

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0045906

Facility Name: McAuley Residence

Address: 2060 West Granville Avenue Chicago 60659
Number City Zip Code

County: Cook

Telephone Number: 773 273-3033 Fax # 773 743-5439

HFS ID Number:

Date of Initial License for Current Owners: 11/03/05

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: Carolyn Sheehan Telephone Number: 773 273-3033
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 July 1, 2011 to June 30, 2012 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) Kevin Connolly
(Title) Chief Financial Officer

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 McAuley Residence# 0045906 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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		Skilled (SNF)			1
2	<u>125</u>	Skilled Pediatric (SNF/PED)	<u>125</u>	<u>43,445</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>125</u>	TOTALS	<u>125</u>	<u>43,445</u>	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					8
9	SNF/PED	<u>41,330</u>	<u>1,525</u>		<u>42,855</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,330</u>	<u>1,525</u>		<u>42,855</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.64%

D. How many bed-hold days during this year were paid by the Department?

590 (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)

Adult Vocational and School

F. Does the facility maintain a daily midnight census?

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 11/03/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/12 Fiscal Year: 06/30/12

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

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	84,493	21,612	5,352	111,457		111,457		111,457		1
2	Food Purchase		261,857		261,857		261,857	(63,632)	198,225		2
3	Housekeeping	339,359	45,084	114,478	498,921		498,921	(16,546)	482,375		3
4	Laundry	140,982	16,741		157,723		157,723	(26)	157,697		4
5	Heat and Other Utilities			316,347	316,347		316,347	(18,606)	297,741		5
6	Maintenance	147,751	51,846	353,796	553,393		553,393	(48,867)	504,526		6
7	Other (specify):*										7
8	TOTAL General Services	712,585	397,140	789,973	1,899,698		1,899,698	(147,677)	1,752,021		8
	B. Health Care and Programs										
9	Medical Director	81,388			81,388		81,388		81,388		9
10	Nursing and Medical Records	4,506,184	499,381	41,474	5,047,039		5,047,039		5,047,039		10
10a	Therapy	1,775,201	3,131	88,685	1,867,017		1,867,017		1,867,017		10a
11	Activities	15,460	703	4,279	20,442		20,442		20,442		11
12	Social Services	74,837	98		74,935		74,935		74,935		12
13	CNA Training	8,828	257		9,085		9,085		9,085		13
14	Program Transportation		27,262		27,262		27,262	(1,768)	25,494		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,461,898	530,832	134,438	7,127,168		7,127,168	(1,768)	7,125,400		16
	C. General Administration										
17	Administrative	120,610	793		121,403		121,403	(14,729)	106,674		17
18	Directors Fees										18
19	Professional Services			75,711	75,711		75,711	(2,537)	73,174		19
20	Dues, Fees, Subscriptions & Promotions			35,328	35,328		35,328	(2,103)	33,225		20
21	Clerical & General Office Expenses	380,928	27,581	32,252	440,761		440,761	(18,009)	422,752		21
22	Employee Benefits & Payroll Taxes			1,870,060	1,870,060		1,870,060	(70,051)	1,800,009		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,170	3,170		3,170	(504)	2,666		24
25	Other Admin. Staff Transportation		283		283		283	(283)			25
26	Insurance-Prop.Liab.Malpractice			57,276	57,276		57,276	(3,756)	53,520		26
27	Other (specify):*										27
28	TOTAL General Administration	501,538	28,657	2,073,797	2,603,992		2,603,992	(111,971)	2,492,021		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,676,021	956,629	2,998,208	11,630,858		11,630,858	(261,417)	11,369,441		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			922,401	922,401		922,401	(50,712)	871,689			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,712	5,712		5,712	(5,712)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			928,113	928,113		928,113	(56,424)	871,689			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	272,916	6,353		279,269		279,269	(263,782)	15,487			39
40	Barber and Beauty Shops			447	447		447		447			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			546,050	546,050		546,050		546,050			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	272,916	6,353	546,497	825,766		825,766	(263,782)	561,984			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,948,937	962,982	4,472,818	13,384,737		13,384,737	(581,623)	12,803,114			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(63,632)	2		3
4	Non-Patient Meals				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				8
9	Non-Straightline Depreciation	9,505	30		9
10	Interest and Other Investment Income	(5,712)	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				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)	\$ (59,839)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (59,839)		37

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

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

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

McAuley ResidenceID# **0045906**Report Period Beginning: **July 1, 2011**Ending: **June 30, 2012**

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Expenses reimbursed from other sources:	\$		1
2	Housekeeping Wages, Supplies	(16,546)	3	2
3	Laundry supplies	(26)	4	3
4	Heat and Other Utilities	(18,606)	5	4
5	Maintenance Wages, Supplies and Other	(20,601)	6	5
6	Program Transportation Other	(1,768)	14	6
7	Administrative Wages, Supplies and other	(3,747)	17	7
8	Professional Services	(2,537)	19	8
9	Dues, Fees, Subscriptions & Promotions	(1,628)	20	9
10	Clerical Wages, Supplies and Other	(18,009)	21	10
11	Employee Benefits & Payroll Taxes	(68,496)	22	11
12	Travel & Seminar	(504)	24	12
13	Other Admin Staff Transportation	(9)	25	13
14	Insurance	(3,756)	26	14
15	Depreciation	(45,190)	30	15
16	Ancillary Service Centers Salaries and Supplies	(259,871)	39	16
17	Donated Administrator's salary	(10,982)	17	17
18	Donated equipment	(309)	6	18
19	Donated other employee benefits	(1,555)	22	19
20	Off-site recreational facility costs	(3,911)	39	20
21	Off-site recreational facility depreciation	(1,453)	30	21
22	Loss on disposal	(27,957)	6	22
23	Subscription	(475)	20	23
24	Non-care auto	(274)	25	24
25	Depreciation on donated fixed assets	(13,574)	30	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	(521,784)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning:

July 1, 2011

Ending:

June 30, 2012

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	(63,632)	0	0	0	0	0	0	0	0	0	0	(63,632)	2
3	Housekeeping	(16,546)	0	0	0	0	0	0	0	0	0	0	(16,546)	3
4	Laundry	(26)	0	0	0	0	0	0	0	0	0	0	(26)	4
5	Heat and Other Utilities	(18,606)	0	0	0	0	0	0	0	0	0	0	(18,606)	5
6	Maintenance	(48,867)	0	0	0	0	0	0	0	0	0	0	(48,867)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(147,677)	0	0	0	0	0	0	0	0	0	0	(147,677)	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	0	0	0	0	0	0	0	0	0	0	0	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	(1,768)	0	0	0	0	0	0	0	0	0	0	(1,768)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,768)	0	0	0	0	0	0	0	0	0	0	(1,768)	16
	C. General Administration													
17	Administrative	(14,729)	0	0	0	0	0	0	0	0	0	0	(14,729)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,537)	0	0	0	0	0	0	0	0	0	0	(2,537)	19
20	Fees, Subscriptions & Promotions	(2,103)	0	0	0	0	0	0	0	0	0	0	(2,103)	20
21	Clerical & General Office Expenses	(18,009)	0	0	0	0	0	0	0	0	0	0	(18,009)	21
22	Employee Benefits & Payroll Taxes	(70,051)	0	0	0	0	0	0	0	0	0	0	(70,051)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(504)	0	0	0	0	0	0	0	0	0	0	(504)	24
25	Other Admin. Staff Transportation	(283)	0	0	0	0	0	0	0	0	0	0	(283)	25
26	Insurance-Prop.Liab.Malpractice	(3,756)	0	0	0	0	0	0	0	0	0	0	(3,756)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(111,971)	0	0	0	0	0	0	0	0	0	0	(111,971)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(261,417)	0	0	0	0	0	0	0	0	0	0	(261,417)	29

Summary B

June 30, 2012

[illegible]

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
Monsignor Michael Boland	BOD			The Catholic Bishop of Chicago, through provisions in Misericordia's		
S. Rosemary Connelly	BOD			By-Laws and Catholic Charities, by virtue of a majority of		
Margaret Murphy	BOD			Board membership, qualify as related organization because		
John Dyer	BOD			each has the ability to influence Misericordia's Operating policy.		
Rob Figliulo	BOD			Misericordia Home, an equal opportunity employer and provider		
Daniel Houlihan	BOD			of service, is separately incorporated and independantly funded		

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$	Certain costs, primarily related to insurance and/or construction, may be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to these organizations on a pass-through basis, as part of our participation in collective purchasing groups. Our share of costs are ultimately paid to external providers not related to us.		\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

*** 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

*** 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

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

<u>Facility Name & ID Number</u>	<u>McAuley Residence</u>
---	---------------------------------

0045906

Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

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

<u>Facility Name & ID Number</u>	<u>McAuley Residence</u>
---	---------------------------------

0045906

Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Patrick Mahoney	BOD						2
3	Robert Soudan	BOD						3
4	Dan Walsh	BOD						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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2011 Ending: June 30, 2012

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	S. Rosemary Connelly	Executive Director	Oversees Misericordi	N/A		50	100.00	Salary	\$ 12,940	17	1
2											2
3											3
4	Note that S. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is further allocated										4
5	between Misericordia North & McAuley).										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,940		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

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
McAuley Residence

COUNTY
Cook

FACILITY IDPH LICENSE NUMBER
0045906

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 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	80,145	B. General Construction Type:	Exterior	Brick	Frame	Solid Masonry	Number of Stories
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	----------------------	--------------------------

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).

Day training facility - approximately 5,002 square feet.

School facility - approximately 4,928 square feet.

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning:

July 1, 2011 Ending: June 30, 2012

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			2006	2006	\$ 17,270,377	\$ 431,758	40	\$ 431,758	\$	\$ 2,887,556
5										
6										
7										
8										
	Improvement Type**									
9	Therapy pool, phones, plumbing, paging system and fence			2006	312,419	16,131	15-20	16,131		97,884
10	Install tile, electric wiring, air conditioning improv, phone			2007	86,018	6,473	15-20	6,473	0	35,140
11	Street signs			2008	6,590	659	10	659	0	3,185
12	Install conduit and wire for chiller for HVAC control, alarm, wire for roof			2010	6,834	356	20	356		712
13	Install conduit for HVAC control, alarm			2011	2,373	119	20	119		208
14	Vinyl flooring			2012	8,350	557	10	557		557
15										
16	Support and MGA allocations:									
17	Connolly Center Laundry allocated based on weight of laund					28,486	25	28486		
18	Resource Center allocated based on # of residents					791	25	791		
19	Staff Development allocation based on # of emp trained					499	25	499		
20	Food Services allocated based on # of meals					3,713	25	5580	1,867	
21	Building Operations allocation based on squ feet					137,873	25	138,734	861	
22	Therapy dept allocation based on staff hours					10,953	25	10,953		
23	MGA alloc based # of employees, direct exp					35,592	25	42,369	6,777	
24	Purchasing dept allocated based on # of requisitions					970	25	970		
25	Religious Services based on census					33,862	25	33,862		
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 17,692,961	\$ 708,792		\$ 718,297	\$ 9,505	\$ 3,025,242	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	\$ 1,695,467	\$ 144,317	\$ 144,317	\$ (0)		\$ 904,974	71
72	Current Year Purchases	39,882	1,095	1,095			1,095	72
73	Fully Depreciated Assets	996,797					996,797	73
74								74
75	TOTALS	\$ 2,732,146	\$ 145,412	\$ 145,412	\$ (0)		\$ 1,902,866	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	campus alloc from bldg operations			\$ 34,028	\$ 7,980	\$ 7,980	\$	3	\$ 127,135
77									
78									
79									
80	TOTALS			\$ 34,028	\$ 7,980	\$ 7,980	\$		\$ 127,135

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)			\$ 20,459,135
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 862,184
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 871,689
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 9,505
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 5,055,243

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	Furn & Equip alloc to other program	\$ 8,190,779	\$ 306,045	\$ 6,689,370	86
87	Auto alloc to other prog	1,142,053	123,776	969,492	87
88	Bldg & Improv alloc to other prog	102,434,537	3,497,146	51,916,372	88
89	Land	1,205,104			89
90					90
91	TOTALS	\$ 112,972,473	\$ 3,926,967	\$ 59,575,234	91

G. Construction-in-Progress			
	Description	Cost	
92	New CILAs	\$ 1,304,489	92
93	Campus expansions	152,764	93
94	HVAC upgrade	197,651	94
95		\$ 1,654,904	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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		257		257
3	Classroom Wages (a)		8,828		8,828
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,085	\$	\$ 9,085
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,085			

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		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program	2900	hrs	15,487				2900	15,487	7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 15,487		\$	\$		\$ 15,487	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	\$ 15,333,806	\$	1
2	Cash-Patient Deposits	334,114		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>35,000</u>)	14,252,635		3
4	Supply Inventory (priced at _____)	333,632		4
5	Short-Term Investments	8,664,060		5
6	Prepaid Insurance	378,926		6
7	Other Prepaid Expenses	58,659		7
8	Accounts Receivable (owners or related parties)	1,057,616		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 40,413,448	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,205,107		13
14	Buildings, at Historical Cost	120,127,495		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,099,006		16
17	Accumulated Depreciation (book methods)	(64,630,477)		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): _____			22
23	Other(specify): <u>CIP</u>	1,654,904		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 70,456,035	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 110,869,483	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 890,333	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	289,891		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,553,327		30
31	Accrued Taxes Payable (excluding real estate taxes)	167,736		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Revenue</u>	644,766		36
37	<u>Other Liabilities and ARO</u>	964,370		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,510,423	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,510,423	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 105,359,060	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 110,869,483	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 101,935,574	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 101,935,574	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,678,984)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	20,513,599	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Loss from North	(6,642,573)	15
16	Other (describe) Development & Community Relations	(2,216,425)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 7,975,617	17
	B. Transfers (Itemize):		
18	Investment activity/insurance proceeds	104,050	18
19	Net Asset Reclassification	(4,656,181)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,552,131)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 105,359,060	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: July 1, 2011Ending: June 30, 2012

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	\$ 9,335,975	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,335,975	3
	B. Ancillary Revenue		
4	Day Care	369,778	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 369,778	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,705,753	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,899,698	31
32	Health Care	7,127,168	32
33	General Administration	2,603,992	33
	B. Capital Expense		
34	Ownership	928,113	34
	C. Ancillary Expense		
35	Special Cost Centers	279,716	35
36	Provider Participation Fee	546,050	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,384,737	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,678,984)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,678,984)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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	3,294	3,755	\$ 145,556	\$ 38.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,222	40,381	1,170,595	28.99	3
4	Licensed Practical Nurses	22,022	24,815	640,028	25.79	4
5	CNAs & Orderlies	167,800	181,389	2,458,995	13.56	5
6	CNA Trainees					6
7	Licensed Therapist	3,881	4,367	149,832	34.31	7
8	Rehab/Therapy Aides	14,548	16,371	302,403	18.47	8
9	Activity Director					9
10	Activity Assistants	611	691	15,460	22.37	10
11	Social Service Workers	2,832	3,265	74,837	22.92	11
12	Dietician	232	285	9,704	34.05	12
13	Food Service Supervisor	310	385	8,834	22.95	13
14	Head Cook	989	1,131	27,389	24.22	14
15	Cook Helpers/Assistants	3,309	3,596	48,270	13.42	15
16	Dishwashers					16
17	Maintenance Workers	5,183	6,082	147,751	24.29	17
18	Housekeepers	22,394	25,549	339,359	13.28	18
19	Laundry	9,328	10,426	140,982	13.52	19
20	Administrator	1,975	2,214	120,610	54.48	20
21	Assistant Administrator					21
22	Other Administrative	8,267	9,320	248,271	26.64	22
23	Office Manager					23
24	Clerical	6,505	7,361	132,657	18.02	24
25	Vocational Instruction	12,697	14,346	272,916	19.02	25
26	Academic Instruction	301	352	8,828	25.08	26
27	Medical Director	820	920	81,388	88.47	27
28	Qualified MR Prof. (QMRP)	16,854	18,308	309,600	16.91	28
29	Resident Services Coordinator	22,196	25,361	516,275	20.36	29
30	Habilitation Aides (DD Homes)	24,266	27,602	487,387	17.66	30
31	Medical Records	2,137	2,463	48,516	19.70	31
32	Other Health Care <u>Respiratory Aide</u>	1,817	2,072	42,494	20.51	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	390,790	432,807	\$ 7,948,937 *	\$ 18.37	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		\$ 5,352	1	35
36	Medical Director				36
37	Medical Records Consultant		38	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,378	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	991	49,816	10a	41
42	Respiratory Therapy Consultant		4,560	10	42
43	Speech Therapy Consultant	544	30,533	10a	43
44	Activity Consultant		4,279	11	44
45	Social Service Consultant				45
46	Other(specify) <u>Physician</u>		34,068	10	46
47	<u>Psych/Behavioral Therapist</u>		8,336	10a	47
48	<u>Dental</u>		430	10	48
49	TOTAL (lines 35 - 48)	1,535	\$ 139,790		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

0045906

Report Period Beginning:

July 1, 2011

Page 21

Ending: June 30, 2012

Facility Name & ID Number

McAuley Residence

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sr. Rosemary Connelly	Executive Director	N/A	\$ 12,940	Workers' Compensation Insurance	\$ 116,819	IDPH License Fee	\$	
Mary Pat O'Brien	Asst. Executive Directro	N/A	15,821	Unemployment Compensation Insurance	29,880	Advertising: Employee Recruitment	783	
Denise Tigges	Admistrator	N/A	15,128	FICA Taxes	560,142	Health Care Worker Background Check		
Michael Diaz	Admistrator	N/A	10,059	Employee Health Insurance	626,577	(Indicate # of checks performed)		
Lois Gates	Asst. Executive Directro	N/A	15,936	Employee Meals		Patient Background Checks	4,635	
Chris Hegg/Joe Ferrera	Administrator	N/A	24,135	Illinois Municipal Retirement Fund (IMRF)*		Dept of Public Health/CLIA license		
Kevin Connelly/Fr. Jack Clair	CFO/Asst Exe Dir	N/A	26,591	Emp Tuition Reimbursement/Other	32,234	Subscription	369	
TOTAL (agree to Schedule V, line 17, col. 1)				Dental Insurance	23,937	Membership Dues	7,733	
(List each licensed administrator separately.)			\$ 120,610	401K Match	366,705	Bank fees	6,120	
B. Administrative - Other				Long-Term Disablility and Life Insurance	43,715	Computer licensing	13,585	
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)		
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,800,009			
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Deloitte & Touche	Audit		\$ 21,370	Taxable fringe benefits - gas	22	\$ 5,409	Out-of-State Travel	\$
ADP Processing	Payroll Service		39,481					
Burke, Warren, MacKay & Serr	Legal		6,318					
Mahoney, Crowe, & Goldrick	Legal		970				In-State Travel	
Correll	Admin for 401K plan		7,572					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 5,409	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 75,711					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.
Ill Health care Assoc \$6550

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?
10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 139,169
Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES
X
NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES
NO
X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 546,050

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

Yes

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

No

Indicate the amount.
\$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.
\$

c. What percent of all travel expense relates to transportation of nurses and patients?

N/a

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes, program vehicles

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.
\$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:
Deloitte

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.