

Facility Name & ID Number Misericordia Home-North# various-see attac Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	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		Skilled Pediatric (SNF/PED)			2
3	177	Intermediate (ICF)	177	64,605	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	124	ICF/DD 16 or Less	124	45,260	6
7	301	TOTALS	301	109,865	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			8	
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
		8	SNF			
9	SNF/PED				9	
10	ICF	61,091	730		61,821	10
11	ICF/DD	39,406	654		40,060	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	100,497	1,384		101,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.73%D. How many bed-hold days during this year were paid by the Department?
7,539 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Vocational Training, 4 CILA Homes, CLF and CCIF. 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 Various-See attachedJ. 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: 06/30/2005 Fiscal Year: 06/30/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Misericordia Home-North # (various-see at Report Period Beginning: 07/01/04 Ending: 06/30/05)

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

	Operating Expenses	Costs 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
A. General Services											
1	Dietary	378,649	150,188	48,598	577,435		577,435	(171,284)	406,151		1
2	Food Purchase		1,526,757		1,526,757		1,526,757	(458,122)	1,068,635		2
3	Housekeeping	781,400	194,006	276,621	1,252,027		1,252,027	(643,175)	608,852		3
4	Laundry	144,660	45,763		190,423		190,423	(43,428)	146,995		4
5	Heat and Other Utilities			798,560	798,560		798,560	(452,456)	346,104		5
6	Maintenance	621,213	226,265	1,048,466	1,895,944		1,895,944	(928,260)	967,684		6
7	Other (specify):*										7
8	TOTAL General Services	1,925,922	2,142,979	2,172,245	6,241,146		6,241,146	(2,696,725)	3,544,421		8
B. Health Care and Programs											
9	Medical Director	21,156			21,156		21,156		21,156		9
10	Nursing and Medical Records	1,676,229	432,734	111,719	2,220,682		2,220,682	(658,420)	1,562,262		10
10a	Therapy	12,931,395	14,797	43,670	12,989,862		12,989,862	(3,330,132)	9,659,730		10a
11	Activities	307,657	19,829	120,913	448,399		448,399	(192,208)	256,191		11
12	Social Services	199,499		21,393	220,892		220,892	(66,422)	154,470		12
13	CNA Training										13
14	Program Transportation		84,210		84,210		84,210	(46,525)	37,685		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	15,135,936	551,570	297,695	15,985,201		15,985,201	(4,293,707)	11,691,494		16
C. General Administration											
17	Administrative	255,042		12,582	267,624		267,624	(120,131)	147,493		17
18	Directors Fees										18
19	Professional Services			166,595	166,595		166,595	(72,689)	93,906		19
20	Dues, Fees, Subscriptions & Promotions			90,659	90,659		90,659	(38,102)	52,557		20
21	Clerical & General Office Expenses	973,504	134,996	123,288	1,231,788		1,231,788	(510,508)	721,280		21
22	Employee Benefits & Payroll Taxes			5,289,017	5,289,017		5,289,017	(1,877,760)	3,411,257		22
23	Inservice Training & Education			191,711	191,711		191,711	(65,221)	126,490		23
24	Travel and Seminar			44,111	44,111		44,111	(19,791)	24,320		24
25	Other Admin. Staff Transportation		2,082		2,082		2,082	(1,933)	149		25
26	Insurance-Prop.Liab.Malpractice			362,459	362,459		362,459	(199,794)	162,665		26
27	Other (specify):*										27
28	TOTAL General Administration	1,228,546	137,078	6,280,422	7,646,046		7,646,046	(2,905,929)	4,740,117		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	18,290,404	2,831,627	8,750,362	29,872,393		29,872,393	(9,896,361)	19,976,032		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-North

#0029876 (vari

Report Period Beginning:

07/01/04

Ending:

06/30/05

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			3,301,202	3,301,202		3,301,202	(1,979,504)	1,321,698			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,021	17,021		17,021	(17,021)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,318,223	3,318,223		3,318,223	(1,996,525)	1,321,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,398,443	619,015	22,303	3,039,761		3,039,761	(3,038,631)	1,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,168,752	1,168,752		1,168,752		1,168,752			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,398,443	619,015	1,191,055	4,208,513		4,208,513	(3,038,631)	1,169,882			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	20,688,847	3,450,642	13,259,640	37,399,129		37,399,129	(14,931,517)	22,467,612			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-North

various-see attac Report Period Beginning: 07/01/04

Ending: 06/30/05

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	(133,677)	10a		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	(69,989)	30		9
10	Interest and Other Investment Income	(10,016)	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	(1,224)	25		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,824)	5		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	(10,784)	19		22
23	Malpractice Insurance for Individuals	(393)	22		23
24	Bad Debt	(15,485)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (243,392)		\$	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))	\$ (243,392)		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-North

ID# 19876 (various-see attached)

Report Period Beginning: 07/01/04

Ending: 06/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Gain on disposal of asset	\$ 316	6	1
2	Off-Site Recreational Facility	(8,316)	17	2
3	Off-Site Recreational Facility/Non care auto-Deprec	(4,801)	30	3
4	Bank Service Fees and other misc fees-Medicaid portion	(2,588)	20	4
5	Unallowable Administrative costs	(21,077)	17	5
6	Unallowable Maintenance costs	(4,405)	6	6
7	Unallowable Religious program-IDPA portion	(50,670)	11	7
8	Expenses reimbursed from other sources:			8
9	Dietary Wages	(111,664)	1	9
10	Dietary Supplies	(45,594)	1	10
11	Dietary Other	(14,026)	1	11
12	Food Supplies	(458,122)	2	12
13	Housekeeping Wages	(407,920)	3	13
14	Housekeeping Supplies	(101,949)	3	14
15	Housekeeping Other	(133,306)	3	15
16	Laundry Wages	(26,088)	4	16
17	Laundry Supplies	(17,340)	4	17
18	Heat and Other Utilities	(450,632)	5	18
19	Maintenance Wages	(290,205)	6	19
20	Maintenance Supplies	(113,716)	6	20
21	Maintenance Other	(520,250)	6	21
22	Nursing/Med Records Wages	(510,667)	10	22
23	Nursing/Med Records Supplies	(114,146)	10	23
24	Nursing/Med Records Other	(33,607)	10	24
25	Therapy Wages	(3,182,418)	10a	25
26	Therapy Supplies	(2,201)	10a	26
27	Therapy Other	(11,836)	10a	27
28	Activities Wages	(102,869)	11	28
29	Activities Supplies	(6,806)	11	29
30	Activities Other	(31,863)	11	30
31	Social Services Wages	(59,989)	12	31
32	Social Services Other	(6,433)	12	32
33	Program Transportation	(46,525)	14	33
34	Administrative Wages	(86,472)	17	34
35	Administrative Other	(4,266)	17	35
36	Professional Services	(61,905)	19	36
37	Dues, Fees, Subscriptions & Promotions	(35,514)	20	37
38	Clerical Wages	(361,867)	21	38
39	Clerical Supplies	(72,429)	21	39
40	Clerical Other	(60,727)	21	40
41	Employee Benefits & Payroll Taxes	(1,877,367)	22	41
42	Inservice Training & Education	(65,221)	23	42
43	Travel & Seminar	(19,791)	24	43
44	Other Administrative Staff Transportation	(709)	25	44
45	Insurance	(199,794)	26	45
46	Depreciation	(1,904,714)	30	46
47	Interest	(7,005)	32	47
48	Ancillary Service Centers	(3,038,631)	39	48
49	Total	(14,688,125)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Misericordia Home-North

(various-see a Report Period Beginning:

07/01/04

Ending:

06/30/05

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	(171,284)	0	0	0	0	0	0	0	0	0	0	(171,284)	1
2	Food Purchase	(458,122)	0	0	0	0	0	0	0	0	0	0	(458,122)	2
3	Housekeeping	(643,175)	0	0	0	0	0	0	0	0	0	0	(643,175)	3
4	Laundry	(43,428)	0	0	0	0	0	0	0	0	0	0	(43,428)	4
5	Heat and Other Utilities	(452,456)	0	0	0	0	0	0	0	0	0	0	(452,456)	5
6	Maintenance	(928,260)	0	0	0	0	0	0	0	0	0	0	(928,260)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,696,725)	0	0	0	0	0	0	0	0	0	0	(2,696,725)	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	(658,420)	0	0	0	0	0	0	0	0	0	0	(658,420)	10
10a	Therapy	(3,330,132)	0	0	0	0	0	0	0	0	0	0	(3,330,132)	10a
11	Activities	(192,208)	0	0	0	0	0	0	0	0	0	0	(192,208)	11
12	Social Services	(66,422)	0	0	0	0	0	0	0	0	0	0	(66,422)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(46,525)	0	0	0	0	0	0	0	0	0	0	(46,525)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,293,707)	0	0	0	0	0	0	0	0	0	0	(4,293,707)	16
	C. General Administration													
17	Administrative	(120,131)	0	0	0	0	0	0	0	0	0	0	(120,131)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(72,689)	0	0	0	0	0	0	0	0	0	0	(72,689)	19
20	Fees, Subscriptions & Promotions	(38,102)	0	0	0	0	0	0	0	0	0	0	(38,102)	20
21	Clerical & General Office Expenses	(510,508)	0	0	0	0	0	0	0	0	0	0	(510,508)	21
22	Employee Benefits & Payroll Taxes	(1,877,760)	0	0	0	0	0	0	0	0	0	0	(1,877,760)	22
23	Inservice Training & Education	(65,221)	0	0	0	0	0	0	0	0	0	0	(65,221)	23
24	Travel and Seminar	(19,791)	0	0	0	0	0	0	0	0	0	0	(19,791)	24
25	Other Admin. Staff Transportation	(1,933)	0	0	0	0	0	0	0	0	0	0	(1,933)	25
26	Insurance-Prop.Liab.Malpractice	(199,794)	0	0	0	0	0	0	0	0	0	0	(199,794)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,905,929)	0	0	0	0	0	0	0	0	0	0	(2,905,929)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,896,361)	0	0	0	0	0	0	0	0	0	0	(9,896,361)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Misericordia Home-North

(various-see a Report Period Beginning:

07/01/04 Ending:

06/30/05

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	(1,979,504)	0	0	0	0	0	0	0	0	0	0	(1,979,504) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(17,021)	0	0	0	0	0	0	0	0	0	0	(17,021) 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	(1,996,525)	0	0	0	0	0	0	0	0	0	0	(1,996,525) 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	(3,038,631)	0	0	0	0	0	0	0	0	0	0	(3,038,631) 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	(3,038,631)	0	0	0	0	0	0	0	0	0	0	(3,038,631) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(14,931,517)	0	0	0	0	0	0	0	0	0	0	(14,931,517) 45

Facility Name & ID Number Misericordia Home-North

(various-see a

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 Board of Directors during FY 05						
Misericordia Home , an equal opportunity employer and provider of service, is separately incorporated and independantly 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 organization 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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$	Certain costs, primarily related to insurance and/or construction, may		\$	\$
2	V			be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to			
3	V			these organizations on a pass-through basis, as part of our participation in collective purchasing			
4	V			groups. Our share of costs are ultimately paid to external providers not related to us			
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Misericordia Home-North #876 (various-see attar) Report Period Beginning: 07/01/04 Ending: 06/30/05

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	Chief Executive Officer	Oversees Misericordia	N/A	N/A	50+	100.00	Salary	\$ 41,760	17	1
2	Margaret Murphy	Co-Director of Development	Grants & Direct M	N/A	N/A	50+	100.00	Salary	0		2
3											3
4	Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is further allocated										4
5	between Misericordia North & South). Also Margaret Murphy's salary is incurred to Development & Community Relations and is not reported										5
6	as an allowable expense on any Cost report.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 41,760		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-North

(various-see a Report Period Beginning: 07/01/04

Ending: 06/30/05

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

Facility Name & ID Number Misericordia Home-North

various-see att: Report Period Beginning:

07/01/04

Ending:

06/30/05

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
						Original	Balance				
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									
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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2004 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 2005 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:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</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 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2000	8																										
2001	9																										
2002	10																										
2003	11																										
2004	12																										
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2004 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Misericordia Home-North COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029876 (various-see attached)

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of total 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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 & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 632,182 B. General Construction Type: Exterior Brick Frame Solid Masonry Number of Stories 1 to 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Day Training Facility - approximately 68,977 square feet with 300+ participants.

Shannon Apartments- approximately 68,000 square feet with 51 participants.

4 CLAs - approximately 14,861 square feet with 24 participants.

CCI facilities - approximately 28,142 square feet with 55 residents.

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Misericordia Home-North

(various-see att Report Period Beginning:

07/01/04

Ending:

06/30/05

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	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	See attached schedule			28,292,341	1,205,792	5-50 yrs	1,135,803	(69,989)	15,791,019
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 Misericordia Home-North

(various-see att Report Period Beginning:

07/01/04 Ending: 06/30/05

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			\$	\$		\$	\$	\$		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)		\$ 28,292,341	\$ 1,205,792		\$ 1,135,803	\$ (69,989)	\$ 15,791,019		70

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

Facility Name & ID Number **Misericordia Home-North** # (various-see atta Report Period Beginning: **07/01/04** Ending: **06/30/05**

XI. OWNERSHIP COSTS (continued)

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	\$ 1,881,338	\$ 153,361	\$ 153,361	\$	3-20 yrs	\$ 1,289,699	71
72	Current Year Purchases	399,259	22,939	22,939		3-20 yrs	22,953	72
73	Fully Depreciated Assets	1,477,937					1,477,937	73
74								74
75	TOTALS	\$ 3,758,534	\$ 176,300	\$ 176,300	\$		\$ 2,790,589	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				\$ 242,134	\$ 9,595	\$ 9,595	\$	3 yrs	\$ 219,828	76
77										77
78										78
79										79
80	TOTALS			\$ 242,134	\$ 9,595	\$ 9,595	\$		\$ 219,828	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)	\$ 32,293,009	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,391,687	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,321,698	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (69,989)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,801,436	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Furn & Equip alloc to other prog	\$ 3,417,835	\$ 175,606	\$ 2,617,539	86
87	Auto alloc to other prog	369,074	14,547	341,535	87
88	Bldg & Improv. Alloc to other prog	34,839,697	1,719,388	17,474,974	88
89					89
90					90
91	TOTALS	\$ 38,626,606	\$ 1,909,541	\$ 20,434,048	91

G. Construction-in-Progress

	Description	Cost	
92	Nursing Home/Chapel	\$ 18,671,965	92
93	New CILA/Campus expansion	708,832	93
94	Technology upgrade	127,622	94
95		\$ 19,508,419	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.

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

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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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 CNA _____</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 CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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.)

	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 prescripts											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 CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **Misericordia Home-North** # **various-see attac** Report Period Beginning: **07/01/04** Ending: **06/30/05**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **06/30/05** (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	\$ 2,508,919	\$	1
2	Cash-Patient Deposits	285,406		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	7,399,019		3
4	Supply Inventory (priced at)	127,245		4
5	Short-Term Investments	8,507,167		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,827,756	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,680		13
14	Buildings, at Historical Cost	68,774,980		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,114,580		16
17	Accumulated Depreciation (book methods)	(44,597,933)		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 (spt CIP)	19,508,419		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 53,809,726	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 72,637,482	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,415,570	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	271,906		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,831,471		30
31	Accrued Taxes Payable (excluding real estate taxes)	71,301		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	Short-term benefits withheld/457 plans	62,584		36
37	Unearned revenue	150,541		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,803,373	\$	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	Gift Annuity	378,260		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 378,260	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,181,633	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 68,455,849	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 72,637,482	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 48,275,426	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 48,275,426	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(6,895,387)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	17,696,202	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Loss from South	(2,985,712)	15
16	Other (describe) Development & Community Relations	(1,903,050)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 5,912,053	17
B. Transfers (Itemize):			
18	Fixed Asset Additions	12,940,910	18
19	Funding of Depreciation	(3,601,352)	19
20	Transfer to Endowment/Contingency fund	4,928,812	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 14,268,370	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 68,455,849	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Misericordia Home-North

various-see attac Report Period Beginning: 07/01/04

Page 19
Ending: 06/30/05

**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	\$ 26,067,144	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 26,067,144	3
B. Ancillary Revenue			
4	Day Care	4,436,598	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,436,598	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA 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)	\$	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)	\$ 30,503,742	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	6,241,146	31
32	Health Care	15,985,201	32
33	General Administration	7,646,046	33
B. Capital Expense			
34	Ownership	3,318,223	34
C. Ancillary Expense			
35	Special Cost Centers	3,039,761	35
36	Provider Participation Fee	1,168,752	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 37,399,129	40
41	Income before Income Taxes (line 30 minus line 40)**	(6,895,387)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (6,895,387)	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-North

various-see attache

Report Period Beginning:

07/01/04

Ending:

06/30/05

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	1,874	2,080	\$ 68,328	\$ 32.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,382	49,756	1,209,397	24.31	3
4	Licensed Practical Nurses	13,012	13,952	306,665	21.98	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	11,486	13,071	383,495	29.34	7
8	Rehab/Therapy Aides	10,560	12,086	174,742	14.46	8
9	Activity Director					9
10	Activity Assistants	17,193	19,434	307,657	15.83	10
11	Social Service Workers	8,653	9,807	199,499	20.34	11
12	Dietician					12
13	Food Service Supervisor	936	1,040	42,914	41.26	13
14	Head Cook	1,832	2,080	53,736	25.83	14
15	Cook Helpers/Assistants	7,366	8,260	153,247	18.55	15
16	Dishwashers	11,059	11,874	128,752	10.84	16
17	Maintenance Workers	26,162	28,500	621,213	21.80	17
18	Housekeepers	57,408	64,194	781,400	12.17	18
19	Laundry	11,391	12,427	144,660	11.64	19
20	Administrator	5,102	5,734	255,042	44.48	20
21	Assistant Administrator					21
22	Other Administrative	17,412	19,751	520,997	26.38	22
23	Office Manager					23
24	Clerical	33,032	33,598	452,507	13.47	24
25	Vocational Instruction	121,426	137,336	2,398,443	17.46	25
26	Academic Instruction					26
27	Medical Director	275	275	21,393	77.79	27
28	Qualified MR Prof. (QMRP)	90,438	100,764	1,764,735	17.51	28
29	Resident Services Coordinator	73,248	82,856	1,480,094	17.86	29
30	Habilitation Aides (DD Homes)	8,653	715,698	9,128,329	12.75	30
31	Medical Records	5,450	5,947	91,602	15.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	578,350	1,350,520	\$ 20,688,847 *	\$ 15.32	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	1,600	\$ 48,598	1	35
36	Medical Director				36
37	Medical Records Consultant		30,732	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,040	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	687	27,470	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	405	16,200	10a	43
44	Activity Consultant				44
45	Social Service Consultant		21,393	12	45
46	Other(specify) Doctor		75,947	10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,692	\$ 225,380		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Misericordia Home-North

various-see attached

Report Period Beginning: 07/01/04

Ending: 06/30/05

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	CEO	N/A	\$ 41,760	Workers' Compensation Insurance	\$ 262,904	IDPH License Fee	\$ 251
Mary Pat O'Brien	Administrato	N/A	39,186	Unemployment Compensation Insurance	47,050	Advertising: Employee Recruitment	29,850
Denise Tigges	Administrato	N/A	41,247	FICA Taxes	961,210	Health Care Worker Background Check	11,562
Terry Petrisko Manaher	Administrato	N/A	31,172	Employee Health Insurance	1,084,664	(Indicate # of checks performed _____)	
Betty Flynn	Administrato	N/A	40,884	Employee Meals		CDW and E- Computer licensing	2,969
Sr. Catherine McGee	Administrato	N/A	31,134	Illinois Municipal Retirement Fund (IMRF)*		CILA labatory	150
Lois Gates	Asst. CEO	N/A	29,659	Pension	893,507	Membership Dues	1,385
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Tuition Reimbursement	65,181	Subscription	881
(List each licensed administrator separately.)			\$ 255,042	Dental Insurance	96,741	Dept of Rev/Secretary of State	14
B. Administrative - Other						CARF-accrediation fee	5,495
Description			Amount			Less: Public Relations Expense ()	
Off-Site Recreational Facility-100% is unallowable and is adjustec			\$ 12,582			Non-allowable advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 12,582			Yellow page advertising ()	
(Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 3,411,257	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 52,557
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
Deloitte & Touche	Audit	\$ 42,819				Out-of-State Travel	\$
ADP Processing	Payroll Service	91,968					
American Express//Kintera/Revere C	Computer Service	4,723				In-State Travel	
Burke, Warren, MacKay & Serr	Legal	5,881					
Ellison, Neilson, Zehe	Legal	14,703					
Bell, Boyd & Lloyd	Legal	6,101				Seminar Expense	24,320
Mahoney, Crowe & Goldrick	Legal	400				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	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	Entertainment Expense ()	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 166,595			(agree to Sch. V, line 24, col. 8)	\$ 24,320

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Misericordia Home-North# (various-see attached) Report Period Beginning: 07/01/04 Ending: 06/30/05**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? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 3-20 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,787 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 1,168,792
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? yes within 50 miles
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? yes, program vehicles
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? yes, under c
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A due to salary is unal
- (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. _____
- (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.