FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0042879

Facility Name: PRESENCE MCAULEY MANOR

Address: 400 WEST SULLIVAN RD (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: 630-859-3700 Fax # 630-264-1862

HFS ID Number:

Date of Initial License for Current Owners: 12-01-97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		
		X	Charitable Corp.
			Trust

IRS Exemption Code 501C3

	PROPRIETARY	
		Individual
		Partnership
		Corporation
		"Sub-S" Corp.
		Limited Liability Co.
		Trust
		Other

	GOVERNMENTAL	
		State
		County
		Other

In the event there are further questions about this report, please contact:
Name: PAULA MILLER Telephone Number: 816-596-5608
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 7/1/19 to 6/30/20 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)	MICHAEL GORDON
	(Title)	CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Eric J. Neidig Senior Manager
	(Firm Name & Address)	Bradley Associates 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225
	(Telephone)	(317) 237-5500 Fax # (317) 237-5503

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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 NONE

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,842	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,842	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,980	2,622	6,175	16,777	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,980	2,622	6,175	16,777	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.69%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A - NONE

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 12-01-97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12-01-97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 87 and days of care provided 3,515

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 6-30-20 Fiscal Year: 6-30-20

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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		2,626	509,938	512,564		512,564		512,564			1
2	Food Purchase		156,194		156,194		156,194		156,194			2
3	Housekeeping	119,704	11,912	1,440	133,056		133,056	2,743	135,799			3
4	Laundry		415	48,342	48,757		48,757	(606)	48,151			4
5	Heat and Other Utilities			154,121	154,121		154,121	2,494	156,615			5
6	Maintenance	90,328	8,056	326,976	425,360		425,360	2,070	427,430			6
7	Other (specify):* Pastoral	8,135	365	15,038	23,538		23,538		23,538			7
8	**TOTAL General Services**	218,167	179,568	1,055,855	1,453,590		1,453,590	6,701	1,460,291			8
	B. Health Care and Programs											
9	Medical Director	19,800			19,800		19,800		19,800			9
10	Nursing and Medical Records	1,883,145	167,630	262,941	2,313,716		2,313,716	(27)	2,313,689			10
10a	Therapy			591,294	591,294		591,294		591,294			10a
11	Activities	58,318	2,282	1,188	61,788		61,788		61,788			11
12	Social Services	47,555		457	48,012		48,012		48,012			12
13	CNA Training											13
14	Program Transportation			19	19		19		19			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,008,818	169,912	855,899	3,034,629		3,034,629	(27)	3,034,602			16
	C. General Administration											
17	Administrative	107,382		715,560	822,942		822,942	(715,560)	107,382			17
18	Directors Fees											18
19	Professional Services			2,985	2,985		2,985	(1,592)	1,393			19
20	Dues, Fees, Subscriptions & Promotions			24,192	24,192		24,192	(1,864)	22,328			20
21	Clerical & General Office Expenses	173,479	22,668	28,032	224,179		224,179	752,235	976,414			21
22	Employee Benefits & Payroll Taxes			500,530	500,530		500,530	(13,506)	487,024			22
23	Inservice Training & Education											23
24	Travel and Seminar			692	692		692		692			24
25	Other Admin. Staff Transportation			2,753	2,753		2,753		2,753			25
26	Insurance-Prop.Liab.Malpractice			50	50		50	166,550	166,600			26
27	Other (specify):*											27
28	**TOTAL General Administration**	280,861	22,668	1,274,794	1,578,323		1,578,323	186,263	1,764,586			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,507,846	372,148	3,186,548	6,066,542		6,066,542	192,937	6,259,479			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 PRESENCE MCAULEY MANOR #0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			85,536	85,536		85,536	105,286	190,822			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,974	28,974		28,974	(8,407)	20,567			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,432	18,432		18,432		18,432			35
36	Other (specify):*											36
37	**TOTAL Ownership**			132,942	132,942		132,942	96,879	229,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			590,762	590,762		590,762		590,762			39
40	Barber and Beauty Shops			394	394		394		394			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,042	129,042		129,042		129,042			42
43	Other (specify):* Lab/Radiology			10,628	10,628		10,628		10,628			43
44	**TOTAL Special Cost Centers**			730,826	730,826		730,826		730,826			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,507,846	372,148	4,050,316	6,930,310		6,930,310	289,816	7,220,126			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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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				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	86,860	30		9
10	Interest and Other Investment Income	(8,407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,372)	20		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 PG5A	(2,810)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 73,271		$	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)	216,545	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 216,545		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 289,816		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.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PRESENCE MCAULEY MANOR

ID# 0042879

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Revenue	$ (606)	4	1
2	Miscellaneous Revenue	(27)	10	2
3	Non-Allowable Legal Fees	(1,592)	19	3
4	Lobbying	(395)	21	4
5	Fund Raising, Advertising, Promotional	(190)	21	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
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**	(2,810)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	2,743	0	0	0	0	0	0	0	0	0	2,743	3
4	Laundry	(606)	0	0	0	0	0	0	0	0	0	0	(606)	4
5	Heat and Other Utilities	0	2,494	0	0	0	0	0	0	0	0	0	2,494	5
6	Maintenance	0	2,070	0	0	0	0	0	0	0	0	0	2,070	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(606)	7,307	0	0	0	0	0	0	0	0	0	6,701	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	(27)	0	0	0	0	0	0	0	0	0	0	(27)	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	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(27)	0	0	0	0	0	0	0	0	0	0	(27)	16
	C. General Administration													
17	Administrative	0	(715,560)	0	0	0	0	0	0	0	0	0	(715,560)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,592)	0	0	0	0	0	0	0	0	0	0	(1,592)	19
20	Fees, Subscriptions & Promotions	(2,372)	508	0	0	0	0	0	0	0	0	0	(1,864)	20
21	Clerical & General Office Expenses	(585)	752,820	0	0	0	0	0	0	0	0	0	752,235	21
22	Employee Benefits & Payroll Taxes	0	(13,506)	0	0	0	0	0	0	0	0	0	(13,506)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	166,550	0	0	0	0	0	0	0	0	0	166,550	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,549)	190,812	0	0	0	0	0	0	0	0	0	186,263	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,182)	198,119	0	0	0	0	0	0	0	0	0	192,937	29

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	86,860	18,426	0	0	0	0	0	0	0	0	0	105,286	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,407)	0	0	0	0	0	0	0	0	0	0	(8,407)	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**	78,453	18,426	0	0	0	0	0	0	0	0	0	96,879	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	73,271	216,545	0	0	0	0	0	0	0	0	0	289,816	45

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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
Rhonda Anderson	BOD	Ascension Health Senior Care	Various	Ascension Health	Various	Healthcare System
Brad Partridge	BOD	Presence Our Lady of Victory	Bourbonnais	Suburban Pharmacy	Various	Pharmacy
Stuart Marcus	BOD	Presence Cor Mariae Center	Rockford			
Danny Stricker	BOD	Presence St. Joseph Center	Freeport			
Michelle Hereford	BOD	Presence St. Anne Center	Rockford			
		Presence Villa Franciscan	Joliet			
		Presence Heritage Village	Kankakee			

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. [X] 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	3	Housekeeping	$	Ascension Health		$ 2,743	$ 2,743	1
2	V	5	Utilities		Ascension Health		2,494	2,494	2
3	V	6	Maintenance		Ascension Health		2,070	2,070	3
4	V	17	Administration	715,560	Ascension Health			(715,560)	4
5	V	20	Dues and Fees		Ascension Health		508	508	5
6	V	21	Clerical and General Office		Ascension Health		752,820	752,820	6
7	V	22	Benefits	301,859	Ascension Health		288,353	(13,506)	7
8	V	26	Insurance		Ascension Health		166,550	166,550	8
9	V	30	Depreciation		Ascension Health		18,426	18,426	9
10	V	32	Interest	851	Ascension Health		851		10
11	V	39	Pharmacy	588,572	Suburban Pharmacy		588,572		11
12	V								12
13	V								13
14	Total			$ 1,606,842			$ 1,823,387	$ * 216,545	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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			Presence Maryhaven Nursing & Rehab Center	Glenview				1
2			Presence Nazarethville	Des Plaines				2
3			Presence Resurrection Life Center	Chicago				3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge				4
5			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake				5
6			A Merkle C Knipprath Nursing Home	Clifton				6
7			Presence St. Benedict	Niles				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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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								TOTAL	$		13

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

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 [X] NO [ ]

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

Name of Related Organization: Ascension Health
Street Address: 12250 Weber Hill Road
City / State / Zip Code: St Louis, Missouri 63127
Phone Number: (816-596-5608
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	3	Housekeeping	Direct Cost	Various	15	$ 64,428	$	Various	$ 2,743	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	2,494	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	2,070	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	508	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	752,820	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	288,353	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	166,550	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	18,426	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	851	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					$ 33,204,518	$ 2,702,670		$ 1,234,815	25

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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 2020 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:		
2015		8
2016		9
2017		10
2018		11
2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE MCAULEY MANOR COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0042879

CONTACT PERSON REGARDING THIS REPORT Paula Miller

TELEPHONE 816-596-5608 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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. [X] (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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	87		1986	1986	$ 4,218,962	$	25	$	$	$ 4,218,962	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1987	9,470		15			9,470	9
10	VARIOUS			1994	18,925		8			18,925	10
11	VARIOUS			1995	4,742		8			4,742	11
12	VARIOUS			1996	1,683		5			1,683	12
13	VARIOUS			1997	5,525		5			5,525	13
14	VARIOUS			1999	2,941		5			2,941	14
15	VARIOUS			2000	1,200		5			1,200	15
16	VARIOUS			2001	62,210		9			62,210	16
17	VARIOUS			2003	76,245		9			76,245	17
18	VARIOUS			2004	104,667		12			104,667	18
19	VARIOUS			2005	236,034	2,433	11	4,904	2,471	236,034	19
20	VARIOUS			2006	44,405	1,574	14	3,172	1,598	44,195	20
21	VARIOUS			2007	368,343	14,058	13	28,334	14,276	349,186	21
22	VARIOUS			2008	110,916		10			110,916	22
23	VARIOUS			2009	111,052	3,182	11	6,413	3,231	111,052	23
24	VARIOUS			2010	155,845	7,733	10	15,585	7,852	149,439	24
25	VARIOUS			2011	86,281	3,892	11	7,844	3,952	78,028	25
26	VARIOUS			2012	54,485	2,704	10	5,449	2,745	45,712	26
27	VARIOUS			2013	25,250	1,253	10	2,525	1,272	19,798	27
28											28
29											29
30	ARCRYLIC SHOWER FLOOR ACRYLIC			2014	33,916	1,683	10	3,392	1,709	20,503	30
31	DOOR RESTRICTORS ON 3 ELEVATOR			2014	6,567	326	10	657	331	3,912	31
32	HEATING UNIT			2014	9,003	298	15	600	302	3,618	32
33	PANIC DEVICES ON DOUBLE DOORS			2014	6,541	324	10	654	330	3,954	33
34	PARKING LOT LIGHTING			2014	7,791	194	20	390	196	2,322	34
35	NEW PARKING LOT			2014	25,725	851	15	1,715	864	10,196	35
36	WANDER GUARD SYSTEM FOR SECOND			2014	2,977		5			2,977	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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	CEILING TILE INSTALLATION	2015	$ 2,153	$ 54	20	$ 108	$ 54	$ 642	37
38	CORNER GUARDS HIGH IMPACT WALL	2015	12,928	642	10	1,293	651	7,582	38
39	DESIGN FEE AND FLOOR PLAN FOR	2015	3,600	89	20	180	91	1,069	39
40	EXTERIOR PAINTING	2015	3,100	205	5	413	208	3,100	40
41	ICE WATER DISPENSER	2015	3,440	244	7	491	247	2,538	41
42	FLOORING IN LOWER LVL HALLS/BREAK RM/THERAPY	2015	58,345	1,930	15	3,890	1,960	23,022	42
43	LABOR FOR INSTALLATION OF LIGH	2015	401	10	20	20	10	119	43
44	NEW MATTRESSES FOR 86 BEDS	2015	19,986	1,983	5	3,997	2,014	19,986	44
45	PAINT MAIN CORRIDOR ELEVATOR C	2015	12,380	331	5	667	336	12,380	45
46	PAINTING LOWER LEVEL HALLWAY	2015	4,965	493	5	993	500	4,965	46
47	PARKING LOT AND DRIVEWAY	2015	14,845	368	20	742	374	3,896	47
48	PATIENT TRANSPORTATION SLINGS	2015	2,769	68	20	138	70	822	48
49	PAVE PARKING LOT AND DRIVEWAY	2015	11,687	725	8	1,461	736	7,792	49
50	PAVING OVERLAY MAIN PARKING LO	2015	18,250	1,132	8	2,281	1,149	12,356	50
51	WALL COVERINGS/CORNERGUARDS IN RESIDENT ROOM	2015	27,840	1,381	10	2,784	1,403	16,356	51
52	INSTALLATION OF NEW ROOF FOR ENTIRE BUILDING	2015	21,320	1,058	10	2,132	1,074	10,660	52
53	REPLACE 5 CONCRETE SECTIONS OF	2015	4,200	104	20	210	106	980	53
54	WALL PROTECTORS FOR DAY ROOMS AND HALLWAYS	2015	25,539	1,267	10	2,554	1,287	12,557	54
55	WARMING DRAWER AND PLATE WARME	2015	5,841	290	10	584	294	2,823	55
56	DOORS & FRAMES - 1st Floor Rooms & Hallway	2015	9,265	230	20	463	233	2,200	56
57									57
58	TEKNOFLOR SHEET VINYL FLOORING - Rooms & Hallway	2016	48,000	1,588	15	3,200	1,612	14,400	58
59									59
60									60
61	DEDUCTION FOR NON-CARE ASSETS	2010	(10,064)		-5			(10,064)	61
62									62
63									63
64	Sink Faucet	2019	3,595	87	20	180	93	360	64
65	Boiler Installation	2019	139,847	3,467	20	6,992	3,525	13,984	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,235,933	$ 58,251		$ 117,407	$ 59,156	$ 5,862,937	70

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 731,739	$ 26,259	$ 52,923	$ 26,664	8	$ 499,175	71
72	Current Year Purchases	20,658	1,026	2,066	1,040	10	2,066	72
73	Fully Depreciated Assets	481,470					481,470	73
74	Home Office Allocation		18,426	18,426				74
75	TOTALS	$ 1,233,867	$ 45,711	$ 73,415	$ 27,704		$ 982,711	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	PLANT ENGINEERING	1999 FORD ELDORADO - 15CA	1999	$ 42,261	$	$	$	8	$ 42,261	76
77										77
78										78
79										79
80	TOTALS			$ 42,261	$	$	$		$ 42,261	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)	$ 7,512,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,962	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,822	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 86,860	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,887,909	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 18,432 Description: Nursing 13,165; Admin 4,368; Facility Services 506; Therapy 393.
    (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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

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

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$		$ 274,651	$		$ 274,651	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			40,085			40,085	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			274,430	2,128		276,558	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				590,762		590,762	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			$		$ 589,166	$ 592,890		$ 1,182,056	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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (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	$ 1,089	$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	620,606	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	4,010	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,793	93,121,433	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 631,498	$ 147,419,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		745,000	11
12	Long-Term Investments		170,652,019	12
13	Land	805,500	84,567,210	13
14	Buildings, at Historical Cost	1,526,097	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	117,254	111,043,559	16
17	Accumulated Depreciation (book methods)	(196,737)	(228,817,338)	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): Misc Assets		11,647,941	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,252,114	$ 636,045,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,883,612	$ 783,464,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 221,043	$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,463	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	84,747	13,470,734	30
31	Accrued Taxes Payable (excluding real estate taxes)		122,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,115,678	32
33	Accrued Interest Payable			33
34	Deferred Compensation		46,484,006	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties	19,054	4,954,006	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 369,307	$ 236,975,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		180,846,178	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)**	$	$ 180,846,178	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 369,307	$ 417,821,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,514,305	$ 365,643,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,883,612	$ 783,464,338	48

*(See instructions.)

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,789,754	1
2	Restatements (describe):		2
3	Adj to Reconcile	558,349	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,348,103	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(833,798)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (833,798)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,514,305	24 *

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

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 5,529,688	1
2	Discounts and Allowances for all Levels	(1,750,570)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,779,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,344,348	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,344,348	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	164,347	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,120	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	751,944	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)**	$ 920,411	23
	D. Non-Operating Revenue		
24	Contributions	7,565	24
25	Interest and Other Investment Income***	8,407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,972	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	36,663	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,663	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,096,512	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,453,590	31
32	Health Care	3,034,629	32
33	General Administration	1,578,323	33
	B. Capital Expense		
34	Ownership	132,942	34
	C. Ancillary Expense		
35	Special Cost Centers	601,784	35
36	Provider Participation Fee	129,042	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,930,310	40
41	**Income before Income Taxes (line 30 minus line 40)****	(833,798)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (833,798)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,503,079	44
45	Private Pay - Net Inpatient Revenue	769,729	45
46	Medicare - Net Inpatient Revenue	1,036,128	46
47	Other-(specify) Insurance	470,182	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,779,118	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	533	583	$ 44,588	$ 76.48	1
2	Assistant Director of Nursing	383	416	18,254	43.88	2
3	Registered Nurses	32,773	35,764	1,323,130	37.00	3
4	Licensed Practical Nurses	356	612	19,878	32.48	4
5	CNAs & Orderlies	26,910	29,373	477,295	16.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,139	42,391	19.82	9
10	Activity Assistants	1,267	1,341	15,927	11.88	10
11	Social Service Workers	1,566	1,737	47,555	27.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,145	4,521	90,328	19.98	17
18	Housekeepers	7,903	8,603	119,704	13.91	18
19	Laundry					19
20	Administrator	2,085	2,160	107,382	49.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,750	1,849	39,382	21.30	23
24	Clerical	5,341	5,915	92,842	15.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	208	208	19,800	95.19	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Admissions	1,114	1,367	41,255	30.18	32
33	Other(specify) Pastoral	288	331	8,135	24.58	33
34	TOTAL (lines 1 - 33)	88,526	96,919	$ 2,507,846 *	$ 25.88	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	3,131	43	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	68	1	10a, 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	264	4	11, 3	44
45	Social Service Consultant	374	6	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,837	$ 54		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	164	7,502	10	51
52	Certified Nurse Assistants/Aides	7,873	187,408	10	52
53	TOTAL (lines 50 - 52)	8,037	$ 194,910		53

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margie Thompson	Administrator		$ 107,382
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,382

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 715,560
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 715,560

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening, Inc	HR Services	$ 1,393
Miscellaneous	Non-Allowable Legal Fees	1,592
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 2,985

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	189,139
Employee Health Insurance	233,296
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	5,075
Life Insurance	2,373
Disability	2,829
Pension	41,379
Tuition Reimbursement	
Other Benefits	26,440
Home Office Allocation	(13,507)
TOTAL (agree to Schedule V, line 22, col.8)	$ 487,024

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		
Health Care Worker Background Check		
(Indicate # of checks performed	33)	
Patient Background Checks	206	
Dues & Subscriptions		21,820
Home Office Allocation		508
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 22,328

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	692
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 692

**See instructions.

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 7/1/19 Ending: 6/30/20

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. **LEADING AGE - $6,581**

(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? **N/A**

(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? **N/A**

(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 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,342** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **129,042**
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? **NO** 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? **NO** 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. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **EY - PERFORMS CONSOLIDATED AUDIT OF ASCENSION HEALTH**

(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.