FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0045906

Facility Name: McAuley Residence

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Carolyn Sheehan **Telephone Number:** 773 273-3033
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1 2009 to June 30, 2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Kevin Connelly
(Title) Chief Financial Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	125	Skilled Pediatric (SNF/PED)	125	43,346	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	43,346	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	40,873	1,825	385	43,083	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,873	1,825	385	43,083	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.39%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Respite, 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 [X]

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	106,922	9,903	8,839	125,664		125,664		125,664			1
2	Food Purchase		264,703		264,703		264,703	(75,505)	189,198			2
3	Housekeeping	289,829	42,464	97,578	429,871		429,871	(15,536)	414,335			3
4	Laundry	149,876	23,209		173,085		173,085	(21)	173,064			4
5	Heat and Other Utilities			304,810	304,810		304,810	(18,025)	286,785			5
6	Maintenance	154,449	45,571	405,815	605,835		605,835	(23,315)	582,520			6
7	Other (specify):*											7
8	TOTAL General Services	701,076	385,850	817,042	1,903,968		1,903,968	(132,402)	1,771,566			8
	B. Health Care and Programs											
9	Medical Director	89,126			89,126		89,126		89,126			9
10	Nursing and Medical Records	4,363,849	490,686	35,682	4,890,217		4,890,217		4,890,217			10
10a	Therapy	1,893,611	1,776	119,117	2,014,504		2,014,504	(6,827)	2,007,677			10a
11	Activities	27,359	1,147	2,838	31,344		31,344	(11,185)	20,159			11
12	Social Services	85,391	103		85,494		85,494		85,494			12
13	CNA Training	13,630	234	1,977	15,841		15,841		15,841			13
14	Program Transportation		24,732		24,732		24,732	(1,181)	23,551			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,472,966	518,678	159,614	7,151,258		7,151,258	(19,193)	7,132,065			16
	C. General Administration											
17	Administrative	116,368	1,653	7,753	125,774		125,774	(30,093)	95,681			17
18	Directors Fees											18
19	Professional Services			79,530	79,530		79,530	(5,854)	73,676			19
20	Dues, Fees, Subscriptions & Promotions			30,421	30,421		30,421	(2,717)	27,704			20
21	Clerical & General Office Expenses	422,713	21,767	24,975	469,455		469,455	(40,171)	429,284			21
22	Employee Benefits & Payroll Taxes			2,070,625	2,070,625		2,070,625	(120,520)	1,950,105			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,196	4,196		4,196	(216)	3,980			24
25	Other Admin. Staff Transportation		104		104		104	(104)				25
26	Insurance-Prop.Liab.Malpractice			853	853		853	(65)	788			26
27	Other (specify):*											27
28	TOTAL General Administration	539,081	23,524	2,218,353	2,780,958		2,780,958	(199,740)	2,581,218			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,713,123	928,052	3,195,009	11,836,184		11,836,184	(351,335)	11,484,849			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.

Facility Name & ID Number McAuley Residence #0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			878,431	878,431		878,431	(42,030)	836,401			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,006	7,006		7,006	(7,006)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			885,437	885,437		885,437	(49,036)	836,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	461,411	7,589	161,325	630,325		630,325	(608,233)	22,092			39
40	Barber and Beauty Shops			78	78		78		78			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			513,160	513,160		513,160		513,160			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	461,411	7,589	674,563	1,143,563		1,143,563	(608,233)	535,330			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,174,534	935,641	4,755,009	13,865,184		13,865,184	(1,008,604)	12,856,580			45

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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	(75,505)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,812	30		9
10	Interest and Other Investment Income	(7,006)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,182)	21		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)**	$ (78,881)		$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (78,881)		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

McAuley Residence

ID# 0045906

Report Period Beginning: July 1 2009

Ending: June 30, 2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gain/Loss on disposal/consultant - IDPA portion	$ 133	6	1
2	Off-site recreational facility/non-care auto	(2,510)	30	2
3	Off-site recreational facility	(7,784)	17	3
4	Governmental Sponsored Special Programs	(6,827)	10a	4
5	Investment Fees and other misc fees-IDPA portion	(1,304)	20	5
6	Donated services and equipment	(931)	6	6
7	Donated services and equipment	(710)	22	7
8	Donated services and equipment	(12,804)	17	8
9	Non-care auto	(97)	25	9
10				10
11	Expenses reimbursed from other sources:			11
12	Food Supplies	0	2	12
13	Housekeeping Wages	(13,747)	3	13
14	Housekeeping Supplies	(1,789)	3	14
15	Laundry supplies	(21)	4	15
16	Heat and Other Utilities	(18,025)	5	16
17	Maintenance Wages	(9,790)	6	17
18	Maintenance Supplies	(1,572)	6	18
19	Maintenance Other	(10,291)	6	19
20	Program Transportation Other	(1,181)	14	20
21	Administrative Wages	(8,111)	17	21
22	Administrative Supplies and Other	(660)	17	22
23	Professional Services	(5,854)	19	23
24	Dues, Fees, Subscriptions & Promotions	(1,413)	20	24
25	Clerical Wages	(28,229)	21	25
26	Clerical Supplies	(1,674)	21	26
27	Clerical Other	(1,559)	21	27
28	Employee Benefits & Payroll Taxes	(116,310)	22	28
29	Travel & Seminar	(216)	24	29
30	Other Admin Staff Transportation	(7)	25	30
31	Insurance	(65)	26	31
32	Depreciation	(44,710)	30	32
33	Ancillary Service Centers Salaries	(439,319)	39	33
34	Ancillary Service Centers and Other	(7,589)	39	34
35	Unallowable program	(4,622)	30	35
36	Unallowable program	(11,185)	11	36
37	Unallowable program	(734)	17	37
38	Unallowable program	(161,325)	39	38
39	Unallowable program	(864)	6	39
40	Unallowable program	(2,527)	21	40
41		(3,500)	22	41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(929,723)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1 2009 **Ending:** June 30, 2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(75,505)	0	0	0	0	0	0	0	0	0	0	(75,505)	2
3	Housekeeping	(15,536)	0	0	0	0	0	0	0	0	0	0	(15,536)	3
4	Laundry	(21)	0	0	0	0	0	0	0	0	0	0	(21)	4
5	Heat and Other Utilities	(18,025)	0	0	0	0	0	0	0	0	0	0	(18,025)	5
6	Maintenance	(23,315)	0	0	0	0	0	0	0	0	0	0	(23,315)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(132,402)	0	0	0	0	0	0	0	0	0	0	(132,402)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	(6,827)	0	0	0	0	0	0	0	0	0	0	(6,827)	10a
11	Activities	(11,185)	0	0	0	0	0	0	0	0	0	0	(11,185)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,181)	0	0	0	0	0	0	0	0	0	0	(1,181)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,193)	0	0	0	0	0	0	0	0	0	0	(19,193)	16
	C. General Administration													
17	Administrative	(30,093)	0	0	0	0	0	0	0	0	0	0	(30,093)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,854)	0	0	0	0	0	0	0	0	0	0	(5,854)	19
20	Fees, Subscriptions & Promotions	(2,717)	0	0	0	0	0	0	0	0	0	0	(2,717)	20
21	Clerical & General Office Expenses	(40,171)	0	0	0	0	0	0	0	0	0	0	(40,171)	21
22	Employee Benefits & Payroll Taxes	(120,520)	0	0	0	0	0	0	0	0	0	0	(120,520)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(216)	0	0	0	0	0	0	0	0	0	0	(216)	24
25	Other Admin. Staff Transportation	(104)	0	0	0	0	0	0	0	0	0	0	(104)	25
26	Insurance-Prop.Liab.Malpractice	(65)	0	0	0	0	0	0	0	0	0	0	(65)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(199,740)	0	0	0	0	0	0	0	0	0	0	(199,740)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(351,335)	0	0	0	0	0	0	0	0	0	0	(351,335)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McAuley Residence # 0045906 **Report Period Beginning:** July 1 2009 **Ending:** June 30, 2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(42,030)	0	0	0	0	0	0	0	0	0	0	(42,030)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,006)	0	0	0	0	0	0	0	0	0	0	(7,006)	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**	(49,036)	0	0	0	0	0	0	0	0	0	0	(49,036)	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	(608,233)	0	0	0	0	0	0	0	0	0	0	(608,233)	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**	(608,233)	0	0	0	0	0	0	0	0	0	0	(608,233)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,008,604)	0	0	0	0	0	0	0	0	0	0	(1,008,604)	45

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of Board of Directors during FY 2010						
Misericordia Home , an equal opportunity employer and provider of service, is separately incorporated and independantly funded.						
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.						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	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.**

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sr. Rosemary Connelly	Executive Director	Oversees Misericor	N/A	N/A	50+	100.00	Salary	$		1
2											2
3											3
4	Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is further allocated										4
5	between Misericordia North & McAuley).										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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: July 1 2009 Ending: ne 30, 2010

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 [X]

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1 2009 **Ending:** June 30, 2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McAuley Residence COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045906

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,145 B. General Construction Type: Exterior Brick Frame Solid Masonry Number of Stories 2 + basement

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 5,002 squre feet.
School facility - approximately 4,928 square feet.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MC AULEY			2006	3,154	79	40	79		348	9
10	FACILITY MANAGEMENT FEES			2006	11,026	276	40	276		1,217	10
11	general construction			2006	3,286	93	40	93		396	11
12	phone system			2006	421	28	15	28		122	12
13	Facility Management Fees			2006	1,904	190	10	190		841	13
14	Phone System Back Up			2006	7,377	295	25	295		1,279	14
15	Fence			2006	13,381	669	20	669		2,676	15
16	Plumbing Works			2006	7,461	746	10	746		3,296	16
17	Phone System			2006	18,258	730	25	730		243,104	17
18	Labor-Construction-Therapy Pool			2006	421	28	15	28		119	18
19	Facility Management Fees			2006	248,670	12,434	20	12,434		49,734	19
20	Paging System-Equipt and Labor			2006	2,979	248	12	248		1,014	20
21	Plaster Entrance			2006	456	23	20	23		95	21
22	Metal Door			2006	158	11	15	11		44	22
23	Labor			2006	158	11	15	11		42	23
24	Labor			2006	3,154	210	15	210		929	24
25	Facility Management Fees			2006	7,278	728	10	728		2,608	25
26	Install Tile			2006	4,764	238	20	238		834	26
27	Electrical Wiring			2007	47,977	3,198	15	3,198		10,395	27
28	Air Conditioning Improvement			2006	17,248	1,725	10	1,725		6,324	28
29	Phone System			2006	600	40	15	40		150	29
30	Facility Management Fees-Sensory Room			2006	1,232	82	15	82		287	30
31	Labor-Install-Sensory Room			2006	1,500	100	15	100		350	31
32	Facility anagement Fees-Sensory Room			2007	1,694	113	15	113		386	32
33	Labor-Install-Sensory Room			2007	1,500	100	15	100		342	33
34	Labor-Install-Sensory Room			2007	960	64	15	64		213	34
35	Labor-Install-Sensory Room			2007	66	4	15	4		14	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Facility anagement Fees-Sensory Room	2006	$ 900	$ 60	15	$ 60	$	$ 220	37
38	Facility anagement Fees-Sensory Room	2006	300	20	15	20		72	38
39	Street Sign-McAuley	2007	4,465	447	10	447		1,265	39
40	Street Sign-McAuley	2007	2,125	212	10	212		602	40
41	Mc Auley Residence-Prior to 2006		17,260,535	431,820	40	431,820		1,784,405	41
42	Install Conduit for HAVC Control Alarm Sensor	2010	2,373		20				42
43	Replace Faulty Wire for Rooftop Exhaust	2010	853		20				43
44	Replace Faulty Wire for Rooftop Exhaust	2010	790		20				44
45	Replace Underground Wire for Chiller	2010	1,977		20				45
46	Misc. Labor	2010	840		20				46
47	Support and MGA allocations:				5 25				47
48	Connolly Center Laundry allocated based on weight of laund		1,263,501	29,556	5 20	29,556		176,183	48
49	Resource Center allocated based on # of residents		39,685	4,700	5 20	4,700		12,453	49
50	Staff Development allocation based on # of emp trained		9,720	971	5 25	971		4,360	50
51	Food Services allocated based on # of meals		87,968	5,236	5 25	7,009	1,773	65,447	51
52	Building Operations allocation based on squ feet		3,013,710	112,010	5 25	112,847	837	1,738,769	52
53	Therapy dept allocation based on staff hours		1,061,867	15,336	5 25	15,336		639,461	53
54	MGA alloc based # of employees, direct exp and # of IT user accts.		752,981	23,243	5 25	30,445	7,202	416,923	54
55	Purchasing dept allocated based on # of requistions		15,554	840		840		6,860	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)		$ 23,927,224	$ 646,914		$ 656,726	$ 9,812	$ 5,174,178	70

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 1,837,810	$ 165,495	$ 165,495	$ 0	10	$ 883,010	71
72	Current Year Purchases	17,385	191	191		10	191	72
73	Fully Depreciated Assets	645,185					645,185	73
74								74
75	TOTALS	$ 2,500,380	$ 165,686	$ 165,686	$ 0		$ 1,528,386	75

D. Vehicle Depreciation (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	residents	2002 Chevy van	1/1/2003	$ 33,545	$	$	$		$ 33,545	76
77	residents	2005 Ford E450 van	11/8/2005	58,435					58,435	77
78	campus alloc from bldg ops-see attached listing of autos			146,561	13,989	13,989		3	108,039	78
79										79
80	TOTALS			$ 238,541	$ 13,989	$ 13,989	$		$ 200,019	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 26,666,146	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 826,589	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 836,401	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,812	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,902,584	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	Furn & Equip alloc to other program	$ 8,463,994	$ 409,550	$ 6,596,730	86
87	Auto alloc to other prog	916,337	92,309	665,528	87
88	Bldg & Improv alloc to other prog	81,567,962	3,000,571	42,082,966	88
89	Land	801,804			89
90					90
91	TOTALS	$ 91,750,097	$ 3,502,430	$ 49,345,224	91

G. Construction-in-Progress

	Description	Cost	
92	4 new homes on campus	$ 10,540,905	92
93	various renovations on campus	1,245,674	93
94			94
95		$ 11,786,579	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.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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 [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		234		234
3	Classroom Wages (a)		13,630		13,630
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,977		1,977
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 15,841	$	$ 15,841
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,841			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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		4363	hrs	22,092				4,363	22,092	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): Hair dresser	40			78					78	12
13	Other (specify):										13
14	TOTAL				$ 22,170		$	$	4,363	$ 22,170	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.

STATE OF ILLINOIS

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,221,571	$	1
2	Cash-Patient Deposits	344,926		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	12,433,244		3
4	Supply Inventory (priced at)	254,007		4
5	Short-Term Investments	3,507,908		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	41,796		7
8	Accounts Receivable (owners or related parties)	1,870,136		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 31,673,588	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	801,804		13
14	Buildings, at Historical Cost	105,495,186		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,119,253		16
17	Accumulated Depreciation (book methods)	(56,247,808)		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	11,786,579		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 73,955,014	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 105,628,602	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,368,137	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	329,768		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,845,808		30
31	Accrued Taxes Payable (excluding real estate taxes)	85,019		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	582,967		36
37	Other Liabilities and ARO	753,427		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,965,126	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,965,126	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 99,663,476	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 105,628,602	$	48

*(See instructions.)

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 94,916,134	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 94,916,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,060,871)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	18,010,203	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Net Loss from North**	(6,985,590)	15
16	Other (describe) **Development & Community Relations**	(1,923,205)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 5,040,537	17
	B. Transfers (Itemize):		
18	**Investment activity/insurance proceeds**	357,443	18
19	**Net Asset Reclassification**	(650,638)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (293,195)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 99,663,476	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,335,435	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,335,435	3
	B. Ancillary Revenue		
4	Day Care	468,878	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 468,878	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,804,313	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,903,968	31
32	Health Care	7,151,258	32
33	General Administration	2,780,958	33
	B. Capital Expense		
34	Ownership	885,437	34
	C. Ancillary Expense		
35	Special Cost Centers	630,403	35
36	Provider Participation Fee	513,160	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,865,184	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,060,871)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,060,871)	43

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

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

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

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,767	2,080	$ 78,616	$ 37.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,081	37,324	1,085,330	29.08	3
4	Licensed Practical Nurses	26,703	30,493	768,881	25.21	4
5	CNAs & Orderlies	166,021	182,641	2,391,119	13.09	5
6	CNA Trainees					6
7	Licensed Therapist	5,118	5,746	184,164	32.05	7
8	Rehab/Therapy Aides	9,718	11,088	148,025	13.35	8
9	Activity Director	131	144	3,883	26.97	9
10	Activity Assistants	1,426	1,597	23,476	14.70	10
11	Social Service Workers	3,179	3,597	74,023	20.58	11
12	Dietician	296	316	10,522	33.30	12
13	Food Service Supervisor	165	189	8,950	47.35	13
14	Head Cook	2,407	2,672	54,146	20.26	14
15	Cook Helpers/Assistants	2,652	2,875	33,304	11.58	15
16	Dishwashers					16
17	Maintenance Workers	6,335	7,008	154,449	22.04	17
18	Housekeepers	19,581	22,134	289,829	13.09	18
19	Laundry	9,910	11,088	149,876	13.52	19
20	Administrator	2,134	2,403	116,368	48.43	20
21	Assistant Administrator					21
22	Other Administrative	10,380	11,720	304,383	25.97	22
23	Office Manager	646	730	14,636	20.05	23
24	Clerical	6,324	7,092	118,330	16.68	24
25	Vocational Instruction					25
26	Academic Instruction	495	559	13,630	24.38	26
27	Medical Director	996	1,040	89,126	85.70	27
28	Qualified MR Prof. (QMRP)	19,223	21,436	489,514	22.84	28
29	Resident Services Coordinator	23,479	26,486	532,437	20.10	29
30	Habilitation Aides (DD Homes)	32,570	36,372	524,835	14.43	30
31	Medical Records	2,439	2,760	51,271	18.58	31
32	Other Health Care(specify)					32
33	Other(specify) Teacher	23,902	26,608	461,411	17.34	33
34	TOTAL (lines 1 - 33)	411,077	458,199	$ 8,174,534 *	$ 17.84	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	253	$ 8,839	1	35
36	Medical Director				36
37	Medical Records Consultant		40	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,158	66,015	10a	41
42	Respiratory Therapy Consultant	80	3,196	10a	42
43	Speech Therapy Consultant	805	41,838	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Academic Inst		1,977	13	46
47	Psych/Behavior Therapist		8,067	10a	47
48	Doctor/dentist/medical waste disposal		35,642	10	48
49	TOTAL (lines 35 - 48)	2,296	$ 165,615		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Rosemary Connelly	Executive Director	N/A	$ 14,118
Mary Pat O'Brien	Asst. Executive Directro	N/A	14,794
Denise Tigges	Admistrator	N/A	14,839
Michael Diaz	Admistrator	N/A	9,479
Lois Gates	Asst. Executive Directro	N/A	14,917
Chris Hegg/Joe Ferrera	Administrator	N/A	22,906
Kevin Connelly/Fr. Jack Clair	CFO/Asst Exe Dir	N/A	25,315
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,368

B. Administrative - Other

Description	Amount
Off-Site Recreational Facility-100% is unallowable and is adjuste	$ 7,753
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 7,753

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Audit	$ 24,758
ADP Processing	Payroll Service	39,799
Burke, Warren, MacKay & Serr	Legal	5,301
Tom DeCarlo	IT Consultant	972
Correll	Admin for 401K plan	8,700
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 79,530

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,753
Unemployment Compensation Insurance	40,027
FICA Taxes	572,686
Employee Health Insurance	677,346
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emp Tuition Reimbursement/Other	63,831
Dental Insurance	38,777
401K Match	376,917
Long-Term Disablility and Life Insurance	53,769
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,950,105

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Taxable fringe benefits - gas	22	$ 2,434
TOTAL		$ 2,434

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	131
Health Care Worker Background Check	
(Indicate # of checks performed)	4,121
Patient Background Checks	
Dept of Public Health/CLIA license	103
Subscription	707
Membership Dues	7,454
Computer Licensing	9,905
Bank Fees	5,283
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,704

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 83
In-State Travel	
Seminar Expense	
See schedule	3,897
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,980

**See instructions.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2009 Ending: June 30, 2010

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

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

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1 2009 **Ending:** June 30, 201

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. **6,555**

(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. $ **149,374** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **513,160**
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. $ **No** 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? **Yes, minimum**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes, program vehicles**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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. $ **N/A Unallowable**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.