

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>07/01/2024</u> to <u>06/30/2025</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>773 273-3033</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>11/03/2005</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Amy Boyle</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Amy Boyle</u>	(Title) <u>CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																				
Officer or Administrator of Provider	(Signed) _____																																	
	(Type or Print Name) <u>Amy Boyle</u>																																	
	(Title) <u>CFO</u>																																	
Paid Preparer	(Signed) _____																																	
	(Date) _____																																	
	(Print Name and Title) _____																																	
	(Firm Name & Address) _____																																	
	(Telephone) <u>()</u> Fax # <u>()</u>																																	
Type of Ownership:																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code <u>501c3</u></td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code <u>501c3</u>		<table><tr><td>☐</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☒</td><td>Corporation</td></tr><tr><td>☐</td><td>"Sub-S" Corp.</td></tr><tr><td>☐</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	PROPRIETARY	☐	Individual	☐	Partnership	☒	Corporation	☐	"Sub-S" Corp.	☐	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
☐	VOLUNTARY, NON-PROFIT																																	
☐	Charitable Corp.																																	
☐	Trust																																	
IRS Exemption Code <u>501c3</u>																																		
☐	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:		MAIL TO: BUREAU OF HEALTH FINANCE																																
Name: <u>Carolyn Sheehan</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																
Telephone Number: <u>773 273-3033</u>		2200 Churchill Rd.																																
Email Address: _____		Springfield, IL 62702-3406																																
		Phone # (217) 782-1630																																

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	125	Skilled Pediatric (SNF/PED)	125	45,625	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	125	TOTALS	125	45,625	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED	36,091							36,091	9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	36,091							36,091	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 79.10%

D. How many bed reserve days during this year were paid by the Department? 1,187 (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 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 certified beds. number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2025 Fiscal Year: 2025

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	299,847	3,666		303,513		303,513		303,513			1
2	Food Purchase		453,064		453,064		453,064		453,064			2
3	Housekeeping	591,862	45,481	111,475	748,818		748,818	(22,293)	726,525			3
4	Laundry	365,360	22,985		388,345		388,345		388,345			4
5	Heat and Other Utilities			388,587	388,587		388,587	(11,445)	377,142			5
6	Maintenance	423,595	68,092	517,720	1,009,407		1,009,407	(24,517)	984,890			6
7	Other (specify):*											7
8	TOTAL General Services	1,680,664	593,288	1,017,782	3,291,734		3,291,734	(58,255)	3,233,479			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	9,846,327	841,317	52,444	10,740,088		10,740,088	(142)	10,739,946			10
10a	Therapy	592,403		99,788	692,191		692,191	(19,883)	672,308			10a
11	Activities	154,695	615	99	155,409		155,409		155,409			11
12	Social Services	79,153		9,000	88,153		88,153		88,153			12
13	CNA Training											13
14	Program Transportation		36,350		36,350		36,350	(1,207)	35,143			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	10,672,578	878,282	161,331	11,712,191		11,712,191	(21,232)	11,690,959			16
	C. General Administration											
17	Administrative	391,483	1,527		393,010		393,010	(3,439)	389,571			17
18	Directors Fees											18
19	Professional Services			274,355	274,355		274,355	(10,179)	264,176			19
20	Dues, Fees, Subscriptions & Promotions			80,479	80,479		80,479	(3,758)	76,721			20
21	Clerical & General Office Expenses	920,635	56,927	83,615	1,061,177		1,061,177	(8,290)	1,052,887			21
22	Employee Benefits & Payroll Taxes			3,441,959	3,441,959		3,441,959	(52,112)	3,389,847			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,196	4,196		4,196	(461)	3,735			24
25	Other Admin. Staff Transportation		102		102		102	(102)				25
26	Insurance-Prop.Liab.Malpractice			137,789	137,789		137,789	(4,369)	133,420			26
27	Other (specify):*											27
28	TOTAL General Administration	1,312,118	58,556	4,022,393	5,393,067		5,393,067	(82,710)	5,310,357			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	13,665,360	1,530,126	5,201,506	20,396,992		20,396,992	(162,197)	20,234,795			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			836,347	836,347		836,347	(26,754)	809,593			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			836,347	836,347		836,347	(26,754)	809,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	128,954	141		129,095		129,095	(94,558)	34,537			39
40	Barber and Beauty Shops		146	424	570		570		570			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			923,192	923,192		923,192		923,192			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	128,954	287	923,616	1,052,857		1,052,857	(94,558)	958,299			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	13,794,314	1,530,413	6,961,469	22,286,196		22,286,196	(283,509)	22,002,687			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	(19,883)	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	(3,202)	19		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)	\$ (23,085)		\$	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))	\$ (23,085)		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	Political Action Committee Payments	\$ (3,138)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Expenses reimbursed from other sources:			3
4	Housekeeping Wages, Supplies	(22,293)	3	4
5	Heat and Other Utilities	(11,445)	5	5
6	Maintenance Wages, Supplies and Other	(23,131)	6	6
7	Nursing/Med Records Wages, Supplies and Other	(142)	10	7
8	Program Transportation Other	(1,207)	14	8
9	Administrative Wages, Supplies and other	(3,439)	17	9
10	Professional Services	(2,392)	19	10
11	Dues, Fees, Subscriptions & Promotions	(620)	20	11
12	Clerical Wages, Supplies and Other	(8,290)	21	12
13	Employee Benefits & Payroll Taxes	(50,639)	22	13
14	Travel & Seminar	(461)	24	14
15	Other Admin Staff Transportation	(102)	25	15
16	Travel & Seminar	(4,369)	26	16
17	Depreciation	(26,754)	30	17
18	Ancillary Service Centers Salaries and Supplies	(94,558)	39	18
19	Loss on disposal	(1,386)	6	19
20	Other employee benefits	(1,295)	22	20
21	Other employee benefits	(178)	22	21
22	Legal	(4,585)	19	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	(260,424)		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mary Dempsey	0			The Catholic Bishop of Chicago, through provisions in Misericordia's By-Laws and Catholic Charities, by virtue of a majority of Board membership, qualify as related organization because each has the ability to influence Misericordia's Operating policy. Misericordia Home, an equal opportunity employer and provider of service, is separately incorporated and independantly funded. Please see page 6-Supp for add'l BOD members		
Sharon O'Keefe	0					
John Dyer	0					
Rob Figliulo	0					
Margaret Houlihan Smith	0					
Robert Soudan	0					
Paul Carbone	0					

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	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					Fr. John Clair	Chicago, IL	BOD	1
2					Fr. Clete Kiley	Chicago, IL	BOD	2
3					Kevin Knoll	Chicago, IL	BOD	3
4					Liz Lombardo Stark	Chicago, IL	BOD	4
5					Archdiocese of Chicag	Chicago, IL	Non-profit	5
6					Misericordia Foundati	Chicago, IL	Non-profit	6
7					Catholic Charities	Chicago, IL	Non-profit	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

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	Fr. John Clair	Executive Director/Board President		0.00	116,142	50			\$ 26,055	17	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	\$ 26,055		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

VIII. ALLOCATION OF INDIRECT COSTS

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

Ending: 6/30/2025

Fax Number

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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.)

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
---------------	-------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (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 7,464 squre feet.
School facility - approximately 2,464 square feet.

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	CILA/Campus					\$ 12,302,156	1
2							2
3	TOTALS					\$ 12,302,156	3

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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	Allocated support and MGA deparments not included in the capital component o	\$	\$		\$	\$	\$	37
38								38
39	Connolly Center Laundry allocated based on weight of laund	1,378,000	37,091		37,091		670,783	39
40	Religious based on census	1,200,047	32,368		32,368		518,226	40
41	Building Operations and Security allocation based on squ feet	4,493,867	108,328		108,328		3,246,539	41
42	IT allocated by # of users	512,174	4,309		4,309		470,369	42
43	Hair salon based on # of residents utilizing	2,127	874		874		816	43
44	Finance alloc based on direct expense	266,040	8,881		8,881		140,243	44
45	Purchasing based on # of requisitions	16,710	261		261		15,600	45
46	HR, Admin and Reception based on # of employees	291,703	21,813		21,813		257,299	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)	\$ 25,979,463	\$ 677,888		\$ 677,888	\$	\$ 14,263,347	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	\$ 786,830	\$ 72,488	\$ 72,488	\$		\$ 426,622	71
72	Current Year Purchases	410,830	26,178	26,178			26,178	72
73	Fully Depreciated Assets	1,950,430	2,912	2,912			1,950,430	73
74								74
75	TOTALS	\$ 3,148,090	\$ 101,578	\$ 101,578	\$		\$ 2,403,230	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	campus alloc from bldg operations			\$ 393,087	\$ 30,128	\$ 30,128	\$	4	\$ 266,241	76
77										77
78										78
79										79
80	TOTALS			\$ 393,087	\$ 30,128	\$ 30,128	\$		\$ 266,241	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)	\$ 41,822,796	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 809,593	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 809,593	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)	\$ 16,932,818	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	\$ 186,353,999	\$ 4,765,174	\$ 106,706,133	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 186,353,999	\$ 4,765,174	\$ 106,706,133	91

G. Construction-in-Progress

	Description	Cost	
92	Campus expansion, misc renov	\$ 10,477,315	92
93	Rosemary Pk Residences	51,880,611	93
94	CILAs	4,536,437	94
95		\$ 66,894,363	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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ 16,429,208	\$ 21,488,746	1
2	Cash-Patient Deposits	878,452	878,452	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	12,735,344	12,735,344	3
4	Supply Inventory (priced at cost)	155,159	155,159	4
5	Short-Term Investments	49,159,309	114,236,066	5
6	Prepaid Insurance	80,286	147,554	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Contribution/Pledges Receivable</u>	4,005,036	4,536,623	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 83,442,794	\$ 154,177,944	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	12,302,156	12,302,156	13
14	Buildings, at Historical Cost	198,695,082	198,695,082	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,179,557	17,179,557	16
17	Accumulated Depreciation (book methods)	(123,638,953)	(123,638,953)	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: <u>CIP</u>)	66,894,363	66,894,363	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 171,432,205	\$ 171,432,205	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 254,874,999	\$ 325,610,149	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,986,359	\$ 3,409,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	863,555	863,555	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,050,247	6,223,685	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	<u>Deferred Revenue</u>	222,993	222,993	36
37	<u>Other Liabilities and ARO</u>	2,130,035	2,334,691	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,253,189	\$ 13,054,191	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)	\$ 12,253,189	\$ 13,054,191	46
47	TOTAL EQUITY(page 18, line 24)	\$ 242,621,810	\$ 312,555,958	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 254,874,999	\$ 325,610,149	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 209,163,643	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 209,163,643	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,367,373)	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 income from Misericordia North	39,825,540	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 33,458,167	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)	\$ 242,621,810	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **McAuley Residence**# **0045906**Report Period Beginning: **07/01/2024**Ending: **06/30/2025**

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	\$ 15,441,618	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,441,618	3
	B. Ancillary Revenue		
4	Day Care	216,385	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 216,385	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Restricted Contributions	260,820	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 260,820	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,918,823	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,291,734	31
32	Health Care	11,712,191	32
33	General Administration	5,393,067	33
	B. Capital Expense		
34	Ownership	836,347	34
	C. Ancillary Expense		
35	Special Cost Centers	129,665	35
36	Provider Participation Fee	923,192	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 22,286,196	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,367,373)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,367,373)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 14,818,880.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	216.00	48
49	Medicare Part A		49
50	Other-(specify) Social Security client payments	602,639.00	50
51	Other-(specify) DHS - employee training reimbursement	19,883.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,441,618	56

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	5,016	5,433	\$ 276,743	\$ 50.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	60,541	67,288	3,126,356	46.46	3
4	Licensed Practical Nurses	11,781	13,496	516,943	38.30	4
5	CNAs & Orderlies	146,410	157,845	3,930,344	24.90	5
6	CNA Trainees					6
7	Licensed Therapist	4,667	5,238	217,849	41.59	7
8	Rehab/Therapy Aides	10,873	11,995	374,554	31.23	8
9	Activity Director	1,741	2,080	60,078	28.88	9
10	Activity Assistants	2,794	3,116	94,617	30.36	10
11	Social Service Workers	1,928	2,239	79,153	35.35	11
12	Dietician	937	1,051	48,737	46.37	12
13	Food Service Supervisor	1,852	2,080	59,934	28.81	13
14	Head Cook	3,643	4,028	95,318	23.66	14
15	Cook Helpers/Assistants	3,716	4,148	95,858	23.11	15
16	Dishwashers					16
17	Maintenance Workers	12,657	13,914	423,595	30.44	17
18	Housekeepers	22,890	25,387	591,862	23.31	18
19	Laundry	13,458	15,155	365,360	24.11	19
20	Administrator	2,488	2,754	244,857	88.91	20
21	Assistant Administrator	1,603	1,847	146,626	79.39	21
22	Other Administrative	11,516	12,779	520,683	40.75	22
23	Office Manager					23
24	Clerical	10,767	12,122	399,952	32.99	24
25	Vocational Instruction	1,950	2,167	35,105	16.20	25
26	Academic Instruction	2,512	2,817	93,849	33.32	26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	12,503	13,863	457,262	32.98	28
29	Resident Services Coordinator	10,856	11,878	382,368	32.19	29
30	Habilitation Aides (DD Homes)	31,234	34,003	894,822	26.32	30
31	Medical Records	3,087	3,649	117,454	32.19	31
32	Other Health C: <u>Clinic Coord</u>	3,223	3,732	144,035	38.59	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	396,643	436,104	\$ 13,794,314 *	\$ 31.63	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,244	69,947	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		750	10a	42
43	Speech Therapy Consultant	500	29,091	10a	43
44	Activity Consultant		99	11	44
45	Social Service Consultant		9,000	12	45
46	Other(specify) <u>Medical waste/med rec software</u>		37,269	10	46
47	<u>Physician</u>	152	15,175	10	47
48	_____			10	48
49	TOTAL (lines 35 - 48)	1,896	\$ 161,331		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Fr Clair/KConnelly/Hkennedy	Exec Directors	0	\$ 101,538	Workers' Compensation Insurance		\$ 205,103	IDPH License Fee	\$ 200	
C Krackenberg/T Stendardo/S Achilles	VP	0	45,087	Unemployment Compensation Insurance		11,749	Advertising: Employee Recruitment	20,084	
MTrejo/Gconnelly/LDaugherty	VP	0	54,882	FICA Taxes		1,033,314	Health Care Worker Background Check	33,268	
A Venegas/Kstrong	AVP	0	38,981	Employee Health Insurance		1,394,229	(Indicate # of checks performed _____)		
J. Ferrara,C.Hawley, V Friel	AVP	0	44,337	Employee Meals					
R. Hrobowski/SKeane/A. Hespen	AVP	0	63,308	Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	9,975	
Sthompson/Kevin Knoll	CIO/Legal	0	43,350	Emp Tuition Reimbursement/Student Loan repayn		50,048	IARF and Infintec Membership	7,082	
TOTAL (agree to Schedule V, line 17, col. 1)				Dental Insurance		27,765	License fees-Dept of Financial Regulation, Dept of Sanitation, (		
(List each licensed administrator separately.)				401K Match		569,253	Bank fees	3,964	
B. Administrative - Other				Long-Term Disability and Life Insurance		65,170	Subscriptions	5,286	
				Employee counseling, turkeys, hams, shirts, misc		33,189	Less: Public Relations Expense	()	
				Ventra		27	PAC and Lobbying payments	(3,138)	
							All non-allowable advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,		\$ 3,389,847	TOTAL (agree to Sch. V,	\$ 76,721	
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Deloitte & Touche	Audit/Tax services		\$ 31,395			\$	Out-of-State Travel	\$	
ADP Processing	Payroll Service		75,420						
Troester, Sharpe. Lanin Muchin	Legal		3,015						
Correll	Admin for 401K plan		8,782				In-State Travel		
IT Savvy, Racom, Healthcare Shift	Software licensing		32,899						
Accufund/Ultra	Accounting software/licensing		16,670						
Strategic Talent Solutions	Leadership training		12,826						
LaSalle Network	Temp Employment		31,799				Seminar Expense		
NY Life	Thrid party benefit admin		8,685					3,735	
Witt&Kieffer/Goodwin/AAS/Chicago	Recruiting Firm		31,088						
Lighthouse/HR consutling	Hotline service		4,958						
Mercer	Compensation Study		16,818				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)							line 24, col. 8)		
\$ 274,355							TOTAL 3,735		

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

IL HEALTHCARE ASSOCIATION (IHCA)

Amount

6,837

6,837

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)

3,138

3,138

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)

9,975

9,975

Total
- (5)

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

\$ 117,658

Line 10
- (6)

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

Yes

If NO, attach a complete explanation.
- (7)

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

\$ 923,192

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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

Yes
- (11)

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. \$
- (12)

Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

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

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

N/A

d. Have vehicle usage logs been maintained?

Yes

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

Yes

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

Yes

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

\$

No
- (13)

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

Firm Name: Deloitte

Yes
- (14)

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

Yes
- (15)

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.