

		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: 0042879

Facility Name: Presence McAuley Manor

Address: 400 West Sullivan Road Aurora 60506
Number City Zip Code

County: Kane

Telephone Number: (630) 859-3700 Fax # (630) 264-1862

HFS ID Number:

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 C 3

☐ 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: Lynda M. Olinski Telephone Number: (708) 478-7916
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 01/01/2012 to 12/31/2012 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) Michael R. Gordon
(Title) CFO, VP 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 McAuley Manor# 0042879 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	<u>87</u>	Skilled (SNF)	<u>87</u>	<u>31,842</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>87</u>	TOTALS	<u>87</u>	<u>31,842</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	<u>3,144</u>	<u>8,609</u>	<u>13,950</u>	<u>25,703</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,144</u>	<u>8,609</u>	<u>13,950</u>	<u>25,703</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.72%

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?

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 12/01/1997

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

YES ☒Date 12/01/1997NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 87 and days of care provided 10,811Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

* 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	248,267	48,145	8,674	305,086		305,086		305,086		1
2	Food Purchase		151,982		151,982		151,982	(5,491)	146,491		2
3	Housekeeping	151,300	32,310		183,610		183,610		183,610		3
4	Laundry	22,203	5,120	74,947	102,270		102,270		102,270		4
5	Heat and Other Utilities			126,071	126,071		126,071	4,308	130,379		5
6	Maintenance	85,307	43,905	86,648	215,860		215,860	65,012	280,872		6
7	Other (specify):* Pastoral Care	32,713	1,929	37,255	71,897		71,897	(18,722)	53,175		7
8	TOTAL General Services	539,790	283,391	333,595	1,156,776		1,156,776	45,107	1,201,883		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,650,778	324,560	96,096	3,071,434		3,071,434		3,071,434		10
10a	Therapy			907,486	907,486		907,486		907,486		10a
11	Activities	57,384	2,618	20,958	80,960		80,960	3,241	84,201		11
12	Social Services	56,581		2,078	58,659		58,659		58,659		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,764,743	327,178	1,056,618	4,148,539		4,148,539	3,241	4,151,780		16
	C. General Administration										
17	Administrative	344,267	12,710	770,312	1,127,289		1,127,289	(337,340)	789,949		17
18	Directors Fees										18
19	Professional Services			12,244	12,244		12,244	41,806	54,050		19
20	Dues, Fees, Subscriptions & Promotions			30,582	30,582		30,582	(15,462)	15,120		20
21	Clerical & General Office Expenses			28,211	28,211		28,211	4,710	32,921		21
22	Employee Benefits & Payroll Taxes			823,939	823,939		823,939	177,604	1,001,543		22
23	Inservice Training & Education			2,377	2,377		2,377	706	3,083		23
24	Travel and Seminar			2,918	2,918		2,918	4,233	7,151		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,002	140,002		140,002	(482)	139,520		26
27	Other (specify):*										27
28	TOTAL General Administration	344,267	12,710	1,810,585	2,167,562		2,167,562	(124,225)	2,043,337		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,648,800	623,279	3,200,798	7,472,877		7,472,877	(75,877)	7,397,000		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			199,882	199,882		199,882	43,823	243,705			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							198,140	198,140			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							22,327	22,327			34
35	Rent-Equipment & Vehicles			4,952	4,952		4,952	1,414	6,366			35
36	Other (specify):*											36
37	TOTAL Ownership			204,834	204,834		204,834	265,704	470,538			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,156,815	1,156,815		1,156,815	(482,577)	674,238			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,107	183,107		183,107		183,107			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,339,922	1,339,922		1,339,922	(482,577)	857,345			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,648,800	623,279	4,745,554	9,017,633		9,017,633	(292,750)	8,724,883			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				3
4	Non-Patient Meals	(8,254)	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				8
9	Non-Straightline Depreciation	2,449	30		9
10	Interest and Other Investment Income	(8,291)	32		10
11	Discounts, Allowances, Rebates & Refunds	(482,577)	39		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	(3,326)	30		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	(20,440)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,305)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (521,744)		\$	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)	247,716		34
35	Other- Attach Schedule	(18,722)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 228,994		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (292,750)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Presence McAuley ManorID# 0042879Report Period Beginning: 01/01/2012Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Misc	\$ (18,722)	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,722)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Presence McAuley Manor # 0042879 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(8,254)	2,763	0	0	0	0	0	0	0	0	0	(5,491)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,308	0	0	0	0	0	0	0	0	0	4,308	5
6	Maintenance	0	1,617	63,395	0	0	0	0	0	0	0	0	65,012	6
7	Other (specify):*	(18,722)	0	0	0	0	0	0	0	0	0	0	(18,722)	7
8	TOTAL General Services	(26,976)	8,688	63,395	0	0	0	0	0	0	0	0	45,107	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	3,241	0	0	0	0	0	0	0	0	0	3,241	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	3,241	0	0	0	0	0	0	0	0	0	3,241	16
	C. General Administration													
17	Administrative	0	(285,114)	(52,226)	0	0	0	0	0	0	0	0	(337,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,174	17,632	0	0	0	0	0	0	0	0	41,806	19
20	Fees, Subscriptions & Promotions	(21,745)	6,283	0	0	0	0	0	0	0	0	0	(15,462)	20
21	Clerical & General Office Expenses	0	4,710	0	0	0	0	0	0	0	0	0	4,710	21
22	Employee Benefits & Payroll Taxes	0	44,824	132,780	0	0	0	0	0	0	0	0	177,604	22
23	Inservice Training & Education	0	706	0	0	0	0	0	0	0	0	0	706	23
24	Travel and Seminar	0	4,233	0	0	0	0	0	0	0	0	0	4,233	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	(482)	0	0	0	0	0	0	0	0	0	(482)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,745)	(200,666)	98,186	0	0	0	0	0	0	0	0	(124,225)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,721)	(188,737)	161,581	0	0	0	0	0	0	0	0	(75,877)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Presence McAuley Manor # 0042879 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(877)	0	44,700	0	0	0	0	0	0	0	0	43,823	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,291)	0	206,431	0	0	0	0	0	0	0	0	198,140	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	22,327	0	0	0	0	0	0	0	0	22,327	34
35	Rent-Equipment & Vehicles	0	0	1,414	0	0	0	0	0	0	0	0	1,414	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,168)	0	274,872	0	0	0	0	0	0	0	0	265,704	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	(482,577)	0	0	0	0	0	0	0	0	0	0	(482,577)	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	(482,577)	0	0	0	0	0	0	0	0	0	0	(482,577)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(540,466)	(188,737)	436,453	0	0	0	0	0	0	0	0	(292,750)	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 C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Vill	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Cai	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Presence Life Connections	100.00%	\$ 2,763	\$ 2,763	1
2	V	5	Utilities		Presence Life Connections	100.00%	4,308	4,308	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	1,617	1,617	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	3,241	3,241	4
5	V	17	Admin - Misc. Other	532,608	Presence Life Connections	100.00%	9,631	(522,977)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	237,863	237,863	6
7	V	19	Professional Services		Presence Life Connections	100.00%	24,174	24,174	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	6,283	6,283	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	4,710	4,710	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	44,824	44,824	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	706	706	11
12	V	24	Travel		Presence Life Connections	100.00%	4,233	4,233	12
13	V	26	Insurance		Presence Life Connections	100.00%	(482)	(482)	13
14	Total			\$ 532,608			\$ 343,871	\$ * (188,737)	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%	\$ 2,284	\$ 2,284	15
16	V	32	Interest		Presence Life Connections	100.00%	71,311	71,311	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	22,327	22,327	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,414	1,414	18
19	V	17	Admin Salaries	76,100	Presence Health	100.00%	80,599	4,499	19
20	V	22	Employee Benefits		Presence Health	100.00%	42,586	42,586	20
21	V	30	Depreciation		Presence Health	100.00%	42,416	42,416	21
22	V	19	Admin Consulting,Other		Presence Health	100.00%	17,632	17,632	22
23	V	17	Information Systems Salaries	161,604	Presence Health	100.00%	33,407	(128,197)	23
24	V	22	Information Systems Benefits		Presence Health	100.00%	26,034	26,034	24
25	V	17	Information Systems - Other		Presence Health	100.00%	23,891	23,891	25
26	V	17	Admin Salaries		Presence Health	100.00%	16,450	16,450	26
27	V	22	Employee Benefits		Presence Health	100.00%	21,299	21,299	27
28	V	17	Information Systems Salaries		Presence Health	100.00%	31,131	31,131	28
29	V	22	Information Systems Benefits		Presence Health	100.00%	42,861	42,861	29
30	V	6	Information Systems - Equip Maint		Presence Health	100.00%	63,395	63,395	30
31	V	32	Admin - Interest Expense		Presence Health	100.00%	135,120	135,120	31
32	V	39	Ancillary Services - Other	1,156,815	Presence Senior Services Pharmacy	100.00%	1,156,815		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,394,519			\$ 1,830,972	\$ * 436,453	39

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

Facility Name & ID Number

Presence McAuley Manor

0042879

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compar	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	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 Ca	Northlake	Independent Living	13
14					Presence Ambulatory	Various	Parent	14
15					Resurrection Develop	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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 McAuley Manor # 0042879 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 19065 Hickory Creek Drive, Ste 310
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	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Management Fee Income	7,895,880	23	\$ 40,958	\$	532,608	\$ 2,763	1
2	5	Utilities	Management Fee Income	7,895,880	23	63,861		532,608	4,308	2
3	6	Maintenance - Other	Management Fee Income	7,895,880	23	23,977		532,608	1,617	3
4	11	Activities-Special Events	Management Fee Income	7,895,880	23	48,049		532,608	3,241	4
5	17	Admin - Misc. Other	Management Fee Income	7,895,880	23	142,773		532,608	9,631	5
6	17	Administrative Salaries	Management Fee Income	7,895,880	23	3,526,307	3,526,307	532,608	237,863	6
7	19	Professional Services	Management Fee Income	7,895,880	23	358,375		532,608	24,174	7
8	20	Dues,Subscriptions	Management Fee Income	7,895,880	23	93,150		532,608	6,283	8
9	21	Clerical Supplies	Management Fee Income	7,895,880	23	69,822		532,608	4,710	9
10	22	Employee Benefits	Management Fee Income	7,895,880	23	664,511		532,608	44,824	10
11	23	Education/Conference	Management Fee Income	7,895,880	23	10,463		532,608	706	11
12	24	Travel	Management Fee Income	7,895,880	23	62,753		532,608	4,233	12
13	26	Insurance	Management Fee Income	7,895,880	23	(7,150)		532,608	(482)	13
14	30	Depreciation	Management Fee Income	7,895,880	23	33,862		532,608	2,284	14
15	32	Interest	Management Fee Income	7,895,880	23	1,057,182		532,608	71,311	15
16	34	Rent - Facility	Management Fee Income	7,895,880	23	330,990		532,608	22,327	16
17	35	Rent - Equipment	Management Fee Income	7,895,880	23	20,962		532,608	1,414	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,540,845	\$ 3,526,307		\$ 441,207	25

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

Presence Health

9223 West St. Francis Road

Frankfort, IL 60423

(815)469-4888

(815)469-4864

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Admin Salaries	Operating Expense	936,340	10	\$ 991,694	\$ 991,694	76,100	\$ 80,599	1
2	22	Employee Benefits	Operating Expense	936,340	10	523,983		76,100	42,586	2
3	30	Depreciation	Operating Expense	936,340	10	521,887		76,100	42,416	3
4	34	Rent Facility	Operating Expense	936,340	10	216,946		76,100	17,632	4
5	19	Admin Consulting,Other	Operating Expense	936,340	10	411,047		76,100	33,407	5
6	17	Information Systems Salaries	Operating Expense	1,983,972	10	319,617	319,617	161,604	26,034	6
7	22	Information Systems Benefits	Operating Expense	1,983,972	10	293,305		161,604	23,891	7
8	17	Information Systems - Other	Operating Expense	1,983,972	10	201,957		161,604	16,450	8
9	17	Admin Salaries	Direct Cost	936,340	10	262,066	262,066	76,100	21,299	9
10	17	Information Systems Salaries	Direct Cost	1,983,972	10	382,190	382,190	161,604	31,131	10
11	6	Information Systems - Equip Mai	Direct Cost	1,983,972	10	526,191		161,604	42,861	11
12	19	Admin Consulting,Other	Direct Cost	936,340	10	780,014		76,100	63,395	12
13	32	Admin - Interest Expense	Direct Cost	936,340	10	1,662,527		76,100	135,120	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					\$ 7,093,424	\$ 1,955,567		\$ 576,821	25

Facility Name & ID Number Presence McAuley Manor # 0042879 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 Senior Services Pharmacy
Street Address 670 North Convent Street
City / State / Zip Code Bourbonnais, Illinois 60914
Phone Number (815)936-3644
Fax Number (815)936-3268

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			\$	\$		\$ 1,156,815	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 1,156,815	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						\$	\$			\$	206,431	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$	206,431	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
15	TOTALS (line 9+line14)						\$	\$			\$	206,431	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
	_____	9
	_____	10
	_____	11
	_____	12

	FOR BHF USE ONLY		
	FROM R. E. TAX STATEMENT FOR 2011	\$	13
	PLUS APPEAL COST FROM LINE 5	\$	14
	LESS REFUND FROM LINE 6	\$	15
	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

Presence McAuley Manor

COUNTY

Kane

FACILITY IDPH LICENSE NUMBER

0042879

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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 [X] 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

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	87		1986	1986	\$ 4,218,962	\$	25	\$		\$ 4,218,962	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	VARIOUS			1986							9	
10	VARIOUS			1987	9,470		13			9,450	10	
11	VARIOUS			1988	18,530		14			18,530	11	
12	VARIOUS			1989	7,670		14			7,670	12	
13	VARIOUS			1990	2,400		12			2,400	13	
14	VARIOUS			1991	8,900		13			8,900	14	
15	VARIOUS			1992	1,500		10			1,500	15	
16	VARIOUS			1993	7,744		9			7,744	16	
17	VARIOUS			1994	18,925		8			18,925	17	
18	VARIOUS			1995	4,742		8			4,742	18	
19	VARIOUS			1996	1,683		7			1,683	19	
20	VARIOUS			1997	5,525		6			5,525	20	
21	VARIOUS			1998							21	
22	VARIOUS			1999	2,941		6			2,941	22	
23	VARIOUS			2000	1,200		7			1,200	23	
24	VARIOUS			2001	62,210		9			62,210	24	
25	VARIOUS			2002	45,675	1,433	8	1,433		45,675	25	
26	VARIOUS			2003	57,530	4,854	11	4,854		45,217	26	
27	VARIOUS			2004	75,363	6,500	11	6,500		64,047	27	
28	VARIOUS			2005	238,378	17,098	11	17,098		142,797	28	
29	VARIOUS			2006	59,391	4,757	12	4,757		31,039	29	
30	VARIOUS			2007	428,047	33,341	12	33,341		183,934	30	
31	VARIOUS			2008	36,226	3,623	10	3,623		15,732	31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Presence McAuley Manor

0042879

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 NEW DRAIN PIPES	2009	\$ 6683	\$ 955	7	\$ 955	\$	\$ 3342	37
38 FIRE DOOR	2009	14215	948	15	948		3317	38
39 NEW ROOF	2009	90154	9015	10	9015		31496	39
40 CEILING AND PIPE REPAIRS IN CONVENT	2009	13125	1313	10	1313		4594	40
41 DEDUCTION OF NON-CARE ASSETS	2009	(13,125)	(1,313)	-10	(1,313)		(4,594)	41
42								42
43 NEW WINDOW TREATMENTS	2010	4279	856	5	856		2140	43
44 DINING ROOM FLOORING AND WALL COVERINGS	2010	20223	2022	10	2022		6067	44
45 PATIENT ROOM WALL COVERINGS AND PAINT	2010	22899	2290	10	2290		5725	45
46 HVAC REPAIRS	2010	20877	2982	7	2982		7456	46
47 NEW WINDOW FRAMES & WINDOW	2010	36723	1836	20	1836		4590	47
48 PAINTING OF HALLWAYS AND CONVENT	2010	10064	2013	5	2013		5032	48
49 NEW CARPETING IN COMMUNITY	2010	8849	1770	5	1770		4425	49
50 INSTALL NEW ELECTRONIC DOOR EDGE	2010	5060	506	10	506		1265	50
51 DX-9100 BASE AND TEMPERATURE CONTROL SYSTEM	2010	3991	399	10	399		998	51
52 LEAK REPAIRS \ DUCTWORK INSULATION AND FLASHING	2010	9757	650	15	650		1626	52
53 DEDUCTION OF NON-CARE ASSETS	2010	(10,064)	(2,013)	-5	(2,013)		(5,032)	53
54								54
55 CHAPEL CARPETING & PAINT	2011	9530	1906	5	1906		2859	55
56 SPRINKLER ELEVATOR PIT	2011	2722	109	25	109		163	56
57 CEILING TILE	2011	2792	349	8	349		524	57
58 FLOORING	2011	3905	391	10	391		586	58
59 DIESEL TANK FOR GENERATORS	2011	4950	990	5	990		1485	59
60 NEW ROOF	2011	19900	1990	10	1990		2985	60
61 CALL LIGHT	2011	1398	93	15	93		140	61
62 VINYL FLOORING 2ND FLOOR	2011	19788	1979	10	1979		2968	62
63 PAINT 1ST AND 2ND FLOOR HALLWAYS	2011	5650	1130	5	1130		1695	63
64 PAINT 2ND FLOOR CORRIDOR	2011	6862	686	5	686		686	64
65 75 NEW PELLA WINDOWS	2011	41084	4108	10	4108		5425	65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,675,302	\$ 109,565		\$ 109,565	\$	\$ 4,992,783	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 5,675,302	\$ 109,565		\$ 109,565	\$	\$ 4,992,783	1
2									2
3	RADIATOR REPAIR	2012	5964	199	15	398	199	199	3
4	HVAC	2012	16220	541	15	1,081	541	541	4
5	TEKNOFLOR SHEET VINYL 2ND FLOOR RESIDENT CORRID	2012	25250	1263	10	2,525	1,263	1263	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,722,736	\$ 111,567		\$ 113,569	\$ 2,002	\$ 4,994,785	34

**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	\$801,775	\$84,542	\$84,542	\$	10	\$359,615	71
72	Current Year Purchases	9,043	447	894	447	11	447	72
73	Fully Depreciated Assets	163,065				8	163,065	73
74	HOME OFFICE ALLOCATION		44,700	44,700				74
75	TOTALS	\$973,883	\$129,689	\$130,136	\$447		\$523,127	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	1999 FORD ELDORADO -15 CAI	1999	\$42,261	\$	\$	\$	8	\$42,261	76
77										77
78										78
79										79
80	TOTALS			\$42,261	\$	\$	\$		\$42,261	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	\$6,738,880	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$241,256	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$243,705	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,449	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,560,173	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? ☐ YES ☐ NO
- If NO, see instructions.

		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				22,327			5
6								6
7	TOTAL				\$ 22,327			7

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 \$ _____

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

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 44,204 Description: Nursing \$37,838; Administration \$4,952; Home Office \$1,414
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist						10a,3	hrs	\$	7,278
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,040	62,136		1,040	62,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		7,492	435,885		7,492	435,885	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				1,156,815		1,156,815	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			\$	15,810	\$ 907,486	\$ 1,156,815	15,810	\$ 2,064,301	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.

Facility Name & ID Number	Presence McAuley Manor
---------------------------	------------------------

0042879

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

_____ (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,086,787	\$	1
2	Cash-Patient Deposits	87,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	19,569,971		3
4	Supply Inventory (priced at)	652,763		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,531		6
7	Other Prepaid Expenses	114,653		7
8	Accounts Receivable (owners or related parties)	152,567		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 33,665,575	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,629,961		12
13	Land	6,033,932		13
14	Buildings, at Historical Cost	86,623,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,565,514		16
17	Accumulated Depreciation (book methods)	(62,295,376)		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: Deferred Comp)	418,087		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 58,975,342	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 92,640,917	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,316,095	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,097,772		28
29	Short-Term Notes Payable	69,804		29
30	Accrued Salaries Payable	3,738,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,523,338		32
33	Accrued Interest Payable	9,580		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	819,992		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,735,600	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	969,488		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	418,087		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	438,744		43
44	<u>Deferred Lease Payable</u>	28,912		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,855,231	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,590,831	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 77,050,086	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 92,640,917	\$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 71,119,277	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(967,209)	3
4	Adj. To reconcile consolidated equity & consolidated income	3,407,773	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,559,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	537,526	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,067,950	11
12	Expenditures for Specific Purposes	(115,231)	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)	\$ 3,490,245	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)	\$ 77,050,086	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Presence McAuley Manor# 0042879Report Period Beginning: 01/01/2012Ending: 12/31/2012**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	\$ 5,693,065	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,693,065	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,123,476	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,123,476	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	21,739	13
14	Non-Patient Meals	8,254	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,109,889	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,611	20
21	Other Medical Services		21
22	Laundry	9,842	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,162,335	23
	D. Non-Operating Revenue		
24	Contributions	49,785	24
25	Interest and Other Investment Income***	8,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58,076	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	482,577	28
28a	Misc Income/Gain Loss SOFA	35,630	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 518,207	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,555,159	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,156,776	31
32	Health Care	4,148,539	32
33	General Administration	2,167,562	33
	B. Capital Expense		
34	Ownership	204,834	34
	C. Ancillary Expense		
35	Special Cost Centers	1,156,815	35
36	Provider Participation Fee	183,107	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,017,633	40
41	Income before Income Taxes (line 30 minus line 40)**	537,526	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 537,526	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 519,957	44
45	Private Pay - Net Inpatient Revenue	2,106,794	45
46	Medicare - Net Inpatient Revenue	2,369,364	46
47	Other-(specify) <u>Insurance</u>	696,950	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,693,065	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? NO 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.

Facility Name & ID Number Presence McAuley Manor# 0042879Report Period Beginning: 01/01/2012Ending: 12/31/2012

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	1,976	2,080	\$ 91,242	\$ 43.87	1
2	Assistant Director of Nursing	1,912	2,080	79,176	38.07	2
3	Registered Nurses	33,825	36,079	1,141,922	31.65	3
4	Licensed Practical Nurses	7,901	8,459	248,464	29.37	4
5	CNAs & Orderlies	61,169	65,410	938,879	14.35	5
6	CNA Trainees					6
7	Licensed Therapist	740	740	11,836	15.99	7
8	Rehab/Therapy Aides	5,173	5,868	95,862	16.34	8
9	Activity Director	1,494	1,560	28,930	18.54	9
10	Activity Assistants	2,875	3,099	30,214	9.75	10
11	Social Service Workers	3,364	3,535	56,358	15.94	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,106	55,266	26.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,977	18,777	188,123	10.02	15
16	Dishwashers					16
17	Maintenance Workers	3,804	4,325	86,599	20.02	17
18	Housekeepers	12,286	13,699	149,960	10.95	18
19	Laundry	1,617	1,832	22,300	12.17	19
20	Administrator	1,880	2,080	85,520	41.12	20
21	Assistant Administrator	1,608	1,664	47,085	28.30	21
22	Other Administrative	4,409	4,683	74,884	15.99	22
23	Office Manager	884	964	22,959	23.82	23
24	Clerical	789	823	22,821	27.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,777	2,064	33,441	16.20	31
32	Other Health Care Admissions	4,782	5,176	105,868	20.45	32
33	Other(specify) <u>Pastoral</u>	1,444	1,664	31,091	18.68	33
34	TOTAL (lines 1 - 33)	175,648	188,767	\$ 3,648,800 *	\$ 19.33	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	96	\$ 5,310	1,3	35
36	Medical Director	40	12,000	9,3	36
37	Medical Records Consultant	23	2,252	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	792	11,3	44
45	Social Service Consultant	33	2,035	12,3	45
46	Other(specify)				46
47					47
48	<u>Rehab Medical Director</u>	60	18,000	9,3	48
49	TOTAL (lines 35 - 48)	268	\$ 40,389		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	238	\$ 15,815	10,3	50
51	Licensed Practical Nurses	383	17,485	10,3	51
52	Certified Nurse Assistants/Aides	69	1,636	10,3	52
53	TOTAL (lines 50 - 52)	690	\$ 34,936		53

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	
Jennifer Roach	Administrator		\$ 45,231	Workers' Compensation Insurance		\$ 96,492	IDPH License Fee	\$	
Administrative Staff	Office Manager		22,959	Unemployment Compensation Insurance		16,249	Advertising: Employee Recruitment		
Administrative Staff	Human Resource		35,730	FICA Taxes		252,264	Health Care Worker Background Check		
Administrative Staff	Receptionist		47,105	Employee Health Insurance		270,315	(Indicate # of checks performed 65)		
Administrative Staff	Admin Asst		47,085	Employee Meals			Patient Background Checks	538	
Administrative Staff	Admissions		105,868	Illinois Municipal Retirement Fund (IMRF)*			Employee Recruitment		
Jim Standish	Administrator		40,289	Life Insurance		13,092	Dues & Subscription	8,754	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension		145,653	Advertisiosg & Public Relations	21,828	
(List each licensed administrator separately.)				Employee Recognition		318			
B. Administrative - Other				Executive Benefots		3,830	Home Office Allocation	6,283	
				Employee Screening		25,726	Less: Public Relations Expense	()	
							Non-allowable advertising	(20,440)	
				Home Office Allocation		177,604	Yellow page advertising	(1,305)	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,001,543	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,120	
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Collection Fee	Various		\$ 242	N/A		\$	Out-of-State Travel	\$ 390	
Survey & Analytical Tools	Various		3,270						
Shredding	Various		861						
Legal	Various		7,871				In-State Travel	2,528	
							Seminar Expense		
							Home Office Allocation	4,233	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 7,151	
(If total legal fees exceed \$5,000, attach copy of invoices.)									

*** 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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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?
If YES, give association name and amount.

Yes
Life Services Network \$5,114
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 Years
- (6)

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

\$ 47,709 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9)

Are you presently operating under a sublease agreement?

YES X NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 183,107
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
Yes 8,254
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

Yes

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
N/A

c.

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

N/A

d.

Have vehicle usage logs been maintained?

N/A

e.

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

N/A

f.

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

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
KPMG

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

Yes