

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

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.

<p>I. IDPH Facility ID Number: <u>0005926</u></p> <p>Facility Name: <u>Misericordia Home-South</u></p> <p>Address: <u>2916 W. 47th Street</u> <u>Chicago</u> <u>60632</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>773 973-6300</u> Fax # <u>773 973-4292</u></p> <p>IDPA ID Number: <u>362170153-001</u></p> <p>Date of Initial License for Current Owners: <u>various</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Amy Boyle</u> Telephone Number: <u>773 273-3032</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2000</u> to <u>06/30/2001</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Kevin Connelly</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Kevin Connelly</u>	Paid Preparer	(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Kevin Connelly</u>																												
Paid Preparer	(Title) <u>Chief Financial Officer</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____																												

Facility Name & ID Number Misericordia Home-South# 0005926 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

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 6/30/99

	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		Skilled (SNF)			1
2	99	Skilled Pediatric (SNF/PED)	99	36,135	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED	30,358	775	471	31,604	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,358	775	471	31,604	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.46%D. How many bed-hold days during this year were paid by Public Aid?
784 (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)RespiteF. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO I. On what date did you start providing long term care at this location?
Date started / /J. Was the facility purchased or leased after January 1, 1978?
YES Date / / NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number
of beds certified / and days of care provided /Medicare Intermediary /

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/01 Fiscal Year: 6/30/01

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

STATE OF ILLINOIS

Facility Name & ID Number Misericordia Home-South # 0005926 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	241,249	34,501	11,070	286,820		286,820	(41,320)	245,500		1
2	Food Purchase		237,946		237,946		237,946	(105,767)	132,179		2
3	Housekeeping	195,708	41,598	1,064	238,370		238,370	(71,096)	167,274		3
4	Laundry	120,935	7,595		128,530		128,530	(22,444)	106,087		4
5	Heat and Other Utilities			53,192	53,192		53,192	(15,865)	37,327		5
6	Maintenance	116,615	24,919	54,646	196,180		196,180	(50,381)	145,799		6
7	Other (specify):*										7
8	TOTAL General Services	674,507	346,559	119,972	1,141,038		1,141,038	(306,871)	834,167		8
B. Health Care and Programs											
9	Medical Director			43,237	43,237		43,237	(1,230)	42,007		9
10	Nursing and Medical Records	3,611,786	546,229	6,842	4,164,857		4,164,857	(241,767)	3,923,090		10
10a	Therapy	573,828	5,636	162,209	741,673		741,673	(6,053)	735,620		10a
11	Activities			4,494	4,494		4,494		4,494		11
12	Social Services	68,888		25,250	94,138		94,138	(30,332)	63,806		12
13	Nurse Aide Training										13
14	Program Transportation		5,144	281	5,425		5,425	(4,346)	1,079		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,254,502	557,009	242,313	5,053,824		5,053,824	(283,729)	4,770,095		16
C. General Administration											
17	Administrative	102,352			102,352		102,352	(16,010)	86,342		17
18	Directors Fees										18
19	Professional Services			35,133	35,133		35,133	(5,559)	29,574		19
20	Dues, Fees, Subscriptions & Promotions			17,878	17,878		17,878	(2,850)	15,028		20
21	Clerical & General Office Expenses	285,148	29,527	38,346	353,021		353,021	(56,175)	296,846		21
22	Employee Benefits & Payroll Taxes			1,190,107	1,190,107		1,190,107	(189,692)	1,000,415		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,765	7,765		7,765	(993)	6,772		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,966	7,966		7,966	(2,093)	5,873		26
27	Other (specify):*										27
28	TOTAL General Administration	387,500	29,527	1,297,195	1,714,222		1,714,222	(273,372)	1,440,850		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,316,509	933,095	1,659,480	7,909,084		7,909,084	(863,972)	7,045,112		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

Misericordia Home-South

#0005926

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			250,610	250,610		250,610	(80,612)	169,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			250,610	250,610		250,610	(80,612)	169,998			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	399,048	5,560	1,750	406,358		406,358	(406,359)	(1)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			343,744	343,744		343,744		343,744			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	399,048	5,560	345,494	750,102		750,102	(406,359)	343,743			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,715,557	938,655	2,255,584	8,909,796		8,909,796	(1,350,943)	7,558,853			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 Misericordia Home-South

0005926

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(71,461)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(20,300)	12		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see pg5A				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,761)		\$	30

OHF 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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (91,761)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Misericordia Home-South

ID# 0005926

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dietary Wages	\$ (35,133)	1	1
2	Dietary Supplies	(5,152)	1	2
3	Dietary Other	(1,035)	1	3
4	Food Supplies	(34,306)	2	4
5	Housekeeping Wages	(58,371)	3	5
6	Housekeeping Supplies	(12,407)	3	6
7	Housekeeping Other	(317)	3	7
8	Laundry Wages	(21,117)	4	8
9	Laundry Supplies	(1,326)	4	9
10	Heat and Other Utilities	(15,865)	5	10
11	Maintenance Wages	(27,440)	6	11
12	Maintenance Supplies	(7,432)	6	12
13	Maintenance Other	(15,508)	6	13
14	Medical Director	(1,230)	9	14
15	Nursing/Med Records Wages	(214,614)	10	15
16	Nursing/Med Records Supplies	(27,153)	10	16
17	Therapy Other	(6,053)	10a	17
18	Social Services Wages	(10,032)	12	18
19	Program Transportation Supplies	(1,604)	14	19
20	Program Transportation Other	(84)	14	20
21	Administrative Wages	(16,010)	17	21
22	Professional Services	(5,559)	19	22
23	Dues, Fees, Subscriptions & Promotions	(2,850)	20	23
24	Clerical Wages	(45,414)	21	24
25	Clerical Supplies	(4,268)	21	25
26	Clerical Other	(6,492)	21	26
27	Employee Benefits & Payroll Taxes	(189,692)	22	27
28	Travel and Seminar (includes out-of-state cof)	(993)	24	28
29	Insurance-Prop, Liab & Malpractice	(2,093)	26	29
30	Depreciation allocated to other	(77,147)	30	30
31	Ancillary Service Center Salaries & Wages	(399,048)	39	31
32	Depreciation of Non-care auto	(3,465)	30	32
33	Fuel & repairs of Non-care auto	(2,658)	14	33
34	Ancillary Service Center Supplies	(5,560)	39	34
35	Ancillary Service Center Other	(1,750)	39	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	(1,259,182)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Misericordia Home-South# 0005926 Report Period Beginning:07/01/2000Ending: 06/30/2001

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	(41,320)	0	0	0	0	0	0	0	0	0	0	(41,320)	1
2	Food Purchase	(105,767)	0	0	0	0	0	0	0	0	0	0	(105,767)	2
3	Housekeeping	(71,096)	0	0	0	0	0	0	0	0	0	0	(71,096)	3
4	Laundry	(22,444)	0	0	0	0	0	0	0	0	0	0	(22,444)	4
5	Heat and Other Utilities	(15,865)	0	0	0	0	0	0	0	0	0	0	(15,865)	5
6	Maintenance	(50,381)	0	0	0	0	0	0	0	0	0	0	(50,381)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(306,871)	0	0	0	0	0	0	0	0	0	0	(306,871)	8
	B. Health Care and Programs													
9	Medical Director	(1,230)	0	0	0	0	0	0	0	0	0	0	(1,230)	9
10	Nursing and Medical Records	(241,767)	0	0	0	0	0	0	0	0	0	0	(241,767)	10
10a	Therapy	(6,053)	0	0	0	0	0	0	0	0	0	0	(6,053)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(30,332)	0	0	0	0	0	0	0	0	0	0	(30,332)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,346)	0	0	0	0	0	0	0	0	0	0	(4,346)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(283,729)	0	0	0	0	0	0	0	0	0	0	(283,729)	16
	C. General Administration													
17	Administrative	(16,010)	0	0	0	0	0	0	0	0	0	0	(16,010)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,559)	0	0	0	0	0	0	0	0	0	0	(5,559)	19
20	Fees, Subscriptions & Promotions	(2,850)	0	0	0	0	0	0	0	0	0	0	(2,850)	20
21	Clerical & General Office Expenses	(56,175)	0	0	0	0	0	0	0	0	0	0	(56,175)	21
22	Employee Benefits & Payroll Taxes	(189,692)	0	0	0	0	0	0	0	0	0	0	(189,692)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(993)	0	0	0	0	0	0	0	0	0	0	(993)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,093)	0	0	0	0	0	0	0	0	0	0	(2,093)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(273,372)	0	0	0	0	0	0	0	0	0	0	(273,372)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(863,972)	0	0	0	0	0	0	0	0	0	0	(863,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Misericordia Home-South# 0005926

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	(80,612)	0	0	0	0	0	0	0	0	0	0	(80,612) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 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	(80,612)	0	0	0	0	0	0	0	0	0	0	(80,612) 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	(406,359)	0	0	0	0	0	0	0	0	0	0	(406,359) 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	(406,359)	0	0	0	0	0	0	0	0	0	0	(406,359) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,350,943)	0	0	0	0	0	0	0	0	0	0	(1,350,943) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of "Board of Directors During FY01"						
Misericordia Home, an equal opportunity employer and provider of services, is separately incorporated and independently funded. The Catholic Bishop of Chicago, through provisions in Misericordia's By-Laws, and Catholic Charities, by virtue of a majority of Board membership, qualify as related organizations because each has the ability to influence Misericordia's operating policy.						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	Certain costs, primarily related to insurance and/or construction, may be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to these organizations on a pass-through basis, as part of our participation in collective purchasing groups. Our share of costs are ultimately paid to external providers not related to us.		\$	\$	1
2	V							2
3	V							3
4	V							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 Misericordia Home-South # 0005926 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sr. Rosemary Connelly	Executive Director	Oversees Misericordia	N/A	N/A	50+	100.00	Salary	\$ 14,482	17	1
2	Margaret Murphy	Co-Director of Development	Grants & Direct Marketing	N/A	N/A	50+	100.00	n/a	0	n/a	2
3											3
4	* Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (The MG&A portion is further allocated between Sr. Rosemary Connelly and Sr. Rosemary Connelly)										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,482		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 Misericordia Home-South # 0005926 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

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

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

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

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

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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

* 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 **Misericordia Home-South**# **0005926** Report Period Beginning: **07/01/2000** Ending: **06/30/2001****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 2000 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 2001 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 19 _____ 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:		1996	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1997	9																	
	1998	10																	
	1999	11																	
	2000	12																	

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.

Facility Name & ID Number Misericordia Home-South# 0005926 Report Period Beginning:07/01/2000 Ending:06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,756 B. General Construction Type: Exterior Brick Frame Solid Masonry Number of Stories 4 + BasementC. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A for Misericordia South, only one building.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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Long-term Care, Day Training, School and CCI Facility</u>			\$ <u>9,680</u>	1
2					2
3	TOTALS			\$ 9,680	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedule										
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

*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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	See attached schedule	\$ 2,023,336	\$ 84,905	5-80 yrs	\$ 84,905	\$	\$ 1,363,033		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)	\$ 2,023,336	\$ 84,905		\$ 84,905	\$	\$ 1,363,033		70

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,325,980	\$ 73,023	\$ 73,023	\$	3-20yrs	\$ 894,617	71
72	Current Year Purchases	59,286	12,070	12,070		3-20yrs	12,070	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,385,266	\$ 85,093	\$ 85,093	\$		\$ 906,687	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residents transportation	1988 Ford E350 Van	1993	\$ 16,700	\$	\$	\$	3	\$ 16,700	76
77										77
78										78
79										79
80	TOTALS			\$ 16,700	\$	\$	\$		\$ 16,700	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,434,982	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 169,998	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,998	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,286,420	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Furn & Equip allocated to other progr	\$ 363,310	\$ 18,434	\$ 274,335	86
87	Non-care automobiles allocated to other p	28,419	4,937	27,365	87
88	Repairs & Improvements allocated to oth	1,329,093	57,241	735,517	88
89					89
90					90
91	TOTALS	\$ 1,720,822	\$ 80,612	\$ 1,037,217	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 Misericordia Home-South

0005926

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

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 Date of Lease	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

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. _____/2002 \$ _____
13. _____/2003 \$ _____
14. _____/2004 \$ _____

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: _____ *

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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>CNA's must have certification prior to hiring; this is consistent with prior years If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	\$			\$			1	
2	Licensed Speech and Language Development Therapist		hrs										2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs										4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										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	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$		\$	\$		\$		\$		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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Misericordia Home-South

0005926

Report Period Beginning: 07/01/2000

Ending:

06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2001

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 1,669,291	\$	1
2 Cash-Patient Deposits	280,196		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,938,067		3
4 Supply Inventory (priced at)	130,180		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,017,734	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable	215,315		11
12 Long-Term Investments			12
13 Land	9,680		13
14 Buildings, at Historical Cost	56,452,879		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	8,502,463		16
17 Accumulated Depreciation (book methods)	(31,544,303)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (spe CIP)	1,614,983		22
23 Other(specify): <u>Pledges/Contributions Rec</u>	80,479		23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 35,331,496	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 45,349,230	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 2,476,085	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	266,696		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	2,015,916		30
31 Accrued Taxes Payable (excluding real estate taxes)	73,844		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 <u>Unearned Revenue</u>	1,334,880		36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,167,421	\$	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 <u>Gift Annuity Liability</u>	282,867		43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 282,867	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,450,288	\$	46
47 TOTAL EQUITY (page 18, line 24)	\$ 38,898,942	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 45,349,230	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 41,305,997	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 41,305,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,353,797)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	8,935,395	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Loss for Misericordia North	(4,488,863)	15
16	Other (describe) Devlopment & Community Relations (unalloc.	(1,417,247)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,675,488	17
	B. Transfers (Itemize):		
18	Fixed Asset Additions	3,542,393	18
19	Funding of Depreciation	(2,989,887)	19
20	Transfers to Endowment/Contingency Fund	(4,635,049)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4,082,543)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 38,898,942	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Misericordia Home-South

0005926

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,062,616	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,062,616	3
B. Ancillary Revenue			
4	Day Care	89,201	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 89,201	8
C. Other Operating Revenue			
9	Payments for Education	320,543	9
10	Other Government Grants	83,639	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 404,182	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)	\$ 7,555,999	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,141,038	31
32	Health Care	5,053,824	32
33	General Administration	1,714,222	33
B. Capital Expense			
34	Ownership	250,610	34
C. Ancillary Expense			
35	Special Cost Centers	406,358	35
36	Provider Participation Fee	343,744	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,909,796	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,353,797)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,353,797)	43

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

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

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

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

Facility Name & ID Number Misericordia Home-South

0005926

Report Period Beginning: 07/01/2000

Ending:

06/30/2001

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	1,843	\$ 57,343	\$ 31.11	1
2	Assistant Director of Nursing				2
3	Registered Nurses	32,575	667,329	20.49	3
4	Licensed Practical Nurses	26,207	486,826	18.58	4
5	Nurse Aides & Orderlies	176,727	2,180,572	12.34	5
6	Nurse Aide Trainees				6
7	Licensed Therapist	6,240	187,708	30.08	7
8	Rehab/Therapy Aides	9,460	132,747	14.03	8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	3,885	68,888	17.73	11
12	Dietician				12
13	Food Service Supervisor	2,080	49,152	23.63	13
14	Head Cook	2,141	32,465	15.16	14
15	Cook Helpers/Assistants	13,123	159,632	12.16	15
16	Dishwashers				16
17	Maintenance Workers	6,880	116,615	16.95	17
18	Housekeepers	16,297	195,708	12.01	18
19	Laundry	10,328	120,935	11.71	19
20	Administrator	2,550	102,352	40.14	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	25,253	285,148	11.29	24
25	Vocational Instruction	13,228	181,762	13.74	25
26	Academic Instruction	11,847	217,286	18.34	26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,080	53,765	25.85	28
29	Resident Services Coordinator	9,381	165,951	17.69	29
30	Habilitation Aides (DD Homes)	19,946	253,373	12.70	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	392,071	\$ 5,715,557 *	\$ 14.58	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	369	\$ 11,070	1	35
36	Medical Director	394	35,777	9	36
37	Medical Records Consultant		237	10	37
38	Nurse Consultant	75	1,296	10	38
39	Pharmacist Consultant	87	5,309	10	39
40	Physical Therapy Consultant	1,736	72,418	10a	40
41	Occupational Therapy Consultant	1,977	79,080	10a	41
42	Respiratory Therapy Consultant	100	1,990	10a	42
43	Speech Therapy Consultant	112	5,971	10a	43
44	Activity Consultant				44
45	Social Service Consultant	110	4,950	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,960	\$ 218,098		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			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sr. Rosemary Connelly	Executive Director	n/a	\$ 14,482	Workers' Compensation Insurance	\$ 72,707	IDPH License Fee	\$ 400	
Betty Flynn	Administrator	n/a	12,900	Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,745	
Mary Pat O'Brien	Administrator	n/a	12,870	FICA Taxes	356,072	Health Care Worker Background Check	2,919	
Teri Petrisko-Manaher	Administrator	n/a	10,434	Employee Health Insurance	306,518	(Indicate # of checks performed 70)		
Denise Tigges	Administrator	n/a	12,911	Employee Meals		Subscriptions	1,568	
Maureen Meter	Administrator	n/a	20,956	Illinois Municipal Retirement Fund (IMRF)*		Membership Dues	3,647	
Sr. Catherine McGee	Administrator	n/a	17,799	Pension Contributions	259,166	Other License Fees	560	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,352	Tuition Reimb & Other Misc	5,952	Bank Service Fees	189	
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,000,415	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,028	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Deloitte & Touche	Audit		10,071					
Martin Boyer Co.	Unemployment Admin Svcs		739				In-State Travel	
ADP	Payroll Processing		18,952					
Burke, Warren, MacKay & Serritell	Legal		3,207					
American Fundware, Inc.			1,516				Seminar Expense	6,772
American Express Tax & Bus Services			648				Due to the small \$ amt of each transaction & the high volume individuals, gathering & providing such detail would require tremendous amt of time; as a result, we have not provided such	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 35,133	TOTAL		\$	TOTAL	\$ 6,772

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Misericordia Home-South# 0005926Report Period Beginning: 07/01/2000Ending: 06/30/2001**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 Health Care Association, \$4139
- (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? 3-20 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 115,524 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 343,744
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? n/a Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? unable to determine
d. Have vehicle usage logs been maintained? yes, for program vehicles
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes, with the exception of non-care related vehicles
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes, with the exception of non-care related vehicles
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: Deloitte & Touche The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.