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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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		X	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 07/01/2014 to 06/30/2015 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) CFO

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: 07/01/2014 Ending: 06/30/2015

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	43,337	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	43,337	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	41,291	1,460		42,751	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,291	1,460		42,751	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.65%

D. How many bed-hold days during this year were paid by the Department?
586 (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: 06/30/2015 Fiscal Year: 06/30/2015

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	120,709	3,841	22	124,572		124,572		124,572			1
2	Food Purchase		267,295		267,295		267,295	(52,317)	214,978			2
3	Housekeeping	284,487	50,101	114,152	448,740		448,740	(15,318)	433,422			3
4	Laundry	150,441	15,683		166,124		166,124	(7)	166,117			4
5	Heat and Other Utilities			335,305	335,305		335,305	(19,478)	315,827			5
6	Maintenance	176,294	38,311	386,646	601,251		601,251	(37,908)	563,343			6
7	Other (specify):*											7
8	**TOTAL General Services**	731,931	375,231	836,125	1,943,287		1,943,287	(125,028)	1,818,259			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	4,829,103	464,174	35,054	5,328,331		5,328,331	(980)	5,327,351			10
10a	Therapy	1,527,876	8,234	143,530	1,679,640		1,679,640		1,679,640			10a
11	Activities	16,658	644	3,662	20,964		20,964		20,964			11
12	Social Services	87,164	395	13,056	100,615		100,615		100,615			12
13	CNA Training	34,999	1,166		36,165		36,165	(1,156)	35,009			13
14	Program Transportation		27,401		27,401		27,401	(1,783)	25,618			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,495,800	502,014	202,802	7,200,616		7,200,616	(3,919)	7,196,697			16
	C. General Administration											
17	Administrative	141,085	464		141,549		141,549	(9,530)	132,019			17
18	Directors Fees											18
19	Professional Services			61,178	61,178		61,178	(2,317)	58,861			19
20	Dues, Fees, Subscriptions & Promotions			32,267	32,267		32,267	(4,976)	27,291			20
21	Clerical & General Office Expenses	364,767	28,905	21,771	415,443		415,443	(14,751)	400,692			21
22	Employee Benefits & Payroll Taxes			2,047,406	2,047,406		2,047,406	(77,881)	1,969,525			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,254	2,254		2,254	(28)	2,226			24
25	Other Admin. Staff Transportation		432		432		432	(432)				25
26	Insurance-Prop.Liab.Malpractice			2,861	2,861		2,861	(107)	2,754			26
27	Other (specify):*											27
28	**TOTAL General Administration**	505,852	29,801	2,167,737	2,703,390		2,703,390	(110,022)	2,593,368			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,733,583	907,046	3,206,664	11,847,293		11,847,293	(238,969)	11,608,324			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:** 07/01/2014 **Ending:** 06/30/2015

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			971,748	971,748		971,748	(45,167)	926,581			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,398	4,398		4,398	(4,398)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			976,146	976,146		976,146	(49,565)	926,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	267,300	5,150	817	273,267		273,267	(256,035)	17,232			39
40	Barber and Beauty Shops			29	29		29		29			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			556,080	556,080		556,080		556,080			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	267,300	5,150	556,926	829,376		829,376	(256,035)	573,341			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,000,883	912,196	4,739,736	13,652,815		13,652,815	(544,569)	13,108,246			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: 07/01/2014 Ending: 06/30/2015

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	(52,311)	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	8,680	30		9
10	Interest and Other Investment Income	(3,528)	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	(49)	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)**	$ (47,208)		$	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))**	$ (47,208)		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

STATE OF ILLINOIS **Page 5A**

McAuley Residence

ID# 0045906

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Expenses reimbursed from other sources:	$		1
2	Housekeeping Wages, Supplies	(15,318)	3	2
3	Laundry supplies	(7)	4	3
4	Heat and Other Utilities	(19,478)	5	4
5	Maintenance Wages, Supplies and Other	(28,792)	6	5
6	Program Transportation Other	(1,783)	14	6
7	Administrative Wages, Supplies and other	(4,527)	17	7
8	Professional Services	(2,020)	19	8
9	Dues, Fees, Subscriptions & Promotions	(998)	20	9
10	Clerical Wages, Supplies and Other	(14,702)	21	10
11	Employee Benefits & Payroll Taxes	(75,128)	22	11
12	Travel & Seminar	(28)	24	12
13	Other Admin Staff Transportation	(432)	25	13
14	Insurance	(107)	26	14
15	Depreciation	(43,580)	30	15
16	Ancillary Service Centers Salaries and Supplies	(251,990)	39	16
17	Staff Training	(1,156)	13	17
18	Investment Fees	(4,398)	32	18
19	Legal fees for CILA program	(297)	19	19
20	Food Supplies	(6)	2	20
21	Govt Sponsored Program-Staff Training Reimbursemetn	(980)	10	21
22	Other employee benefits	(2,753)	22	22
23	Off-site recreational facility costs	(4,045)	39	23
24	Off-site recreational facility depreciation	(873)	30	24
25	Loss on disposal	(2,420)	6	25
26	Subscription	(450)	20	26
27	Donated Administrator's salary	(5,003)	17	27
28	Depreciation on donated fixed assets	(9,394)	30	28
29	Donated Equipment	(6,696)	6	29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(497,361)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	(52,317)	0	0	0	0	0	0	0	0	0	0	(52,317)	2
3	Housekeeping	(15,318)	0	0	0	0	0	0	0	0	0	0	(15,318)	3
4	Laundry	(7)	0	0	0	0	0	0	0	0	0	0	(7)	4
5	Heat and Other Utilities	(19,478)	0	0	0	0	0	0	0	0	0	0	(19,478)	5
6	Maintenance	(37,908)	0	0	0	0	0	0	0	0	0	0	(37,908)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(125,028)	0	0	0	0	0	0	0	0	0	0	(125,028)	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	(980)	0	0	0	0	0	0	0	0	0	0	(980)	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	(1,156)	0	0	0	0	0	0	0	0	0	0	(1,156)	13
14	Program Transportation	(1,783)	0	0	0	0	0	0	0	0	0	0	(1,783)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,919)	0	0	0	0	0	0	0	0	0	0	(3,919)	16
	C. General Administration													
17	Administrative	(9,530)	0	0	0	0	0	0	0	0	0	0	(9,530)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,317)	0	0	0	0	0	0	0	0	0	0	(2,317)	19
20	Fees, Subscriptions & Promotions	(4,976)	0	0	0	0	0	0	0	0	0	0	(4,976)	20
21	Clerical & General Office Expenses	(14,751)	0	0	0	0	0	0	0	0	0	0	(14,751)	21
22	Employee Benefits & Payroll Taxes	(77,881)	0	0	0	0	0	0	0	0	0	0	(77,881)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(28)	0	0	0	0	0	0	0	0	0	0	(28)	24
25	Other Admin. Staff Transportation	(432)	0	0	0	0	0	0	0	0	0	0	(432)	25
26	Insurance-Prop.Liab.Malpractice	(107)	0	0	0	0	0	0	0	0	0	0	(107)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(110,022)	0	0	0	0	0	0	0	0	0	0	(110,022)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(238,969)	0	0	0	0	0	0	0	0	0	0	(238,969)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	(45,167)	0	0	0	0	0	0	0	0	0	0	(45,167)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,398)	0	0	0	0	0	0	0	0	0	0	(4,398)	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**	(49,565)	0	0	0	0	0	0	0	0	0	0	(49,565)	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	(256,035)	0	0	0	0	0	0	0	0	0	0	(256,035)	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**	(256,035)	0	0	0	0	0	0	0	0	0	0	(256,035)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(544,569)	0	0	0	0	0	0	0	0	0	0	(544,569)	45

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

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			$			$	$	1
2	V				Certain costs, primarily related to insurance and/or construction, may				2
3	V				be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to				3
4	V				these organizations on a pass-through basis, as part of our participation in collective purchasing				4
5	V				groups. Our share of costs are ultimately paid to external providers not related to us.				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: 07/01/2014 Ending: 06/30/2015

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	Philip O'Connor	BOD						2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	S. Rosemary Connelly					50	100.00	Salary	$ 12,425	17	1
2											2
3											3
4											4
5	Note that S. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is further allocated										5
6	between Misericordia North & McAuley).										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,425		13

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

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: 07/01/2014 Ending: 06/30/2015

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:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 07/01/2014 Ending: 06/30/2015

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 [ ] 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: 07/01/2014 Ending: 06/30/2015

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			2005	$ 17,176,915	$ 429,862	40	$ 429,862	$ (1)	$ 4,160,829	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		146,277	9
10	Install tile, electric wiring, air conditioning improv, phone			2007	86,018	6,473	15-20	6,473		54,559	10
11	Street signs			2008	6,590	659	10	659		5,162	11
12	Install conduit and wire for chiller for HVAC control, alarm, wire for roof			2010	6,834	356	20	356		1,779	12
13	Install conduit for HVAC control, alarm			2011	2,373	119	20	119		564	13
14	Vinyl flooring			2012	8,350	835	10	835		3,062	14
15	Install 480V fire pump controller			2014	10,318	274	10	274		548	15
16	Carpet installation			2014	4,690	547	5	547		1,094	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				1,174,425	29,908		29,908		313,087	19
20	Resource Center allocated based on # of residents				10,486	679		679		6,768	20
21	Food Services allocated based on # of meals				149,798	3,851		5,318	1,467	123,886	21
22	Building Operations allocation based on squ feet				3,865,961	127,259		128,928	1,669	2,536,684	22
23	Therapy dept allocation based on staff hours				240,683	10,645		10,645		205,591	23
24	MGA alloc based # of employees				832,027	20,750		26,294	5,544	321,049	24
25	Finance alloc based on direct expense				218,121	5,721		5,721		60,007	25
26	IT alloc based on # of users				49,166	1,992		1,992		36,182	26
27	Purchasing dept allocated based on # of requistions				19,791	935		935		12,956	27
28	Religious Services based on census				1,594,387	41,895		41,895		280,284	28
29	Driskill Home based on # of volunteers				250,889	10,289		10,289		45,238	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: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 26,020,240	$ 709,180		$ 717,859	$ 8,679	$ 8,315,607	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: 07/01/2014 Ending: 06/30/2015

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	$ 1,983,713	$ 196,876	$ 196,876	$	10	$ 1,281,423	71
72	Current Year Purchases	72,995	4,565	4,565		10	4,565	72
73	Fully Depreciated Assets	666,426					666,426	73
74								74
75	TOTALS	$ 2,723,133	$ 201,441	$ 201,441	$		$ 1,952,414	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	campus alloc from bldg operations			$ 162,992	$ 7,281	$ 7,281	$	3	$ 149,686	76
77										77
78										78
79										79
80	TOTALS			$ 162,992	$ 7,281	$ 7,281	$		$ 149,686	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)	$ 28,906,365	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 917,902	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 926,581	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,679	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,417,707	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	$ 8,799,599	$ 244,436	$ 7,697,941	86
87	Auto alloc to other prog	1,172,963	53,581	1,075,988	87
88	Bldg & Improv alloc to other prog	100,893,756	3,432,314	58,807,842	88
89	Land	1,497,957			89
90					90
91	TOTALS	$ 112,364,275	$ 3,730,331	$ 67,581,771	91

G. Construction-in-Progress

	Description	Cost	
92	Quinlan homes	$ 14,465,555	92
93	CILA reno	85,644	93
94	Building Operations reno and misc	101,473	94
95		$ 14,652,672	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: 07/01/2014 Ending: 06/30/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 07/01/2014 Ending: 06/30/2015

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	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,166		1,166
3	Classroom Wages (a)		34,999		34,999
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 36,165	$	$ 36,165
10	SUM OF line 9, col. 1 and 2 (e)	$ 36,165			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	3156	hrs	17,232					17,232	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			$ 17,232		$	$		$ 17,232	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.

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2015 **(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	$ 14,313,443	$	1
2	Cash-Patient Deposits	364,257		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	6,810,312		3
4	Supply Inventory (priced at cost)	250,592		4
5	Short-Term Investments	22,306,959		5
6	Prepaid Insurance	572,617		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,760,552		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 46,378,732	$	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	126,913,996		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,858,687		16
17	Accumulated Depreciation (book methods)	(77,999,478)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	14,652,672		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 77,923,834	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 124,302,566	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 799,719	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	349,685		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,047,843		30
31	Accrued Taxes Payable (excluding real estate taxes)	258,399		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	704,757		36
37	Other Liabilities and ARO	2,461,373		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,621,776	$	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)**	$ 7,621,776	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 116,680,790	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 124,302,566	$	48

***(See instructions.)**

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 108,821,703	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 108,821,703	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,897,115)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	25,114,452	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**	(9,552,141)	15
16	Other (describe) **Development & Community Relations**	(2,580,689)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 9,084,507	17
	B. Transfers (Itemize):		
18	**Investment activity/insurance proceeds**	260,128	18
19	**Net Asset Reclassification**	(1,485,548)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,225,420)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 116,680,790	24 *

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	405,077	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 405,077	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)**	$ 9,755,700	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,943,287	31
32	Health Care	7,200,616	32
33	General Administration	2,703,390	33
	B. Capital Expense		
34	Ownership	976,146	34
	C. Ancillary Expense		
35	Special Cost Centers	273,296	35
36	Provider Participation Fee	556,080	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,652,815	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,897,115)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,897,115)	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.**

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	3,036	3,673	$ 145,262	$ 39.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,721	41,753	1,236,002	29.60	3
4	Licensed Practical Nurses	23,671	25,989	669,717	25.77	4
5	CNAs & Orderlies	174,026	187,696	2,725,805	14.52	5
6	CNA Trainees					6
7	Licensed Therapist	4,630	5,160	172,095	33.35	7
8	Rehab/Therapy Aides	9,862	11,358	190,010	16.73	8
9	Activity Director	24	30	945	31.50	9
10	Activity Assistants	632	731	15,713	21.50	10
11	Social Service Workers	3,373	3,846	87,164	22.66	11
12	Dietician			35,108		12
13	Food Service Supervisor	192	217	11,961	55.12	13
14	Head Cook			17,997		14
15	Cook Helpers/Assistants			55,643		15
16	Dishwashers					16
17	Maintenance Workers	6,974	7,821	176,294	22.54	17
18	Housekeepers	18,945	21,455	284,487	13.26	18
19	Laundry	10,856	11,665	150,441	12.90	19
20	Administrator	2,226	2,506	141,085	56.30	20
21	Assistant Administrator					21
22	Other Administrative	9,646	11,169	308,915	27.66	22
23	Office Manager			15,710		23
24	Clerical	2,829	3,176	55,852	17.59	24
25	Vocational Instruction	12,480	13,847	267,300	19.30	25
26	Academic Instruction	1,230	1,402	34,999	24.96	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)			440,012		28
29	Resident Services Coordinator			326,224		29
30	Habilitation Aides (DD Homes)			383,825		30
31	Medical Records	456	527	8,935	16.95	31
32	Other Health Care(specify)					32
33	Other(specify) Medical Secretary	1,806	2,080	43,382	20.86	33
34	TOTAL (lines 1 - 33)	322,615	356,101	$ 8,000,883 *	$ 22.47	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		$ 22	1	35
36	Medical Director		7,500	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,868	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	2,546	117,266	10a	41
42	Respiratory Therapy Consultant	54	2,150	10a	42
43	Speech Therapy Consultant	298	17,172	10a	43
44	Activity Consultant		3,662	11	44
45	Social Service Consultant		13,056	12	45
46	Other(specify) Hab Aide stipends		6,942	10a	46
47	Vocational		817	39	47
48	Medical waste/lab/doctor		32,186	10	48
49	TOTAL (lines 35 - 48)	2,898	$ 203,641		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: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
S. Rosemary Connelly	Executive Director	N/A	$ 12,425
Mary Pat O'Brien	Asst. Executive Directro	N/A	16,013
Denise Tigges/M. Diaz	Admistrator	N/A	24,397
K. Golden/G. Connelly	Admistrator	N/A	20,056
Lois Gates	Asst. Executive Directro	N/A	15,810
Chris Hegg/Joe Ferrera	Administrator	N/A	23,123
Kevin Connelly/Fr. Jack Clair	CFO/Asst Exe Dir	N/A	29,261
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 141,085

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	$ 19,048
ADP Processing	Payroll Service	28,328
LaPointe Law	Legal	2,866
Correll	Admin for 401K plan	8,260
Benefit and Compensation Resource	Admin recruitment	2,315
Mahoney, Crowe & Goldrick	Legal	361
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 61,178

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 163,468
Unemployment Compensation Insurance	39,443
FICA Taxes	525,722
Employee Health Insurance	796,272
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emp Tuition Reimbursement/Other	33,357
Dental Insurance	11,290
401K Match	358,502
Long-Term Disablility and Life Insurance	41,471
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,969,525

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	1,106
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	6,297
License fees-Computer lic, Dept of Financial	5,611
Subscription	803
Membership Dues	10,170
Bank fees	3,304
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
	2,226
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,226

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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: 07/01/2014 Ending: 06/30/2015

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Assoc $7,500**

(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. $ **125,965** 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. $ **556,080**
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. $ **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? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.