

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0042879 Facility Name: PRESENCE MCAULEY MANOR Address: 400 WEST SULLIVAN RD AURORA 60506 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 501C3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: GEORGE VIEU Telephone Number: 708-478-7943

Email Address:

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879 Report Period Beginning: 1/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,842	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	87	TOTALS	87	31,842	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	8,296	3,576	8,838	20,710	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,296	3,576	8,838	20,710	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.04%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A-NONE

F. Does the facility maintain a daily midnight census? YES

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO X

I. On what date did you start providing long term care at this location?
Date started 12-01-97

J. Was the facility purchased or leased after January 1, 1978?
YES X Date 12-01-97 NO

K. Was the facility certified for Medicare during the reporting year?
YES X NO If YES, enter number of beds certified 87 and days of care provided 6,858

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12-31-16 Fiscal Year: 12-31-16

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 1/01/16 Ending: 12/31/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		8,013	402,277	410,290		410,290		410,290			1
2	Food Purchase		155,929		155,929		155,929	(2,576)	153,353			2
3	Housekeeping	87,715	17,187		104,902		104,902		104,902			3
4	Laundry	5,675	8,071	23,825	37,571		37,571		37,571			4
5	Heat and Other Utilities			143,339	143,339		143,339	2,183	145,522			5
6	Maintenance	72,303	32,739	136,321	241,363		241,363	8,949	250,312			6
7	Other (specify):* Pastoral	28,275	15,049		43,324		43,324		43,324			7
8	TOTAL General Services	193,968	236,988	705,762	1,136,718		1,136,718	8,556	1,145,274			8
	B. Health Care and Programs											
9	Medical Director			24,600	24,600		24,600		24,600			9
10	Nursing and Medical Records	1,805,119	111,756	364,605	2,281,480		2,281,480		2,281,480			10
10a	Therapy	761,756	10,530	15,112	787,398		787,398		787,398			10a
11	Activities	53,795	2,468	9,688	65,951		65,951	106	66,057			11
12	Social Services	78,395	26	1,243	79,664		79,664		79,664			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,699,065	124,780	415,248	3,239,093		3,239,093	106	3,239,199			16
	C. General Administration											
17	Administrative	335,828	135,504	754,825	1,226,157		1,226,157	(34,085)	1,192,072			17
18	Directors Fees											18
19	Professional Services			17,192	17,192		17,192	22,652	39,844			19
20	Dues, Fees, Subscriptions & Promotions			31,176	31,176		31,176	1,995	33,171			20
21	Clerical & General Office Expenses			17,275	17,275		17,275	1,342	18,617			21
22	Employee Benefits & Payroll Taxes			770,994	770,994		770,994	68,561	839,555			22
23	Inservice Training & Education			1,884	1,884		1,884	506	2,390			23
24	Travel and Seminar			939	939		939	3,772	4,711			24
25	Other Admin. Staff Transportation			2,490	2,490		2,490		2,490			25
26	Insurance-Prop.Liab.Malpractice			126,728	126,728		126,728	797	127,525			26
27	Other (specify):*											27
28	TOTAL General Administration	335,828	135,504	1,723,503	2,194,835		2,194,835	65,540	2,260,375			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,228,861	497,272	2,844,513	6,570,646		6,570,646	74,202	6,644,848			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			323,441	323,441		323,441	10,098	333,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,062	100,062		100,062	(18,099)	81,963			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,535	30,535		30,535	15,492	46,027			35
36	Other (specify):*											36
37	TOTAL Ownership			454,038	454,038		454,038	7,491	461,529			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			291,164	291,164		291,164		291,164			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,105	132,105		132,105		132,105			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			423,269	423,269		423,269		423,269			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,228,861	497,272	3,721,820	7,447,953		7,447,953	81,693	7,529,646			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,648)	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	5,455	30		9
10	Interest and Other Investment Income	(18,099)	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	(325)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,617)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	98,310		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 98,310		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 81,693		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/16

Ending:

12/31/16

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,648)	1,072	0	0	0	0	0	0	0	0	0	(2,576)	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	2,183	0	0	0	0	0	0	0	0	0	2,183	5
6	Maintenance	0	7,343	1,606	0	0	0	0	0	0	0	0	8,949	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,648)	10,598	1,606	0	0	0	0	0	0	0	0	8,556	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	106	0	0	0	0	0	0	0	0	0	106	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	106	0	0	0	0	0	0	0	0	0	106	16
	C. General Administration													
17	Administrative	0	(113,289)	79,204	0	0	0	0	0	0	0	0	(34,085)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,652	0	0	0	0	0	0	0	0	0	22,652	19
20	Fees, Subscriptions & Promotions	(325)	2,320	0	0	0	0	0	0	0	0	0	1,995	20
21	Clerical & General Office Expenses	0	1,342	0	0	0	0	0	0	0	0	0	1,342	21
22	Employee Benefits & Payroll Taxes	0	58,966	9,595	0	0	0	0	0	0	0	0	68,561	22
23	Inservice Training & Education	0	506	0	0	0	0	0	0	0	0	0	506	23
24	Travel and Seminar	0	3,772	0	0	0	0	0	0	0	0	0	3,772	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	797	0	0	0	0	0	0	0	0	0	797	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(325)	(22,934)	88,799	0	0	0	0	0	0	0	0	65,540	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(3,973)	(12,230)	90,405	0	0	0	0	0	0	0	0	74,202	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,455	0	4,643	0	0	0	0	0	0	0	0	10,098	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,099)	0	0	0	0	0	0	0	0	0	0	(18,099)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	15,492	0	0	0	0	0	0	0	0	15,492	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,644)	0	20,135	0	0	0	0	0	0	0	0	7,491	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,617)	(12,230)	110,540	0	0	0	0	0	0	0	0	81,693	45

VII. RELATED PARTIES

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

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

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

☐ YES☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Presence Life Connections	100.00%	\$ 1,072	\$ 1,072	1
2	V	5	Utilities		Presence Life Connections	100.00%	2,183	2,183	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	7,343	7,343	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	106	106	4
5	V	17	Admin - Misc. Other	340,719	Presence Life Connections	100.00%	3,726	(336,993)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	223,704	223,704	6
7	V	19	Professional Services		Presence Life Connections	100.00%	22,652	22,652	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	2,320	2,320	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	1,342	1,342	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	58,966	58,966	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	506	506	11
12	V	24	Travel		Presence Life Connections	100.00%	3,772	3,772	12
13	V	26	Insurance		Presence Life Connections	100.00%	797	797	13
14	Total			\$ 340,719			\$ 328,489	\$ * (12,230)	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%	\$ 4,643	\$ 4,643	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	0		17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	15,492	15,492	18
19	V	17	Admin Salaries		Presence Health	100.00%	0		19
20	V	22	Employee Benefits		Presence Health	100.00%	9,595	9,595	20
21	V	30	Depreciation	120,453	Presence Health	100.00%	120,453		21
22	V	34	Rent Facility		Presence Health	100.00%	0		22
23	V	17	Admin Consulting,Other	413,417	Presence Health	100.00%	369,835	(43,582)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	0		24
25	V	17	Information Systems - Other		Presence Health	100.00%	88,334	88,334	25
26	V	17	Admin Salaries		Presence Health	100.00%	0		26
27	V	17	Information Systems Salaries		Presence Health	100.00%	27,118	27,118	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	1,606	1,606	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	7,334	7,334	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	0		30
31	V	39	Ancillary Services - Other	291,164	Presence Senior Services Pharmacy	100.00%	291,164		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 825,034			\$ 935,574	\$ * 110,540	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:

1/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 1/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number	PRESENCE MCAULEY MANOR
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0042879

Report Period Beginning:

1/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Presence Life Connections

Street Address

18927 Hickory Creek Dr, Ste 300

City / State / Zip Code

Mokena, IL 60448

Phone Number

(708-478-7900

Fax Number

(708-478-5387

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6				
1	2	Food	Management Fee Income	9,455,191	33	\$ 29,753	\$ 340,719	\$ 1,072	1	
2	5	Utilities	Management Fee Income	9,455,191	33	60,575	340,719	2,183	2	
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785	340,719	7,343	3	
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934	340,719	106	4	
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412	340,719	3,726	5	
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	340,719	223,704	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607	340,719	22,652	7	
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374	340,719	2,320	8	
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236	340,719	1,342	9	
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354	340,719	58,966	10	
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049	340,719	506	11	
12	24	Travel	Management Fee Income	9,455,191	33	104,676	340,719	3,772	12	
13	26	Insurance	Management Fee Income	9,455,191	33	22,118	340,719	797	13	
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835	340,719	4,643	14	
15	32	Interest	Management Fee Income	9,455,191	33	0	340,719	0	15	
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0	340,719	0	16	
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912	340,719	15,492	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,674,560	\$ 6,207,940	\$ 348,624	25	

Ending: 12/31/16

()

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 1/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 291,164	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				\$	\$		\$ 291,164	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						\$					\$ 7,334	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 7,334	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 7,334	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.)

B. Real Estate Taxes

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.

FACILITY NAME	PRESENCE MCAULEY MANOR	COUNTY	KANE
---------------	------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

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

C. Tax Bills

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.**

A. Square Feet: 51,000

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

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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			1987	9,470		15	11	11	9,450	9
10	VARIOUS			1994	18,925		8			18,925	10
11	VARIOUS			1995	4,742		8			4,742	11
12	VARIOUS			1996	1,683		5			1,683	12
13	VARIOUS			1997	5,525		5			5,525	13
14	VARIOUS			1999	2,941		5			2,941	14
15	VARIOUS			2000	1,200		5			1,200	15
16	VARIOUS			2001	62,210		9			62,210	16
17	VARIOUS			2003	76,245		9			76,245	17
18	VARIOUS			2004	104,667	2,139	12	2,122	(17)	99,559	18
19	VARIOUS			2005	236,034	9,330	11	9,495	165	195,590	19
20	VARIOUS			2006	44,405	2,875	14	2,911	36	34,342	20
21	VARIOUS			2007	368,343	26,250	13	27,186	937	260,079	21
22	VARIOUS			2008	110,916	9,467	10	11,092	1,625	99,012	22
23	VARIOUS			2009	111,052	9,554	11	10,304	750	80,349	23
24	VARIOUS			2010	155,845	12,361	10	12,141	(220)	103,847	24
25	VARIOUS			2011	86,281	8,131	11	8,423	292	52,072	25
26	VARIOUS			2012	54,485	5,759	10	5,536	(223)	29,661	26
27											27
28	TEKNOFLOR SHEET VINYL 2ND FLOOR			2013	25,250	2,353	10	2,525	172	11,133	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ARCrylic SHOWER FLOOR ACRYLIC	2014	\$ 33,916	\$ 3,457	10	\$ 3,392	\$ (65)	\$ 8,566	37
38	DOOR RESTRICTORS ON 3 ELEVATOR	2014	6,567	645	10	657	12	1,626	38
39	HEATING UNIT	2014	9,003	607	15	600	(7)	1,510	39
40	PANIC DEVICES ON DOUBLE DOORS	2014	6,541	667	10	654	(13)	1,652	40
41	PARKING LOT LIGHTING	2014	7,791	383	20	390	7	965	41
42	NEW PARKING LOT	2014	25,725	1,675	15	1,715	40	4,234	42
43	WANDER GUARD SYSTEM FOR SECOND	2014	2,977	595	5	595		1,489	43
44									44
45	CEILING TILE INSTALLATION	2015	2,153	105	20	108	3	268	45
46	CORNER GUARDS HIGH IMPACT WALL	2015	12,928	1,226	10	1,293	67	3,124	46
47	DESIGN FEE AND FLOOR PLAN FOR	2015	3,600	175	20	180	5	444	47
48	EXTERIOR PAINTING	2015	3,100	620	5	620		1,137	48
49	ICE WATER DISPENSER	2015	3,440	491	7	491	(0)	819	49
50	FLOORING IN LOWER LVL HALLS/BREAK RM/THERAPY I	2015	58,345	3,754	15	3,890	136	9,543	50
51	LABOR FOR INSTALLATION OF LIGH	2015	401	20	20	20	1	49	51
52	NEW MATTRESSES FOR 86 BEDS	2015	19,986	3,997	5	3,997		5,996	52
53	PAINT MAIN CORRIDOR ELEVATOR C	2015	12,380	2,190	5	2,476	286	5,809	53
54	PAINTING LOWER LEVEL HALLWAY	2015	4,965	993	5	993		1,490	54
55	PARKING LOT AND DRIVEWAY	2015	14,845	742	20	742	0	1,299	55
56	PATIENT TRANSPORTATION SLINGS	2015	2,769	135	20	138	4	341	56
57	PAVE PARKING LOT AND DRIVEWAY	2015	11,687	1,461	8	1,461		2,678	57
58	PAVING OVERLAY MAIN PARKING LO	2015	18,250	2,281	8	2,281		4,372	58
59	WALL COVERINGS/CORNERGUARDS IN RESIDENT ROOM	2015	27,840	2,635	10	2,784	149	6,761	59
60	INSTALLATION OF NEW ROOF FOR ENTIRE BUILDING	2015	21,320	2,132	10	2,132		3,198	60
61	REPLACE 5 CONCRETE SECTIONS OF	2015	4,200	210	20	210		245	61
62	WALL PROTECTORS FOR DAY ROOMS AND HALLWAYS	2015	25,539	2,554	10	2,554	0	3,618	62
63	WARMING DRAWER AND PLATE WARME	2015	5,841	584	10	584	0	779	63
64	DOORS & FRAMES - 1st Floor Rooms & Hallway	2015	9,265	579	20	463	(116)	579	64
65									65
66	TEKNOFLOR SHEET VINYL FLOORING - Rooms & Hallway	2016	48,000	3,200	15	3,200	(0)	3,200	66
67									67
68	DEDUCTION FOR NON-CARE ASSETS	2010	(10,064)		-5			(10,064)	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,092,491	\$ 126,330		\$ 130,367	\$ 4,036	\$ 5,433,251	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	\$ 871,110	\$ 68,994	\$ 70,438	\$ 1,444	12	\$ 480,287	71
72	Current Year Purchases	30,974	1,929	1,905	(25)	16	1,929	72
73	Fully Depreciated Assets	358,132	5,734	5,734		7	358,132	73
74	Home Office Allocation		125,096	125,096				74
75	TOTALS	\$ 1,260,215	\$ 201,753	\$ 203,172	\$ 1,419		\$ 840,348	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 CA	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	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)	\$ 7,394,966	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 328,084	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 333,539	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,455	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,315,860	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				0			5
6								6
7	TOTAL				\$			7

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$46,026Description: Admin 5,173; Nursing 25,362; Home Office; 15,492
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

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

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

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

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a, 1	7002	hrs	\$ 304,008		\$		7,002	\$ 304,008	1
2	Licensed Speech and Language Development Therapist	10a, 1	1448	hrs	63,749				1,448	63,749	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1	8029	hrs	323,294				8,029	323,294	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				291,164		291,164	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Director</u>	10a, 1	1480		70,705				1,480	70,705	12
13	Other (specify): _____										13
14	TOTAL				\$ 761,756		\$	\$ 291,164	17,959	\$ 1,052,920	14

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

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

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	7,037,981	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 182,940,984	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,146,960)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	515,397	11
12	Expenditures for Specific Purposes	(913,464)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,545,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 181,395,957	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning: 1/01/16

Ending:

12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,098,671	1
2	Discounts and Allowances for all Levels	(2,824,186)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,274,485	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,956,680	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,956,680	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,648	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	986,232	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)	\$ 989,880	23
	D. Non-Operating Revenue		
24	Contributions	61,849	24
25	Interest and Other Investment Income***	18,099	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79,948	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		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)	\$ 6,300,993	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,136,718	31
32	Health Care	3,239,093	32
33	General Administration	2,194,835	33
	B. Capital Expense		
34	Ownership	454,038	34
	C. Ancillary Expense		
35	Special Cost Centers	291,164	35
36	Provider Participation Fee	132,105	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,447,953	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,146,960)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,146,960)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,177,963	44
45	Private Pay - Net Inpatient Revenue	455,689	45
46	Medicare - Net Inpatient Revenue	1,132,239	46
47	Other-(specify) <u>Insurance</u>	508,594	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,274,485	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,311	1,649	\$ 72,801	\$ 44.15	1
2	Assistant Director of Nursing	1,807	2,017	74,162	36.77	2
3	Registered Nurses	22,792	24,564	854,402	34.78	3
4	Licensed Practical Nurses	5,440	5,827	158,088	27.13	4
5	CNAs & Orderlies	36,536	39,202	582,991	14.87	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	16,344	17,959	761,756	42.42	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,942	2,115	40,288	19.05	9
10	Activity Assistants	1,155	1,176	13,507	11.49	10
11	Social Service Workers	3,423	3,885	78,347	20.17	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,362	3,807	72,303	18.99	17
18	Housekeepers	7,008	7,533	87,715	11.64	18
19	Laundry	455	455	5,675	12.47	19
20	Administrator	1,730	1,998	86,656	43.37	20
21	Assistant Administrator	1,135	1,224	37,359	30.52	21
22	Other Administrative	0	0	0		22
23	Office Manager	2,031	2,248	47,347	21.06	23
24	Clerical	7,785	8,456	138,460	16.37	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care Admissions	4,227	4,375	88,729	20.28	32
33	Other(specify) Pastoral	940	1,046	28,275	27.03	33
34	TOTAL (lines 1 - 33)	119,423	129,536	\$ 3,228,861 *	\$ 24.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	24,600	9,3	36
37	Medical Records Consultant	29	1,979	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	8	528	11,3	44
45	Social Service Consultant	18	1,206	12,3	45
46	Other(specify) MDS	119	11,277	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	174	\$ 39,590		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,348	\$ 94,345	10,3	50
51	Licensed Practical Nurses	4,849	218,212	10,3	51
52	Certified Nurse Assistants/Aides	2,122	21,217	10,3	52
53	TOTAL (lines 50 - 52)	8,319	\$ 333,774		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Brian Thor	Administrator		\$ 86,656
Administrative Staff	Office Manager		47,348
Administrative Staff	Receptionists		57,490
Administrative Staff	Administrative Asst		37,359
Administrative Staff	Admissions		88,729
Administrative Staff	Other Administrative		18,246
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 335,828
B. Administrative - Other			
Description			Amount
Corp Office Management Fee		\$	754,825
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 754,825
C. Professional Services			
Vendor/Payee	Type		Amount
Iron Mountain	Storage/Ground Charge	\$	2,274
Sebert Landscaping	Outsourced Services		1,688
Murphy and Miller Inc	Outsourced Services		5,730
Maul Paving Inc.	Outsourced Services		7,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 17,192
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	39,140
Unemployment Compensation Insurance			10,578
FICA Taxes			232,309
Employee Health Insurance			323,738
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Home Office Allocation			68,561
Dental			10,223
Life Insurance			2,394
Disability Insurance			12,785
Pension			144,319
Tuition Reimbursement			6,630
Other Benefits			(11,122)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 839,555
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 36)			
Patient Background Checks			323
Employee Recruitment			0
Dues & Subscriptions			30,851
Advertising & Public Relations			325
Home Office Allocation			2,320
Less: Public Relations Expense		(	
Non-allowable advertising			(325)
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 33,171
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			939
Seminar Expense			
Home Office Allocation			3,772
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	4,711

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0042879

Report Period Beginning:

1/01/16

Ending:

Page 22

12/31/16

- (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. LEADING AGE \$5,405.49
- (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? N/A
- (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? 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
13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,626 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. 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 X 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. \$ 132,105
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? NO 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? NO 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 benefit on Schedule V. \$ NONE Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,648
- (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. \$ 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? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees