,240			5
6	Maintenance	154,834	6,847	595,535	757,216		757,216	18,736	775,952			6
7	Other (specify):* Pastoral	152,582	12,985	20,231	185,798		185,798		185,798			7
8	TOTAL General Services	748,922	829,503	1,884,527	3,462,952		3,462,952	27,982	3,490,934			8
	B. Health Care and Programs											
9	Medical Director			80,370	80,370		80,370		80,370			9
10	Nursing and Medical Records	6,779,548	459,047	1,315	7,239,910		7,239,910		7,239,910			10
10a	Therapy	1,309,679	31,981	101,168	1,442,828		1,442,828		1,442,828			10a
11	Activities	173,915	30,096	1,631	205,642		205,642	270	205,912			11
12	Social Services	162,751	164	1,092	164,007		164,007		164,007			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,425,893	521,288	185,576	9,132,757		9,132,757	270	9,133,027			16
	C. General Administration											
17	Administrative	414,586	38,359	2,105,660	2,558,605		2,558,605	(188,324)	2,370,281			17
18	Directors Fees											18
19	Professional Services			(901)	(901)		(901)	57,793	56,892			19
20	Dues, Fees, Subscriptions & Promotions			43,632	43,632		43,632	4,603	48,235			20
21	Clerical & General Office Expenses			27,165	27,165		27,165	3,423	30,588			21
22	Employee Benefits & Payroll Taxes			2,457,532	2,457,532		2,457,532	150,444	2,607,976			22
23	Inservice Training & Education			1,087	1,087		1,087	1,292	2,379			23
24	Travel and Seminar			2,980	2,980		2,980	9,624	12,604			24
25	Other Admin. Staff Transportation			2,392	2,392		2,392		2,392			25
26	Insurance-Prop.Liab.Malpractice			203,608	203,608		203,608	2,033	205,641			26
27	Other (specify):*											27
28	TOTAL General Administration	414,586	38,359	4,843,155	5,296,100		5,296,100	40,888	5,336,988			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,589,401	1,389,150	6,913,258	17,891,809		17,891,809	69,140	17,960,949			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			925,838	925,838		925,838	119,663	1,045,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			234,836	234,836		234,836	(3,221)	231,615			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			105,617	105,617		105,617	39,525	145,142			35
36	Other (specify):*											36
37	TOTAL Ownership			1,266,291	1,266,291		1,266,291	155,967	1,422,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,545,639	1,545,639		1,545,639		1,545,639			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			515,099	515,099		515,099		515,099			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			2,060,738	2,060,738		2,060,738		2,060,738			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,589,401	1,389,150	10,240,287	21,218,838		21,218,838	225,107	21,443,945			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	12,150	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	(11,208)	4		8
9	Non-Straightline Depreciation	107,818	30		9
10	Interest and Other Investment Income	(3,221)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,315)	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)	\$ 104,224		\$	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)	120,883		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 120,883		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 225,107		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#0044792

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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE VILLA SCALABRINI NR # 0044792 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	12,150	2,735	0	0	0	0	0	0	0	0	0	14,885	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(11,208)	0	0	0	0	0	0	0	0	0	0	(11,208)	4
5	Heat and Other Utilities	0	5,569	0	0	0	0	0	0	0	0	0	5,569	5
6	Maintenance	0	18,736	0	0	0	0	0	0	0	0	0	18,736	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	942	27,040	0	0	0	0	0	0	0	0	0	27,982	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	270	0	0	0	0	0	0	0	0	0	270	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	270	0	0	0	0	0	0	0	0	0	270	16
	C. General Administration													
17	Administrative	0	(289,039)	100,715	0	0	0	0	0	0	0	0	(188,324)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	57,793	0	0	0	0	0	0	0	0	0	57,793	19
20	Fees, Subscriptions & Promotions	(1,315)	5,918	0	0	0	0	0	0	0	0	0	4,603	20
21	Clerical & General Office Expenses	0	3,423	0	0	0	0	0	0	0	0	0	3,423	21
22	Employee Benefits & Payroll Taxes	0	150,444	0	0	0	0	0	0	0	0	0	150,444	22
23	Inservice Training & Education	0	1,292	0	0	0	0	0	0	0	0	0	1,292	23
24	Travel and Seminar	0	9,624	0	0	0	0	0	0	0	0	0	9,624	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,033	0	0	0	0	0	0	0	0	0	2,033	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,315)	(58,512)	100,715	0	0	0	0	0	0	0	0	40,888	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(373)	(31,202)	100,715	0	0	0	0	0	0	0	0	69,140	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	107,818	0	11,845	0	0	0	0	0	0	0	0	119,663	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,221)	0	0	0	0	0	0	0	0	0	0	(3,221)	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	39,525	0	0	0	0	0	0	0	0	39,525	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	104,597	0	51,370	0	0	0	0	0	0	0	0	155,967	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)	104,224	(31,202)	152,085	0	0	0	0	0	0	0	0	225,107	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%	\$ 2,735	\$ 2,735	1
2	V	5	Utilities		Presence Life Connections	100.00%	5,569	5,569	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	18,736	18,736	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	270	270	4
5	V	17	Admin - Misc. Other	869,295	Presence Life Connections	100.00%	9,508	(859,787)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	570,748	570,748	6
7	V	19	Professional Services		Presence Life Connections	100.00%	57,793	57,793	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	5,918	5,918	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,423	3,423	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	150,444	150,444	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,292	1,292	11
12	V	24	Travel		Presence Life Connections	100.00%	9,624	9,624	12
13	V	26	Insurance		Presence Life Connections	100.00%	2,033	2,033	13
14	Total			\$ 869,295			\$ 838,093	\$ * (31,202)	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%	\$ 11,845	\$ 11,845	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%	39,525	39,525	18
19	V	17	Admin Salaries		Presence Health	100.00%	122,848	122,848	19
20	V	30	Depreciation	318,215	Presence Health	100.00%	318,215		20
21	V	17	Admin Consulting,Other	1,236,205	Presence Health	100.00%	1,214,072	(22,133)	21
22	V	39	Ancillary Services - Other	1,545,639	Presence Senior Services Pharmacy	100.00%	1,545,639		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			\$ 3,100,059			\$ 3,252,144	\$ * 152,085	39

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

Facility Name & ID Number

PRESENCE VILLA SCALABRINI NR

0044792

Report Period Beginning:

1/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Susan Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Ann Sherline	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral Health	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Carlo	Northlake	Independent Living	13
14					Presence Ambulatory Services	Various	Parent	14
15					Resurrection Development	Chicago	Parent	15
16					Presence Healthcare Services	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care Services	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retirement	Chicago	Independent Living	24
25					Resurrection University	Chicago	College	25
26					Presence Health Partners	Various	Parent	26
27					Presence Properties Plus	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Estate	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE VILLA SCALABRINI NR # 0044792 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number	PRESENCE VILLA SCALABRINI NR
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10
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92	92
93	93
94	94
95	95
96	96
97	97
98	98
99	99
100	100

0044792

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	\$	869,295	\$ 2,735	1
2	5	Utilities	Management Fee Income	9,455,191	33	60,575		869,295	5,569	2
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785		869,295	18,736	3
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934		869,295	270	4
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412		869,295	9,508	5
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	869,295	570,748	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607		869,295	57,793	7
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374		869,295	5,918	8
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236		869,295	3,423	9
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354		869,295	150,444	10
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049		869,295	1,292	11
12	24	Travel	Management Fee Income	9,455,191	33	104,676		869,295	9,624	12
13	26	Insurance	Management Fee Income	9,455,191	33	22,118		869,295	2,033	13
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835		869,295	11,845	14
15	32	Interest	Management Fee Income	9,455,191	33	0		869,295	0	15
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0		869,295	0	16
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912		869,295	39,525	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 9,674,560	\$ 6,207,940		\$ 889,463	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI NR # 0044792 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	6,627,442	10	\$ 658,602	\$ 658,602	1,236,205	\$ 122,848	1
2	30	Depreciation	Operating Expense	1,658,013	10	1,658,013		318,215	318,215	2
3	17	Admin Consulting,Other	Operating Expense	6,627,442	10	6,508,786		1,236,205	1,214,072	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		\$ 1,655,135	25

Facility Name & ID Number PRESENCE VILLA SCALABRINI NR # 0044792 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			\$	\$		1,545,639	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		1,545,639	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	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE VILLA SCALABRINI NR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. **Summary of Real Estate Tax Cost**

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

A. Square Feet: 195,174

B. General Construction Type: Exterior BrickFrame Steel/ConcreteNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	696,960	2000	\$ 1,500,000	1
2					2
3	TOTALS	696,960		\$ 1,500,000	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	253		2000		\$ 7,510,695	\$ 152,606	40	\$ 187,686	\$ 35,080	\$ 3,924,447	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			2000	87,374		8			87,374	9
10	VARIOUS			2001	22,045		15			22,045	10
11	VARIOUS			2002	2,385		11			2,385	11
12	VARIOUS			2004	23,112	1,144	15	1,156	11	15,008	12
13	VARIOUS			2005	74,417	1,934	15	2,120	186	67,808	13
14	VARIOUS			2006	2,077,086	83,406	9	85,629	2,222	1,125,536	14
15	VARIOUS			2007	87,391	1,724	11	1,800	76	69,289	15
16	VARIOUS			2008	7,411	363	8	371	7	3,325	16
17											17
18	ADDITIONAL FLOOR PREP FOR HALL			2012	5,377	538	10	538	0	2,688	18
19	CONSTRUCTION OF PHYSICAL THERA			2012	127,361	8,578	60	8,491	(88)	38,325	19
20	DESIGN INSTALLATION OF WIFI SY			2012	49,000	5,151	10	4,900	(251)	22,385	20
21	NEW FLOOR FINISHING IN UNITS C			2012	2,751	712	5	550	(162)	2,692	21
22	NEW FLOOR FINISHING SEALED PT			2012	3,001	574	5	600	26	2,666	22
23	NEW FLOORING FOR PT ROOM SURR			2012	39,106	3,864	30	3,911	47	17,535	23
24	NEW SPRINKLER SYSTEM THERAPY R			2012	7,500	300	25	300		1,350	24
25	PHYSICAL THERAPY ROOM RENOVATI			2012	8,500	583	15	567	(16)	2,572	25
26	REPLACE 2 MOTOR CONTROL PANELS			2012	17,200	1,139	15	1,147	8	5,149	26
27	REPLACE KITCHEN FLOORING PORT			2012	31,500	1,567	20	1,575	8	7,077	27
28	SPRINKLER INSTALLATION PROJECT			2012	30,000	1,195	25	1,200	5	5,394	28
29	33 NEW SMOKE DETECTORS 4 PULL			2013	44,443	4,329	20	4,444	115	15,402	29
30	60 RUSKIN FIRE DAMPERS CEILING			2013	14,100	922	15	940	18	3,266	30
31	A BUILDING REPLACEMENT OF A C			2013	10,785	705	15	719	14	2,498	31
32	BURKE PLANK VINYL FLOORING WIT			2013	7,814	757	10	781	24	2,703	32
33	INSTALLATION OF DOORS IN CONFE			2013	9,180	608	15	612	4	2,137	33
34	L M TO REMOVE OLD CARPET AND R			2013	16,800	1,645	10	1,680	35	5,833	34
35	REMODELING OF 8 ROOMS			2013	25,932	1,729	15	1,729		6,051	35
36	SPRINKLER INSTALLATION PROJECT			2013	738,131	29,355	150	29,525		103,112	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE VILLA SCALABRINI NR

0044792

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	33 NEW SMOKE DETECTORS 4 PULL	2014	\$ 12,662	\$ 1,225	20	\$ 1,266	\$ 41	\$ 3,800	37
38	ARCHITECTURAL SERVICE FOR ALL	2014	46,000	3,048	15	3,067	18	7,642	38
39	INSTALL NEW FLOOR IN WALK IN F	2014	9,050	922	10	905	(17)	2,286	39
40	RENOVATION OF QUAD UNITS INTO	2014	638,000	40,220	150	40,400	180	100,760	40
41	RENOVATIONS OF QUAD UNITS INTO	2014	101,261	6,917	15	6,751	(167)	17,099	41
42	REPLACEMENT OF DOORS IN SEVERA	2014	17,175	1,145	15	1,145		2,863	42
43	SIDEWALK ADDED FROM THERAPY RO	2014	8,000	540	15	533	(7)	1,342	43
44									44
45	: 3 SHOWER REMODEL UNIT 3	2015	11,600	580	20	580		677	45
46	24 RM CONVERT INTO SHORT TERM	2015	55,467	2,773	20	2,773	(0)	3,467	46
47	24 SEMI PRIV RMS TO 15 PRIV SK	2015	110,934	5,547	20	5,547	0	9,244	47
48	BACKUP GENERATOR FIRE PUMP REP	2015	128,500	8,567	15	8,567	(0)	10,708	48
49	CHANGE ORDER REQUEST #3	2015	10,850	588	20	543	(45)	588	49
50	CONVER 24 RMS TO PRIVIATE SNF	2015	5,666	283	20	283	0	331	50
51	INSTALL NEW R 22 CARRIER AIR C	2015	41,573	2,675	15	2,772	97	6,800	51
52	PHASE 2 NURSE CALL	2015	4,200	245	20	210	(35)	245	52
53	PHASE 2 OF WING REMODEL AND NU	2015	375,000	18,750	60	18,750		28,292	53
54	PHASE 2 WING REMODEL NURSE SUB	2015	257,000	12,850	40	12,850		15,392	54
55	RENOVATE OF QUAD UNITS INTO 15	2015	8,532	427	20	427	(0)	782	55
56	RENOVATIONS OF QUAD UNITS INTO	2015	67,507	3,288	20	3,375	87	8,322	56
57	REPLACE KITCHEN FLOOR SINK PIP	2015	8,950	179	50	179		254	57
58	SPRINKLER HEAD REPLACE	2015	39,700	2,647	15	2,647	(0)	3,308	58
59									59
60	: A- wings air handler&AC re	2016	44,708	373	20	186	(186)	373	60
61	: Elevator Repair Hydraulic	2016	7,900	230	20	198	(33)	230	61
62	: INSTALLATION OF NEW Nurse Station Flooring	2016	10,995	122	15	61	(61)	122	62
63	INTERIOR FINISH HANNA Z - Vinyl Flooring Nurse Station	2016	12,951	791	15	719	(72)	791	63
64	PHASE 2 WING REMODEL NURSE Station - Painting	2016	1,750	88	20	88	(0)	88	64
65	INTERIOR FINISH HANNA Z - Paneling Nurse Station	2016	3,777	231	15	210	(21)	231	65
66	PHASE 2 WING REMODEL NURSE Station Buildout/Constructi	2016	68,870	3,413	20	3,444	31	3,413	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,188,975	\$ 424,094		\$ 461,444	\$ 37,180	\$ 5,795,499	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	\$ 4,119,129	\$ 172,061	\$ 243,496	\$ 71,435	12	\$ 2,949,563	71
72	Current Year Purchases	97,810	4,434	3,467	(967)	13	4,434	72
73	Fully Depreciated Assets	845,783	7,034	7,034		7	845,783	73
74	Home Office Allocation		330,060	330,060				74
75	TOTALS	\$ 5,062,722	\$ 513,589	\$ 584,057	\$ 70,468		\$ 3,799,780	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)	\$ 19,751,697	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 937,683	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,045,501	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 107,818	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,595,279	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: \$145,142
- Description: Nursing 70,950; Admin 22,498; Dietary 4,268; Pastoral 216; Plant 120; Rehab 7,565; Home Office 39,525
(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)	\$			

(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.

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	

(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	13132	hrs	\$ 491,815		\$	13,132	\$ 491,815	1
2	Licensed Speech and Language Development Therapist	10a, 1	2226	hrs	88,204			2,226	88,204	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a, 1	15874	hrs	632,650			15,874	632,650	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			1,545,639		1,545,639	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): <u>Director</u>	10a, 1	1842		97,010			1,842	97,010	12
13	Other (specify): _____									13
14	TOTAL				\$ 1,309,679		\$ 1,545,639	33,074	\$ 2,855,318	14

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

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

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	6,948,991	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 182,851,994	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,057,970)	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)	\$ (1,456,037)	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 VILLA SCALABRINI NR

0044792

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	\$ 21,820,606	1
2	Discounts and Allowances for all Levels	(7,358,698)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,461,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,375,795	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,375,795	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	(12,150)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,265,905	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	11,208	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,264,963	23
	D. Non-Operating Revenue		
24	Contributions	24,729	24
25	Interest and Other Investment Income***	3,221	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,950	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	30,252	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,252	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,160,868	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,462,952	31
32	Health Care	9,132,757	32
33	General Administration	5,296,100	33
	B. Capital Expense		
34	Ownership	1,266,291	34
	C. Ancillary Expense		
35	Special Cost Centers	1,545,639	35
36	Provider Participation Fee	515,099	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,218,838	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,057,970)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,057,970)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,707,209	44
45	Private Pay - Net Inpatient Revenue	3,552,767	45
46	Medicare - Net Inpatient Revenue	3,552,696	46
47	Other-(specify) <u>Insurance</u>	649,236	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,461,908	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	1,857	2,111	\$ 111,044	\$ 52.60	1
2	Assistant Director of Nursing	1,848	2,103	100,640	47.86	2
3	Registered Nurses	94,841	104,943	3,944,876	37.59	3
4	Licensed Practical Nurses	5,161	6,269	186,723	29.79	4
5	CNAs & Orderlies	145,212	160,613	2,313,840	14.41	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	30,925	33,075	1,309,679	39.60	7
8	Rehab/Therapy Aides	768	868	13,506	15.56	8
9	Activity Director	1,947	2,097	42,773	20.40	9
10	Activity Assistants	10,944	11,756	131,141	11.16	10
11	Social Service Workers	6,745	8,184	159,539	19.49	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	6,469	7,297	154,834	21.22	17
18	Housekeepers	21,792	24,580	302,090	12.29	18
19	Laundry	11,014	12,123	139,416	11.50	19
20	Administrator	1,995	2,256	143,910	63.79	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,866	2,097	53,735	25.62	22
23	Office Manager	1,403	1,774	37,916	21.37	23
24	Clerical	12,941	14,261	202,843	14.22	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	3,404	3,678	88,314	24.01	32
33	Other(specify) Pastoral	4,530	4,898	152,582	31.15	33
34	TOTAL (lines 1 - 33)	365,662	404,983	\$ 9,589,401 *	\$ 23.68	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	80,370	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	825	49,476	10a,3	40
41	Occupational Therapy Consultant	401	24,033	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	7	457	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,233	\$ 154,336		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

PRESENCE VILLA SCALABRINI NR

0044792

Report Period Beginning:

1/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Daryce Fields	Administrator		\$ 143,910
Administrative Staff	Office Manager		37,916
Administrative Staff	Receptionists		89,783
Administrative Staff	Administrative Asst		0
Administrative Staff	Admissions		88,314
Administrative Staff	Other Administrative		54,663
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 414,586

B. Administrative - Other

Description	Amount
Corp Office Management Fee	\$ 2,105,660
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 2,105,660

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	\$ 0
Collections	Various	0
Shredding/Storage	Various	320
Survey & Analytical Tools	Various	0
Ground Charge	Various	53
Biomed	Various	750
Outsourced Services	Various	(2,024)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ (901)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 119,941
Unemployment Compensation Insurance	32,457
FICA Taxes	734,539
Employee Health Insurance	990,677
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	150,444
Dental	31,442
Life Insurance	7,370
Disability Insurance	39,226
Pension	442,144
Tuition Reimbursement	19,807
Other Benefits	39,928
TOTAL (agree to Schedule V, line 22, col.8)	\$ 2,607,976

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 81)	
Patient Background Checks	342
Employee Recruitment	1,200
Dues & Subscriptions	41,117
Advertising & Public Relations	1,315
Home Office Allocation	5,918
Less: Public Relations Expense	()
Non-allowable advertising	(1,315)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,235

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	2,980
Seminar Expense	
Home Office Allocation	9,624
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 12,604

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

(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