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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 773 973-6300 **Fax #** 773 743-5439

HFS ID Number:

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

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [X] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 503c3

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, 2015 to June 30, 2016 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, 2015 Ending: June 30, 2016

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	42,981	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	42,981	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	41,259	1,198		42,457	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,259	1,198		42,457	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.78%

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: June 30, 2016 Fiscal Year: June 30, 2016

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	83,759	6,973		90,732		90,732		90,732			1
2	Food Purchase		334,474		334,474		334,474	(44,111)	290,363			2
3	Housekeeping	327,149	46,238	126,147	499,534		499,534	(18,310)	481,224			3
4	Laundry	154,616	16,016		170,632		170,632		170,632			4
5	Heat and Other Utilities			337,304	337,304		337,304	(19,891)	317,413			5
6	Maintenance	179,772	42,757	319,090	541,619		541,619	(31,922)	509,697			6
7	Other (specify):*											7
8	TOTAL General Services	745,296	446,458	782,541	1,974,295		1,974,295	(114,234)	1,860,061			8
	B. Health Care and Programs											
9	Medical Director			6,667	6,667		6,667		6,667			9
10	Nursing and Medical Records	4,984,323	487,357	44,430	5,516,110		5,516,110	(2,950)	5,513,160			10
10a	Therapy	1,483,733	6,340	170,966	1,661,039		1,661,039	(9,179)	1,651,860			10a
11	Activities	16,059	672	4,346	21,077		21,077		21,077			11
12	Social Services	82,929	61		82,990		82,990		82,990			12
13	CNA Training	33,652	1,134		34,786		34,786	(927)	33,859			13
14	Program Transportation		22,223		22,223		22,223	(1,473)	20,750			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,600,696	517,787	226,409	7,344,892		7,344,892	(14,529)	7,330,363			16
	C. General Administration											
17	Administrative	150,838	4,053		154,891		154,891	(8,139)	146,752			17
18	Directors Fees											18
19	Professional Services			68,855	68,855		68,855	(8,292)	60,563			19
20	Dues, Fees, Subscriptions & Promotions			36,145	36,145		36,145	(13,543)	22,602			20
21	Clerical & General Office Expenses	363,343	30,853	17,852	412,048		412,048	(15,436)	396,612			21
22	Employee Benefits & Payroll Taxes			2,099,001	2,099,001		2,099,001	(67,667)	2,031,334			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,722	3,722		3,722	(905)	2,817			24
25	Other Admin. Staff Transportation		278		278		278	(278)				25
26	Insurance-Prop.Liab.Malpractice			50,222	50,222		50,222	(3,222)	47,000			26
27	Other (specify):*											27
28	TOTAL General Administration	514,181	35,184	2,275,797	2,825,162		2,825,162	(117,482)	2,707,680			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,860,173	999,429	3,284,747	12,144,349		12,144,349	(246,245)	11,898,104			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, 2015 Ending: June 30, 2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			949,459	949,459		949,459	(52,624)	896,835			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,334	6,334		6,334	(6,334)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			955,793	955,793		955,793	(58,958)	896,835			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	265,179	5,049	512	270,740		270,740	(240,630)	30,110			39
40	Barber and Beauty Shops			264	264		264		264			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			549,416	549,416		549,416		549,416			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	265,179	5,049	550,192	820,420		820,420	(240,630)	579,790			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,125,352	1,004,478	4,790,732	13,920,562		13,920,562	(545,833)	13,374,729			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, 2015 Ending: June 30, 2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(43,927)	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	3,202	30		9
10	Interest and Other Investment Income	(3,727)	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	(6,037)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,489)		$	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))**	$ (50,489)		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, 2015

Ending: June 30, 2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Expenses reimbursed from other sources:	$		1
2	Housekeeping Wages, Supplies	(18,310)	3	2
3	Heat and Other Utilities	(19,891)	5	3
4	Maintenance Wages, Supplies and Other	(26,387)	6	4
5	Program Transportation Other	(1,473)	14	5
6	Administrative Wages, Supplies and other	(4,130)	17	6
7	Professional Services	(1,973)	19	7
8	Dues, Fees, Subscriptions & Promotions	(1,308)	20	8
9	Clerical Wages, Supplies and Other	(15,436)	21	9
10	Employee Benefits & Payroll Taxes	(67,431)	22	10
11	Travel & Seminar	(52)	24	11
12	Other Admin Staff Transportation	(278)	25	12
13	Insurance	(3,222)	26	13
14	Depreciation	(43,909)	30	14
15	Ancillary Service Centers Salaries and Supplies	(236,420)	39	15
16	Staff Training	(927)	13	16
17	Investment Fees	(6,334)	32	17
18	Govt Sponsored Program-Staff Training Reimbursemetn	(9,179)	10a	18
19	Other employee benefits	(236)	22	19
20	Off-site recreational facility costs	(4,210)	39	20
21	Off-site recreational facility depreciation	(291)	30	21
22	Loss on disposal	(3,206)	6	22
23	Subscription	(504)	20	23
24	Donated Administrator's salary	(4,009)	17	24
25	Depreciation on donated fixed assets	(11,626)	30	25
26	Legal Fees alloc to other program	(282)	19	26
27	Donated supplies	(2,950)	10	27
28	Donated services	(2,329)	6	28
29	Donated food	(184)	2	29
30	Donated computer license	(8,004)	20	30
31	Unallowable Conferences	(853)	24	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**	(495,344)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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	(44,111)	0	0	0	0	0	0	0	0	0	0	(44,111)	2
3	Housekeeping	(18,310)	0	0	0	0	0	0	0	0	0	0	(18,310)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(19,891)	0	0	0	0	0	0	0	0	0	0	(19,891)	5
6	Maintenance	(31,922)	0	0	0	0	0	0	0	0	0	0	(31,922)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(114,234)	0	0	0	0	0	0	0	0	0	0	(114,234)	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	(2,950)	0	0	0	0	0	0	0	0	0	0	(2,950)	10
10a	Therapy	(9,179)	0	0	0	0	0	0	0	0	0	0	(9,179)	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	(927)	0	0	0	0	0	0	0	0	0	0	(927)	13
14	Program Transportation	(1,473)	0	0	0	0	0	0	0	0	0	0	(1,473)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(14,529)	0	0	0	0	0	0	0	0	0	0	(14,529)	16
	C. General Administration													
17	Administrative	(8,139)	0	0	0	0	0	0	0	0	0	0	(8,139)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,292)	0	0	0	0	0	0	0	0	0	0	(8,292)	19
20	Fees, Subscriptions & Promotions	(13,543)	0	0	0	0	0	0	0	0	0	0	(13,543)	20
21	Clerical & General Office Expenses	(15,436)	0	0	0	0	0	0	0	0	0	0	(15,436)	21
22	Employee Benefits & Payroll Taxes	(67,667)	0	0	0	0	0	0	0	0	0	0	(67,667)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(905)	0	0	0	0	0	0	0	0	0	0	(905)	24
25	Other Admin. Staff Transportation	(278)	0	0	0	0	0	0	0	0	0	0	(278)	25
26	Insurance-Prop.Liab.Malpractice	(3,222)	0	0	0	0	0	0	0	0	0	0	(3,222)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(117,482)	0	0	0	0	0	0	0	0	0	0	(117,482)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(246,245)	0	0	0	0	0	0	0	0	0	0	(246,245)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McAuley Residence **#** 0045906 **Report Period Beginning:** July 1, 2015 **Ending:** June 30, 2016

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	(52,624)	0	0	0	0	0	0	0	0	0	0	(52,624)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,334)	0	0	0	0	0	0	0	0	0	0	(6,334)	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**	(58,958)	0	0	0	0	0	0	0	0	0	0	(58,958)	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	(240,630)	0	0	0	0	0	0	0	0	0	0	(240,630)	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**	(240,630)	0	0	0	0	0	0	0	0	0	0	(240,630)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(545,833)	0	0	0	0	0	0	0	0	0	0	(545,833)	45

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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

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

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

1 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, 2015 Ending: June 30, 2016

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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				50	100.00	Salary	$ 12,160	17	1
2	Kevin Connelly	CFO				50	100.00	Salary	17,916	17	2
3	Fr. John Clair	Assoc. Exec Director				50	100.00	Salary	13,429	17	3
4	Note that S. Rosemary Connelly's, Kevin Connelly and Fr. John Clair salaries are allocated between Development & Community Relations and ProgramMG&A portion is f										4
5	(MG&A is allocated to Misericordia North & McAuley).										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 43,505		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, 2015 Ending: ne 30, 2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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, 2015 Ending: June 30, 2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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: July 1, 2015 Ending: June 30, 2016

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	$ 429,416	40	$ 429,416	$	$ 4,589,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Therapy pool, phones, plumbing, paging system and fence			2006	312,419	15,741	15 20	15,741		162,018	9
10	Install tile, electric wiring, air conditioning improv, phone			2007	86,018	6,473	15-20	6,473		61,031	10
11	Street signs			2008	6,590	659	10	659		5,821	11
12	Install conduit and wire for chiller for HVAC control, alarm, wire for roof			2010	6,834	356	20	356		2,135	12
13	Install conduit for HVAC control, alarm			2011	2,373	119	20	119		682	13
14	Vinyl flooring			2012	8,350	835	10	835		3,897	14
15	Install 480V fire pump controller			2014	10,318	329	10	329		933	15
16	Carpet installation			2014	4,690	938	5	938		2,423	16
17											17
18	Allocated support and MGA deparments not included in the capital component of daily rate:										18
19	Connolly Center Laundry allocated based on weight of laund				1,130,339	29,229		29,229		797,442	19
20	Resource Center allocated based on # of residents				9,720	509		509		7,354	20
21	Food Services allocated based on # of meals				139,933	4,108		4,108		117,791	21
22	Building Operations and Security allocation based on squ feet				9,599,348	139,783		140,416	633	7,998,593	22
23	Therapy dept allocation based on staff hours				61,139	16,143		16,143		53,022	23
24	MGA alloc based # of employees				947,762	28,147		30,716	2,569	644,904	24
25	Finance alloc based on direct expense				235,824	6,254		6,254		83,115	25
26	IT alloc based on # of users				352,712	2,322		2,322		339,423	26
27	Purchasing dept allocated based on # of requistions				19,153	887		887		13,425	27
28	Religious Services based on census				1,862,454	48,939		48,939		752,696	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, 2015 Ending: June 30, 2016

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)		$ 31,972,891	$ 731,187		$ 734,389	$ 3,202	$ 15,636,507	70

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

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	$ 1,410,888	$ 155,352	$ 155,352	$		$ 907,263	71
72	Current Year Purchases	43,263	1,758	1,758		10	1,758	72
73	Fully Depreciated Assets	659,671					659,671	73
74								74
75	TOTALS	$ 2,113,822	$ 157,110	$ 157,110	$		$ 1,568,692	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			$ 100,900	$ 5,336	$ 5,336	$	4	$ 91,629	76
77										77
78										78
79										79
80	TOTALS			$ 100,900	$ 5,336	$ 5,336	$		$ 91,629	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)	$ 34,187,612	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 893,633	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 896,835	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,202	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 17,296,829	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg & Equip alloc to other prog	$ 122,276,575	$ 3,801,613	$ 64,019,342	86
87	Auto alloc to other prog	1,321,207	69,871	1,199,821	87
88					88
89	Land	1,497,957			89
90					90
91	TOTALS	$ 125,095,739	$ 3,871,484	$ 65,219,163	91

G. Construction-in-Progress

	Description	Cost	
92	CILA reno	$ 581,514	92
93	Main entrance reno	408,033	93
94	Bldg improvements campus	134,440	94
95		$ 1,123,987	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, 2015 Ending: June 30, 2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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, 2015 Ending: June 30, 2016

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 [X]
- 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		1,135		1,135
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		33,652		33,652
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 34,787	$	$ 34,787
10	SUM OF line 9, col. 1 and 2 (e)	$ 34,787			

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	10,655					10,655	6
7	Work Related Program	1946	hrs	19,455					19,455	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			$ 30,110		$	$		$ 30,110	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:** July 1, 2015 **Ending:** June 30, 2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2016 **(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	$ 15,153,893	$	1
2	Cash-Patient Deposits	367,847		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	6,179,505		3
4	Supply Inventory (priced at cost)	221,951		4
5	Short-Term Investments	31,488,671		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	677,850		7
8	Accounts Receivable (owners or related parties)	3,093,090		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 57,182,807	$	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	144,691,094		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,094,300		16
17	Accumulated Depreciation (book methods)	(82,515,992)		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	1,123,987		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 77,891,346	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 135,074,153	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 961,548	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	353,264		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,283,008		30
31	Accrued Taxes Payable (excluding real estate taxes)	333,952		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	283,167		36
37	Other Liabilities and ARO	1,617,375		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,832,314	$	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)**	$ 6,832,314	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 128,241,839	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 135,074,153	$	48

***(See instructions.)**

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 Ending: June 30, 2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 116,680,790	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 116,680,790	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(4,538,219)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	30,134,757	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment	66,207	14
15	Other (describe) **Net Loss from Misericordia North**	(11,482,273)	15
16	Other (describe) **Development & Community Relations**	(2,790,598)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,389,874	17
	B. Transfers (Itemize):		
18	**Investment activity/insurance proceeds**	171,175	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 171,175	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 128,241,839	24 *

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

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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	$ 8,924,281	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,924,281	3
	B. Ancillary Revenue		
4	Day Care	448,883	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 448,883	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	9,179	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,179	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)**	$ 9,382,343	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,974,295	31
32	Health Care	7,344,892	32
33	General Administration	2,825,162	33
	B. Capital Expense		
34	Ownership	955,793	34
	C. Ancillary Expense		
35	Special Cost Centers	271,004	35
36	Provider Participation Fee	549,416	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,920,562	40
41	**Income before Income Taxes (line 30 minus line 40)****	(4,538,219)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (4,538,219)	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	3,601	3,953	$ 151,963	$ 38.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,107	38,553	1,189,915	30.86	3
4	Licensed Practical Nurses	25,590	28,968	755,170	26.07	4
5	CNAs & Orderlies	176,623	185,688	2,832,692	15.26	5
6	CNA Trainees					6
7	Licensed Therapist	4,568	5,147	178,810	34.74	7
8	Rehab/Therapy Aides	8,691	9,900	181,235	18.31	8
9	Activity Director	23	26	842	32.38	9
10	Activity Assistants	592	687	15,217	22.15	10
11	Social Service Workers	3,217	3,759	82,929	22.06	11
12	Dietician	925	1,016	36,878	36.30	12
13	Food Service Supervisor	100	110	6,650	60.45	13
14	Head Cook	285	337	9,189	27.27	14
15	Cook Helpers/Assistants	1,890	2,076	31,042	14.95	15
16	Dishwashers					16
17	Maintenance Workers	6,815	7,609	179,772	23.63	17
18	Housekeepers	21,473	23,742	327,149	13.78	18
19	Laundry	10,365	11,151	154,616	13.87	19
20	Administrator	1,914	2,137	150,838	70.58	20
21	Assistant Administrator					21
22	Other Administrative	9,377	10,540	277,769	26.35	22
23	Office Manager	642	732	18,049	24.66	23
24	Clerical	4,599	5,133	85,573	16.67	24
25	Vocational Instruction	11,115	12,335	265,180	21.50	25
26	Academic Instruction	1,106	1,299	33,652	25.91	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	18,545	20,282	443,322	21.86	28
29	Resident Services Coordinator	12,405	14,181	292,572	20.63	29
30	Habilitation Aides (DD Homes)	18,652	20,957	369,745	17.64	30
31	Medical Records	448	520	9,374	18.03	31
32	Other Health C: Medical Secretary	1,823	2,080	45,209	21.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	379,491	412,918	$ 8,125,352 *	$ 19.68	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		6,667	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,836	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	2,413	144,791	10a	41
42	Respiratory Therapy Consultant	40	1,600	10a	42
43	Speech Therapy Consultant	170	10,205	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) medical waste		7,034	10	46
47	Doctor		34,560	10	47
48	Hab aide/Psych		14,370	10a	48
49	TOTAL (lines 35 - 48)	2,623	$ 222,063		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		$ 12,160
Mary Pat O'Brien/L. Gate	Asst. Executive Directro		33,402
Denise Tigges/C. Krackenberger	Admistrator		28,250
K. Golden/G. Connelly	Admistrator		22,424
Joseph Ferrara	Admistrator		11,800
Mike Diaz/Tina Stendardo	Admistrator		11,457
Kevin Connelly/Fr. Jack Clair	CFO/Assoc Exe Dir		31,345
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 150,838

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	$ 21,115
ADP Processing	Payroll Service	31,976
LaPointe Law	Legal	2,791
Correll	Admin for 401K plan	6,467
Holland & Knight	Unallowable legal	6,216
Mahoney, Crowe, Goldrick	Legal alloc to other prog	290
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 68,855

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 146,408
Unemployment Compensation Insurance	14,043
FICA Taxes	558,571
Employee Health Insurance	858,724
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Emp Tuition Reimbursement/Other	31,997
Dental Insurance	17,189
401K Match	360,157
Long-Term Disablility and Life Insurance	44,245
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,031,334

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	1,340
Health Care Worker Background Check	
(Indicate # of checks performed 178)	6,009
Patient Background Checks	
Membership Dues	131
License fees-Computer lic, Dept of Financial I	4,805
Membership Dues/Subscriptions	7,155
Bank fees	3,162
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,602

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,817
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,817

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2015 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 $7,125**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **123,169** 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 fo
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 Departmen
during this cost report period. $ **549,416**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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 & Touche**

(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