		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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0045906

Facility Name: McAuley Residence

Address: 2060 W Granville Ave (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, 2013 to June 30, 2014 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, 2013 Ending: June 30, 2014

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	43,978	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	43,978	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	42,049	1,460		43,509	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,049	1,460		43,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.93%

D. How many bed-hold days during this year were paid by the Department?
469 (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)
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 [ ] NO [ ]

Tax Year: 06/30/2014 Fiscal Year: 06/30/2014

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	76,462	4,308		80,770		80,770		80,770			1
2	Food Purchase		322,816		322,816		322,816	(56,156)	266,660			2
3	Housekeeping	305,308	40,645	114,748	460,701		460,701	(16,157)	444,544			3
4	Laundry	144,759	9,544		154,303		154,303	(9)	154,294			4
5	Heat and Other Utilities			359,485	359,485		359,485	(21,121)	338,364			5
6	Maintenance	189,205	44,915	398,631	632,751		632,751	(46,614)	586,137			6
7	Other (specify):*											7
8	TOTAL General Services	715,734	422,228	872,864	2,010,826		2,010,826	(140,057)	1,870,769			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	4,657,847	462,527	35,552	5,155,926		5,155,926	(21,969)	5,133,957			10
10a	Therapy	1,701,695	4,898	121,699	1,828,292		1,828,292		1,828,292			10a
11	Activities	17,035	701	4,555	22,291		22,291		22,291			11
12	Social Services	106,095	183	11,430	117,708		117,708		117,708			12
13	CNA Training	38,289	742		39,031		39,031	(1,210)	37,821			13
14	Program Transportation		25,682		25,682		25,682	(1,678)	24,004			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,520,961	494,733	188,236	7,203,930		7,203,930	(24,857)	7,179,073			16
	C. General Administration											
17	Administrative	147,646	176		147,822		147,822	(9,791)	138,031			17
18	Directors Fees											18
19	Professional Services			68,083	68,083		68,083	(2,220)	65,863			19
20	Dues, Fees, Subscriptions & Promotions			30,634	30,634		30,634	(3,209)	27,425			20
21	Clerical & General Office Expenses	359,119	24,850	20,874	404,843		404,843	(16,291)	388,552			21
22	Employee Benefits & Payroll Taxes			2,010,317	2,010,317		2,010,317	(76,613)	1,933,704			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,730	4,730		4,730	(55)	4,675			24
25	Other Admin. Staff Transportation		209		209		209	(209)				25
26	Insurance-Prop.Liab.Malpractice			62,302	62,302		62,302	(4,086)	58,216			26
27	Other (specify):*											27
28	TOTAL General Administration	506,765	25,235	2,196,940	2,728,940		2,728,940	(112,474)	2,616,466			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,743,460	942,196	3,258,040	11,943,696		11,943,696	(277,388)	11,666,308			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, 2013 Ending: June 30, 2014

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			930,023	930,023		930,023	(45,149)	884,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,724	4,724		4,724	(4,724)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			934,747	934,747		934,747	(49,873)	884,874			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	272,355	4,595		276,950		276,950	(263,567)	13,383			39
40	Barber and Beauty Shops			220	220		220		220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			552,697	552,697		552,697		552,697			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	272,355	4,595	552,917	829,867		829,867	(263,567)	566,300			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,015,815	946,791	4,745,704	13,708,310		13,708,310	(590,828)	13,117,482			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, 2013 Ending: June 30, 2014

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	(56,156)	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	8,821	30		9
10	Interest and Other Investment Income	(1,475)	20		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	(641)	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)**	$ (49,451)		$	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))**	$ (49,451)		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, 2013

Ending: June 30, 2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Expenses reimbursed from other sources:	$		1
2	Housekeeping Wages, Supplies	(16,157)	3	2
3	Laundry supplies	(9)	4	3
4	Heat and Other Utilities	(21,121)	5	4
5	Maintenance Wages, Supplies and Other	(27,838)	6	5
6	Program Transportation Other	(1,678)	14	6
7	Administrative Wages, Supplies and other	(4,583)	17	7
8	Professional Services	(2,220)	19	8
9	Dues, Fees, Subscriptions & Promotions	(1,260)	20	9
10	Clerical Wages, Supplies and Other	(15,650)	21	10
11	Employee Benefits & Payroll Taxes	(72,995)	22	11
12	Travel & Seminar	(55)	24	12
13	Other Admin Staff Transportation	(209)	25	13
14	Insurance	(4,086)	26	14
15	Depreciation	(43,860)	30	15
16	Ancillary Service Centers Salaries and Supplies	(259,510)	39	16
17	Staff Training	(1,210)	13	17
18	Investment Fees	(4,724)	32	18
19	Medical supplies	(795)	10	19
20	Donated Administrator's salary	(5,208)	17	20
21	Govt Sponsored Program-Staff Training Reimbursemetn	(13,230)	10	21
22	Donated other employee benefits	(3,618)	22	22
23	Off-site recreational facility costs	(4,057)	39	23
24	Off-site recreational facility depreciation	(1,477)	30	24
25	Loss on disposal	(16,196)	6	25
26	Subscription	(474)	20	26
27				27
28	Depreciation on donated fixed assets	(8,633)	30	28
29	Donated Equipment	(2,580)	6	29
30	Donated Equipment	(7,944)	10	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**	(541,377)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(56,156)	0	0	0	0	0	0	0	0	0	0	(56,156)	2
3	Housekeeping	(16,157)	0	0	0	0	0	0	0	0	0	0	(16,157)	3
4	Laundry	(9)	0	0	0	0	0	0	0	0	0	0	(9)	4
5	Heat and Other Utilities	(21,121)	0	0	0	0	0	0	0	0	0	0	(21,121)	5
6	Maintenance	(46,614)	0	0	0	0	0	0	0	0	0	0	(46,614)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(140,057)	0	0	0	0	0	0	0	0	0	0	(140,057)	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	(21,969)	0	0	0	0	0	0	0	0	0	0	(21,969)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(1,210)	0	0	0	0	0	0	0	0	0	0	(1,210)	13
14	Program Transportation	(1,678)	0	0	0	0	0	0	0	0	0	0	(1,678)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(24,857)	0	0	0	0	0	0	0	0	0	0	(24,857)	16
	C. General Administration													
17	Administrative	(9,791)	0	0	0	0	0	0	0	0	0	0	(9,791)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,220)	0	0	0	0	0	0	0	0	0	0	(2,220)	19
20	Fees, Subscriptions & Promotions	(3,209)	0	0	0	0	0	0	0	0	0	0	(3,209)	20
21	Clerical & General Office Expenses	(16,291)	0	0	0	0	0	0	0	0	0	0	(16,291)	21
22	Employee Benefits & Payroll Taxes	(76,613)	0	0	0	0	0	0	0	0	0	0	(76,613)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(55)	0	0	0	0	0	0	0	0	0	0	(55)	24
25	Other Admin. Staff Transportation	(209)	0	0	0	0	0	0	0	0	0	0	(209)	25
26	Insurance-Prop.Liab.Malpractice	(4,086)	0	0	0	0	0	0	0	0	0	0	(4,086)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(112,474)	0	0	0	0	0	0	0	0	0	0	(112,474)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(277,388)	0	0	0	0	0	0	0	0	0	0	(277,388)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McAuley Residence # 0045906 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 2014

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(45,149)	0	0	0	0	0	0	0	0	0	0	(45,149)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,724)	0	0	0	0	0	0	0	0	0	0	(4,724)	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**	(49,873)	0	0	0	0	0	0	0	0	0	0	(49,873)	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	(263,567)	0	0	0	0	0	0	0	0	0	0	(263,567)	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**	(263,567)	0	0	0	0	0	0	0	0	0	0	(263,567)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(590,828)	0	0	0	0	0	0	0	0	0	0	(590,828)	45

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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
Monsignor Michael Boland				The Catholic Bishop of Chicago, through provisions in Misericordia's		
S. Rosemary Connelly				By-Laws and Catholic Charities, by virture of a majority of		
Margaret Murphy				Board membership, qualify as related organization because		
John Dyer				each has the ability to influence Misericordia's Operating policy.		
Rob Figliulo				Misericordia Home, an equal opportunity employer and provider		
Margaret Houlihan Smith				of service, is separately incorporated and independantly funded.		
Patrick Mahoney						

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, 2013 Ending: June 30, 2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Robert Soudan	BOD						2
3	Fr. Jack Clair	BOD						3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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	S. Rosemary Connelly	Executive Director	Oversees Misericor	N/A		50	100.00	Salary	$ 12,501	17	1
2											2
3											3
4	Note that S. 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	$ 12,501		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, 2013 Ending: ne 30, 2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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.)**

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1, 2013 **Ending:** June 30, 2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		**8**
	2010		**9**
	2011		**10**
	2012		**11**
	2013		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	**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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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, 2013 Ending: June 30, 2014

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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, 2013 Ending: June 30, 2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	125		2006	2006	$ 17,176,915	$ 430,944	40	$ 430,944	$ 0	$ 3,730,967	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Therapy pool, phones, plumbing, paging system and fence			2006	312,419	16,131	15 20	16,131		130,146	9
10	Install tile, electric wiring, air conditioning improv, phone			2007	86,018	6,473	15-20	6,473		48,086	10
11	Street signs			2008	6,590	659	10	659		4,503	11
12	Install conduit and wire for chiller for HVAC control, alarm, wire for roof			2010	6,834	356	20	356		1,423	12
13	Install conduit for HVAC control, alarm			2011	2,373	119	20	119		445	13
14	Vinyl flooring			2012	8,350	835	10	835		2,227	14
15	Install 480V fire pump controller			2014	10,318	274	10	274		274	15
16	Carpet installation			2014	4,690	547	5	547		547	16
17											17
18	Allocated support and MGA deparments not included in the capital component of rate:										18
19	Connolly Center Laundry allocated based on weight of laund				1,074,406	27,494		27,494		259,062	19
20	Resource Center allocated based on # of residents				8,486	616		616		4,928	20
21	Food Services allocated based on # of meals				78,043	2,064		3,413	1,349	62,882	21
22	Building Operations allocation based on squ feet				3,547,584	128,929		130,596	1,667	2,380,288	22
23	Therapy dept allocation based on staff hours				316,673	14,825		14,825		256,495	23
24	MGA alloc based # of employees				1,122,572	30,119		35,844	5,725	429,117	24
25	Finance alloc based on direct expense				240,001	6,048		6,048		59,732	25
26	IT alloc based on # of users				48,384	2,088		2,088		33,647	26
27	Purchasing dept allocated based on # of requistions				19,793	1,042		1,042		12,023	27
28	Religious Services based on census				1,763,749	47,146		47,146		263,712	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,645,316	$ 121,996	$ 121,996	$	10	$ 1,146,942	71
72	Current Year Purchases	297,151	34,560	34,560			34,560	72
73	Fully Depreciated Assets	907,870					907,870	73
74								74
75	TOTALS	$ 2,850,337	$ 156,556	$ 156,556	$		$ 2,089,372	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 opera	various		$ 192,950	$ 2,868	$ 2,868	$	3	$ 180,818	76
77										77
78										78
79										79
80	TOTALS			$ 192,950	$ 2,868	$ 2,868	$		$ 180,818	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)	$ 28,877,485	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 876,132	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 884,874	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,741	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,950,694	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	$ 8,363,448	$ 240,368	$ 7,115,106	86
87	Auto alloc to other prog	1,176,234	69,342	1,063,822	87
88	Bldg & Improv alloc to other prog	98,226,679	3,473,675	55,301,450	88
89	Land	1,497,957			89
90					90
91	TOTALS	$ 109,264,318	$ 3,783,385	$ 63,480,378	91

G. Construction-in-Progress

	Description	Cost	
92	Quinlan homes	$ 4,901,672	92
93	CILA reno	633,623	93
94	Building Operations reno and misc	206,882	94
95		$ 5,742,177	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, 2013 Ending: June 30, 2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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, 2013 Ending: June 30, 2014

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? [X] 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	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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		742		742
3	Classroom Wages (a)		38,289		38,289
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 39,031	$	$ 39,031
10	SUM OF line 9, col. 1 and 2 (e)	$ 39,031			

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, 2013 Ending: June 30, 2014

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	39	hrs	13,383					13,383	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			$ 13,383		$	$		$ 13,383	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, 2013 Ending: June 30, 2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2014 (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	$ 14,960,522	$	1
2	Cash-Patient Deposits	340,364		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	7,709,580		3
4	Supply Inventory (priced at cost)	289,962		4
5	Short-Term Investments	18,584,757		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	533,174		7
8	Accounts Receivable (owners or related parties)	2,916,776		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 45,335,135	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,497,957		13
14	Buildings, at Historical Cost	124,060,877		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,582,969		16
17	Accumulated Depreciation (book methods)	(73,431,072)		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 (spe CIP	5,742,177		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 70,452,908	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 115,788,043	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 668,338	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	325,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,785,239		30
31	Accrued Taxes Payable (excluding real estate taxes)	238,351		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	677,509		36
37	Other Liabilities and ARO	2,271,038		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,966,340	$	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)**	$ 6,966,340	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 108,821,703	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 115,788,043	$	48

*(See instructions.)

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 103,352,782	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 103,352,782	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,865,704)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	28,832,254	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 Misericordia North**	(7,216,346)	15
16	Other (describe) **Development & Community Relations**	(2,273,364)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 15,476,840	17
	B. Transfers (Itemize):		
18	**Investment activity/insurance proceeds**	114,527	18
19	**Net Asset Reclassification**	(10,122,446)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (10,007,919)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 108,821,703	24 *

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,337,393	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,337,393	3
	B. Ancillary Revenue		
4	Day Care	491,983	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 491,983	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	13,230	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)**	$ 13,230	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)**	$ 9,842,606	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,010,826	31
32	Health Care	7,203,930	32
33	General Administration	2,728,940	33
	B. Capital Expense		
34	Ownership	934,747	34
	C. Ancillary Expense		
35	Special Cost Centers	277,170	35
36	Provider Participation Fee	552,697	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,708,310	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,865,704)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,865,704)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

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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	3,581	3,846	$ 151,735	$ 39.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,569	42,067	1,247,215	29.65	3
4	Licensed Practical Nurses	26,693	28,324	627,789	22.16	4
5	CNAs & Orderlies	182,778	190,069	2,631,108	13.84	5
6	CNA Trainees					6
7	Licensed Therapist	4,413	4,713	156,461	33.20	7
8	Rehab/Therapy Aides	12,770	13,774	239,749	17.41	8
9	Activity Director	28	30	964	32.13	9
10	Activity Assistants	693	750	16,071	21.43	10
11	Social Service Workers	3,926	4,182	98,376	23.52	11
12	Dietician	947	1,000	34,314	34.31	12
13	Food Service Supervisor	150	165	4,744	28.75	13
14	Head Cook	1,063	1,155	24,187	20.94	14
15	Cook Helpers/Assistants	1,161	1,207	13,217	10.95	15
16	Dishwashers					16
17	Maintenance Workers	8,129	8,640	189,205	21.90	17
18	Housekeepers	22,029	23,638	305,308	12.92	18
19	Laundry	10,023	10,578	144,759	13.68	19
20	Administrator	2,477	2,600	147,646	56.79	20
21	Assistant Administrator					21
22	Other Administrative	11,565	12,652	296,496	23.43	22
23	Office Manager					23
24	Clerical	3,768	4,004	62,623	15.64	24
25	Vocational Instruction	12,113	13,087	272,355	20.81	25
26	Academic Instruction	1,416	1,558	38,289	24.58	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	17,028	18,069	337,624	18.69	28
29	Resident Services Coordinator	23,313	24,786	600,218	24.22	29
30	Habilitation Aides (DD Homes)	22,141	23,306	323,758	13.89	30
31	Medical Records	477	525	7,719	14.70	31
32	Other Health Care(specify)					32
33	Other(specify) Medical Sec	1,876	2,080	43,885	21.10	33
34	TOTAL (lines 1 - 33)	414,127	436,805	$ 8,015,815 *	$ 18.35	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		$		35
36	Medical Director		15,000	9	36
37	Medical Records Consultant		1,672	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,910	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	2,111	84,448	10a	41
42	Respiratory Therapy Consultant	67	2,670	10a	42
43	Speech Therapy Consultant	627	34,492	10a	43
44	Activity Consultant		4,555	11	44
45	Social Service Consultant		11,430	12	45
46	Other(specify) Dental		266	10	46
47	Behavior Therapist		89	10a	47
48	Medical waste/lab/doctor		30,704	10	48
49	TOTAL (lines 35 - 48)	2,805	$ 188,236		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
S. Rosemary Connelly	Executive Director	N/A	$ 12,501
Mary Pat O'Brien	Asst. Executive Directro	N/A	16,606
Denise Tigges/K Golden	Admistrator	N/A	24,650
Michael Diaz/G. Connelly	Admistrator	N/A	26,164
Lois Gates	Asst. Executive Directro	N/A	16,547
Chris Hegg/Joe Ferrera	Administrator	N/A	24,692
Kevin Connelly/Fr. Jack Clair	CFO/Asst Exe Dir	N/A	26,486
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 147,646

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Audit	$ 19,690
ADP Processing	Payroll Service	34,308
LaPointe Law	Legal	5,179
Correll	Admin for 401K plan	8,906
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 68,083

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 165,483
Unemployment Compensation Insurance	19,804
FICA Taxes	564,004
Employee Health Insurance	751,610
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emp Tuition Reimbursement/Other	12,640
Dental Insurance	14,309
401K Match	366,351
Long-Term Disablility and Life Insurance	39,503
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,933,704

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	510
Health Care Worker Background Check	6,554
(Indicate # of checks performed)	
Patient Background Checks	
License fees-Computer lic, Dept of Financial	8,561
Subscription	781
Membership Dues	6,967
Bank fees	3,235
Surety Bond	817
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,425

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 580
In-State Travel	58
Seminar Expense	4,037
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,675

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2013 Ending: June 30, 2014

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, 2013 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. **Illinois Healthcare Assoc $6555**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **128,815** 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. $ **552,697**
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? **No**

(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. $ **0** 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**
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.