

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0045906</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>McAuley Residence</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2019</u> to <u>06/30/2020</u> 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.																																															
Address: <u>2060 W Granville Ave</u> <u>Chicago</u> <u>60659</u>																																																		
Number City Zip Code																																																		
County: <u>Cook</u>																																																		
Telephone Number: <u>773 273-3033</u> Fax # <u>773 743-5439</u>																																																		
HFS ID Number: _____			<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Kevin Connelly</u></td><td></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr><tr><td colspan="2">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</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Kevin Connelly</u>		(Title) <u>Chief Financial Officer</u>		(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u>	Fax # <u>()</u>	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																												
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																																
	(Type or Print Name) <u>Kevin Connelly</u>																																																	
	(Title) <u>Chief Financial Officer</u>																																																	
	(Signed) _____	(Date) _____																																																
Paid Preparer	(Print Name and Title) _____																																																	
	(Firm Name & Address) _____																																																	
	(Telephone) <u>()</u>	Fax # <u>()</u>																																																
	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																																																	
Date of Initial License for Current Owners: <u>11/03/2005</u>																																																		
Type of Ownership:																																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table>			☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐		☐	Corporation	☐	Other _____	☐		☐	"Sub-S" Corp.	☐	_____	☐		☐	Limited Liability Co.	☐	_____	☐		☐	Trust	☐	_____	☐		☐	Other	☐	_____
☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																													
☒	Charitable Corp.	☐	Individual	☐	State																																													
☐	Trust	☐	Partnership	☐	County																																													
☐		☐	Corporation	☐	Other _____																																													
☐		☐	"Sub-S" Corp.	☐	_____																																													
☐		☐	Limited Liability Co.	☐	_____																																													
☐		☐	Trust	☐	_____																																													
☐		☐	Other	☐	_____																																													
IRS Exemption Code <u>501c3</u>																																																		
In the event there are further questions about this report, please contact:																																																		
Name: <u>Carolyn Sheehan</u> Telephone Number: <u>773 273-3033</u>																																																		
Email Address: _____																																																		

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>125</u>	Skilled Pediatric (SNF/PED)	<u>125</u>	<u>43,079</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>125</u>	TOTALS	<u>125</u>	<u>43,079</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>42,360</u>	<u>16</u>		<u>42,376</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,360</u>	<u>16</u>		<u>42,376</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.37%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Vocational, Respite and School

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 ☒

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

I. On what date did you start providing long term care at this location?
Date started 11/03/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	118,502	8,689	47	127,238		127,238		127,238			1
2	Food Purchase		253,844		253,844		253,844	(24)	253,820			2
3	Housekeeping	398,013	44,194	105,852	548,059		548,059	(29,938)	518,121			3
4	Laundry	243,738	20,002		263,740		263,740		263,740			4
5	Heat and Other Utilities			333,334	333,334		333,334	(18,883)	314,451			5
6	Maintenance	223,122	41,729	384,992	649,843		649,843	(39,759)	610,084			6
7	Other (specify):*											7
8	TOTAL General Services	983,375	368,458	824,225	2,176,058		2,176,058	(88,604)	2,087,454			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	5,727,212	712,897	39,426	6,479,535		6,479,535	(117)	6,479,418			10
10a	Therapy	2,373,396	4,646	92,431	2,470,473		2,470,473	(9,077)	2,461,396			10a
11	Activities	24,573	513	315	25,401		25,401		25,401			11
12	Social Services	85,163	40	10,258	95,461		95,461		95,461			12
13	CNA Training	82,912	4,458		87,370		87,370	(2,310)	85,060			13
14	Program Transportation		25,423		25,423		25,423	(1,620)	23,803			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,293,256	747,977	152,430	9,193,663		9,193,663	(13,124)	9,180,539			16
	C. General Administration											
17	Administrative	247,434	2,235		249,669		249,669	(6,602)	243,067			17
18	Directors Fees											18
19	Professional Services			122,614	122,614		122,614	(4,802)	117,812			19
20	Dues, Fees, Subscriptions & Promotions			36,728	36,728		36,728	(1,122)	35,606			20
21	Clerical & General Office Expenses	516,706	29,079	31,921	577,706		577,706	(20,424)	557,282			21
22	Employee Benefits & Payroll Taxes			2,623,160	2,623,160		2,623,160	(88,213)	2,534,947			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,378	3,378		3,378	(356)	3,022			24
25	Other Admin. Staff Transportation		336		336		336	(187)	149			25
26	Insurance-Prop.Liab.Malpractice			47,428	47,428		47,428	(3,027)	44,401			26
27	Other (specify):*											27
28	TOTAL General Administration	764,140	31,650	2,865,229	3,661,019		3,661,019	(124,733)	3,536,286			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,040,771	1,148,085	3,841,884	15,030,740		15,030,740	(226,461)	14,804,279			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			863,207	863,207		863,207	(43,235)	819,972			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			863,207	863,207		863,207	(43,235)	819,972			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	270,344		144	270,488		270,488	(260,492)	9,996			39
40	Barber and Beauty Shops		92	6,455	6,547		6,547		6,547			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			652,009	652,009		652,009		652,009			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	270,344	92	658,608	929,044		929,044	(260,492)	668,552			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,311,115	1,148,177	5,363,699	16,822,991		16,822,991	(530,188)	16,292,803			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	(9,077)	10a		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,077)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (9,077)		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	Expenses reimbursed from other sources:	\$		1
2	Food Supplies	(24)	2	2
3	Housekeeping Wages, Supplies	(29,938)	3	3
4	Heat and Other Utilities	(18,883)	5	4
5	Maintenance Wages, Supplies and Other	(28,007)	6	5
6	Staff Training	(2,310)	13	6
7	Program Transportation Other	(1,620)	14	7
8	Administrative Wages, Supplies and other	(6,602)	17	8
9	Professional Services	(4,075)	19	9
10	Dues, Fees, Subscriptions & Promotions	(774)	20	10
11	Clerical Wages, Supplies and Other	(20,424)	21	11
12	Employee Benefits & Payroll Taxes	(86,806)	22	12
13	Travel & Seminar	(48)	24	13
14	Other Admin Staff Transportation	(187)	25	14
15	Insurance	(3,027)	26	15
16	Depreciation	(43,235)	30	16
17	Ancillary Service Centers Salaries and Supplies	(260,492)	39	17
18	Nursing/Med Records Wages, Supplies and Other	(117)	10	18
19	Loss on disposal	(11,752)	6	19
20	Conferences out of state	(308)	24	20
21	Subscription	(348)	20	21
22	Other employee benefits	(1,407)	22	22
23	Attorney fees exempt property for CILA program	(727)	19	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	(521,111)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence# 0045906

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24)	0	0	0	0	0	0	0	0	0	0	(24)	2
3	Housekeeping	(29,938)	0	0	0	0	0	0	0	0	0	0	(29,938)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(18,883)	0	0	0	0	0	0	0	0	0	0	(18,883)	5
6	Maintenance	(39,759)	0	0	0	0	0	0	0	0	0	0	(39,759)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(88,604)	0	0	0	0	0	0	0	0	0	0	(88,604)	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	(117)	0	0	0	0	0	0	0	0	0	0	(117)	10
10a	Therapy	(9,077)	0	0	0	0	0	0	0	0	0	0	(9,077)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(2,310)	0	0	0	0	0	0	0	0	0	0	(2,310)	13
14	Program Transportation	(1,620)	0	0	0	0	0	0	0	0	0	0	(1,620)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(13,124)	0	0	0	0	0	0	0	0	0	0	(13,124)	16
	C. General Administration													
17	Administrative	(6,602)	0	0	0	0	0	0	0	0	0	0	(6,602)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,802)	0	0	0	0	0	0	0	0	0	0	(4,802)	19
20	Fees, Subscriptions & Promotions	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	20
21	Clerical & General Office Expenses	(20,424)	0	0	0	0	0	0	0	0	0	0	(20,424)	21
22	Employee Benefits & Payroll Taxes	(88,213)	0	0	0	0	0	0	0	0	0	0	(88,213)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(356)	0	0	0	0	0	0	0	0	0	0	(356)	24
25	Other Admin. Staff Transportation	(187)	0	0	0	0	0	0	0	0	0	0	(187)	25
26	Insurance-Prop.Liab.Malpractice	(3,027)	0	0	0	0	0	0	0	0	0	0	(3,027)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(124,733)	0	0	0	0	0	0	0	0	0	0	(124,733)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(226,461)	0	0	0	0	0	0	0	0	0	0	(226,461)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(43,235)	0	0	0	0	0	0	0	0	0	0	(43,235)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(43,235)	0	0	0	0	0	0	0	0	0	0	(43,235)	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	(260,492)	0	0	0	0	0	0	0	0	0	0	(260,492)	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	(260,492)	0	0	0	0	0	0	0	0	0	0	(260,492)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(530,188)	0	0	0	0	0	0	0	0	0	0	(530,188)	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
Kathleen Donahue (acting)	BOD			The Catholic Bishop of Chicago, through provisions in Misericordia's		
S. Rosemary Connelly	BOD			By-Laws and Catholic Charities, by virtue of a majority of		
Fr. John Clair	BOD			Board membership, qualify as related organization because		
John Dyer	BOD			each has the ability to influence Misericordia's Operating policy.		
Rob Figliulo	BOD			Misericordia Home, an equal opportunity employer and provider		
Margaret Houlihan Smith	BOD			of service, is separately incorporated and independantly funded.		
Robert Soudan	BOD					

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

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	Kevin Connelly	BOD						1
2	Daniel Walsh	BOD						2
3	Mary Dempsey	BOD						3
4	Sharon O'Keefe	BOD						4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	S. Rosemary Connelly					50	100.00	salary	\$ 12,492	17	1
2	Kevin Connelly					50	100.00	salary	29,364	17	2
3	Fr. John Clair					50	100.00	salary	19,020	17	3
4	Note that S. Rosemary Connelly's, Kevin Connelly and Fr. John Clair salaries are allocated between Development & Community Relations and ProgramMG&A portion is 1										4
5	(MG&A is allocated to Misericordia North & McAuley).										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,876		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 McAuley Residence# 0045906 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

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

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2020 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:	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

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	McAuley Residence	COUNTY	Cook
---------------	-------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0045906

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(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		\$	\$

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,145 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 3+

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Day training facility - approximately 5,002 squre feet.
School facility - approximately 4,928 square feet.
Respite - private

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	<u>Campus/CILA</u>			\$ <u>11,001,462</u>	1
2					2
3	TOTALS			\$ <u>11,001,462</u>	3

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

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 26,088,636	\$ 699,846		\$ 699,846	\$	\$ 11,515,548	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,256,150	\$ 95,791	\$ 95,791	\$		\$ 1,027,183	71
72	Current Year Purchases	70,992	5,427	5,427			5,427	72
73	Fully Depreciated Assets	1,856,882					1,856,882	73
74								74
75	TOTALS	\$ 3,184,023	\$ 101,218	\$ 101,218	\$		\$ 2,889,492	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	Various			\$ 247,663	\$ 18,908	\$ 18,908	\$	4	\$ 215,106	76
77										77
78										78
79										79
80	TOTALS			\$ 247,663	\$ 18,908	\$ 18,908	\$		\$ 215,106	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)	\$ 40,521,784	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 819,972	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 819,972	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,620,146	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	Bldg, Equip, auto alloc to other prog	\$ 126,995,502	\$ 4,182,369	\$ 85,965,103	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 126,995,502	\$ 4,182,369	\$ 85,965,103	91

G. Construction-in-Progress

	Description	Cost	
92	CILA/Besser/Bakery/Unity	\$ 11,281,494	92
93	Campus expansion/WIFI/Roof	745,481	93
94	Bakery program construction	2,125,984	94
95		\$ 14,152,959	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.
9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

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.	_____/2021	\$ _____
13.	_____/2022	\$ _____
14.	_____/2023	\$ _____

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

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)					
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		4,458		4,458
3	Classroom Wages (a)		82,912		82,912
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 87,370	\$	\$ 87,370
10	SUM OF line 9, col. 1 and 2 (e)	\$ 87,370			

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

\$

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

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

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

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

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

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

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

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

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$		1				
2	Licensed Speech and Language Development Therapist		hrs								2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist		hrs								4				
5	Physician Care		visits								5				
6	Dental Care		visits	144					144		6				
7	Work Related Program		hrs	9,852					9,852		7				
8	Habilitation		hrs								8				
9	Pharmacy		# of prescripts								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			\$ 9,996		\$	\$		\$ 9,996		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	\$ 11,986,469	\$	1
2	Cash-Patient Deposits	966,100		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	8,183,893		3
4	Supply Inventory (priced at cost)	369,581		4
5	Short-Term Investments	36,748,690		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	880,168		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contribution/Pledges Receivable	7,080,893		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 66,215,794	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,001,462		13
14	Buildings, at Historical Cost	153,783,651		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,733,635		16
17	Accumulated Depreciation (book methods)	(100,585,249)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	14,152,959		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 92,086,458	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 158,302,252	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,390,432	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	951,340		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,700,741		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Revenue	160,320		36
37	Other Liabilities and ARO	2,758,759		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,961,592	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,961,592	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 147,340,660	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 158,302,252	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 138,074,239	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 138,074,239	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,732,324)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net gain from Misericordia North	10,998,745	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 9,266,421	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)	\$ 147,340,660	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **McAuley Residence**# **0045906**Report Period Beginning: **07/01/2019**Ending: **06/30/2020****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.****1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,646,652	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,646,652	3
	B. Ancillary Revenue		
4	Day Care	433,692	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 433,692	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	9,077	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,077	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Federal work study program	1,246	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,246	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,090,667	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,176,058	31
32	Health Care	9,193,663	32
33	General Administration	3,661,019	33
	B. Capital Expense		
34	Ownership	863,207	34
	C. Ancillary Expense		
35	Special Cost Centers	277,035	35
36	Provider Participation Fee	652,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,822,991	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,732,324)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,732,324)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 14,173,678	44
45	Private Pay - Net Inpatient Revenue	472,974	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,646,652	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.

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	1,833	2,080	\$ 97,016	\$ 46.64	1
2	Assistant Director of Nursing	1,853	2,080	80,211	38.56	2
3	Registered Nurses	42,272	47,688	1,629,542	34.17	3
4	Licensed Practical Nurses	25,425	29,521	885,614	30.00	4
5	CNAs & Orderlies	142,894	157,257	2,976,659	18.93	5
6	CNA Trainees					6
7	Licensed Therapist	5,510	6,483	246,778	38.07	7
8	Rehab/Therapy Aides	13,812	15,654	343,457	21.94	8
9	Activity Director	445	497	15,123	30.43	9
10	Activity Assistants	521	542	9,450	17.44	10
11	Social Service Workers	2,752	3,270	85,163	26.04	11
12	Dietician	753	1,003	39,369	39.25	12
13	Food Service Supervisor	548	614	23,728	38.64	13
14	Head Cook	1,555	1,785	34,645	19.41	14
15	Cook Helpers/Assistants	1,156	1,267	20,759	16.38	15
16	Dishwashers					16
17	Maintenance Workers	7,757	8,879	223,122	25.13	17
18	Housekeepers	19,374	22,175	398,013	17.95	18
19	Laundry	17,889	13,115	243,738	18.58	19
20	Administrator	2,760	3,135	247,434	78.93	20
21	Assistant Administrator					21
22	Other Administrative	6,389	7,277	280,150	38.50	22
23	Office Manager	757	864	20,955	24.25	23
24	Clerical	9,028	10,254	236,555	23.07	24
25	Vocational Instruction	9,056	10,729	270,344	25.20	25
26	Academic Instruction	2,092	2,691	82,912	30.81	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	19,947	22,938	605,090	26.38	28
29	Resident Services Coordinator	18,215	20,278	505,745	24.94	29
30	Habilitation Aides (DD Homes)	29,740	31,203	651,373	20.88	30
31	Medical Records	1,839	2,392	58,170	24.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	386,172	425,671	\$ 10,311,115 *	\$ 24.22	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	2	\$ 48	1	35
36	Medical Director		10,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,805	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,042	62,493	10a	41
42	Respiratory Therapy Consultant	34	1,350	10a	42
43	Speech Therapy Consultant	434	24,572	10a	43
44	Activity Consultant		315	11	44
45	Social Service Consultant		10,258	12	45
46	Other(specify) Medical records sftw/medical waste		10,446	10	46
47	Physician	252	25,175	10	47
48	Rehab Aide		4,016	10a	48
49	TOTAL (lines 35 - 48)	1,762	\$ 152,478		49

C. CONTRACT NURSES

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

Facility Name & ID Number		McAuley Residence	STATE OF ILLINOIS		#	0045906	Report Period Beginning:		07/01/2019	Page 21		Ending:	06/30/2020		
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions					
Name		Function	%	Amount		Description		Amount		Description		Amount			
SRC/Fr Clair/MPO/L Gates		Executive Director		\$ 82,424		Workers' Compensation Insurance		\$ 133,661		IDPH License Fee		\$			
Denise Tigges		Adminstrator		22,106		Unemployment Compensation Insurance		10,957		Advertising: Employee Recruitment					
Chris Krackenberger		Adminstrator		19,817		FICA Taxes		724,227		Health Care Worker Background Check					
Michael Diaz		Adminstrator		17,432		Employee Health Insurance		1,090,952		(Indicate # of checks performed)					
Joseph Ferrara		Adminstrator		20,121		Employee Meals				Patient Background Checks		11,402			
Tina Stendardo/G. Connelly		Adminstrator		36,095		Illinois Municipal Retirement Fund (IMRF)*				License fees-Dept of Financial Regulation, De		351			
Kevin Connelly/Amurray/Kgolden		CFO/Chief HR		49,439		Emp Tuition Reimbursement/Other		56,677		Membership Dues		13,367			
TOTAL (agree to Schedule V, line 17, col. 1)						Dental Insurance		7,427		Bank fees		4,242			
(List each licensed administrator separately.)				\$ 247,434		401K Match		461,664		Subscriptions		842			
B. Administrative - Other						Long-Term Disablility and Life Insurance		49,382		Recruiting		5,402			
Description				Amount						Less: Public Relations Expense		()			
				\$						Non-allowable advertising		()			
										Yellow page advertising		()			
										TOTAL (agree to Sch. V,		\$ 35,606			
						TOTAL (agree to Schedule V,		\$ 2,534,947		line 20, col. 8)					
						line 22, col.8)									
TOTAL (agree to Schedule V, line 17, col. 3)				\$		E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)						Description				Line #		Amount			
C. Professional Services															
Vendor/Payee		Type	Amount								Description		Amount		
Deloitte & Touche		Audit	\$ 27,787								Out-of-State Travel		\$		
ADP Processing		Payroll Service	57,344												
LaPointe Law		Legal	10,302												
Correll		Admin for 401K plan	10,718								In-State Travel				
Kelly Schroeder		Migration of email	13,245												
Accufund		Accounting software/licensing	3,218												
											Seminar Expense				
													3,022		
											Entertainment Expense		()		
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				\$		(agree to Sch. V,			
(For legal fee disclosure, see page 39 of instructions)				\$ 122,614								line 24, col. 8)		\$ 3,022	
* Attach copy of IMRF notifications															
**See instructions.															

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Assoc \$7,766

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 128,390 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.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 652,009
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? 0

d. Have vehicle usage logs been maintained? Yes

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

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

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte

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