

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0045906

Facility Name: McAuley Residence

Address: 2060 West Granville Avenue Chicago 60660
 Number City Zip Code

County: Cook

Telephone Number: (773) 273-3033 Fax # (773) 743-5439

HFS ID Number: 362170153-0001 and 362170153-0014

Date of Initial License for Current Owners: 01/01/1981 and 11/03/05

Type of Ownership:

<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 <u>501C3</u>	<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 _____	

In the event there are further questions about this report, please contact:
Name: Carolyn Sheehan **Telephone Number:** (773) 273-3033

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Kevin Connelly</u>	
	(Title) <u>Chief Financial Officer</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning: 0701/05 Ending: 06/30/06

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	<u>99</u>	Skilled Pediatric (SNF/PED)	<u>105</u>	<u>37,575</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>105</u>	<u>37,575</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>31,548</u>	<u>1,912</u>	<u>219</u>	<u>33,679</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>31,548</u>	<u>1,912</u>	<u>219</u>	<u>33,679</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.63%

D. How many bed-hold days during this year were paid by the Department?

477 (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)

Respite, Adult Vocational Training and School

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 South 01/01/81 and McAuley 11/03/05

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: 06/30/2006 Fiscal Year: 06/30/06

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 0701/05 Ending: 06/30/06

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	139,186	42,478	28,230	209,894		209,894		209,894			1
2	Food Purchase		218,515		218,515		218,515	(70,398)	148,117			2
3	Housekeeping	245,141	133,921	118,232	497,294		497,294	(25,302)	471,992			3
4	Laundry	183,092	12,277		195,369		195,369		195,369			4
5	Heat and Other Utilities				250,277		250,277	(25,206)	225,071			5
6	Maintenance	176,300	65,373	293,286	534,959		534,959	(83,473)	451,486			6
7	Other (specify):*											7
8	TOTAL General Services	743,719	472,564	439,748	1,906,308		1,906,308	(204,379)	1,701,929			8
	B. Health Care and Programs											
9	Medical Director	20,635			20,635		20,635		20,635			9
10	Nursing and Medical Records	3,782,650	600,186	109,046	4,491,882	(796,625)	3,695,257	(2)	3,695,255			10
10a	Therapy	1,899,951	16,928	61,734	1,978,613		1,978,613	(11,375)	1,967,238			10a
11	Activities			11,356	11,356		11,356		11,356			11
12	Social Services	63,263	27	8,901	72,191		72,191		72,191			12
13	CNA Training											13
14	Program Transportation		25,293		25,293		25,293	(4,781)	20,512			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,766,499	642,434	191,037	6,599,970	(796,625)	5,803,345	(16,158)	5,787,187			16
	C. General Administration											
17	Administrative	61,133		3,078	64,211		64,211	(11,747)	52,464			17
18	Directors Fees											18
19	Professional Services			65,952	65,952		65,952	(9,683)	56,269			19
20	Dues, Fees, Subscriptions & Promotions			43,790	43,790		43,790	(4,023)	39,767			20
21	Clerical & General Office Expenses	372,958	25,342	35,638	433,938		433,938	(70,757)	363,181			21
22	Employee Benefits & Payroll Taxes			1,821,052	1,821,052		1,821,052	(113,143)	1,707,909			22
23	Inservice Training & Education			323	323		323	(2)	321			23
24	Travel and Seminar			5,009	5,009		5,009	(268)	4,741			24
25	Other Admin. Staff Transportation			1,067	1,067		1,067	(991)	76			25
26	Insurance-Prop.Liab.Malpractice			52,047	52,047		52,047	(15,329)	36,718			26
27	Other (specify):*											27
28	TOTAL General Administration	434,091	25,342	2,027,956	2,487,389		2,487,389	(225,943)	2,261,446			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,944,309	1,140,340	2,658,741	10,993,667	(796,625)	10,197,042	(446,480)	9,750,562			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number McAuley Residence #0045906 Report Period Beginning: 0701/05 Ending: 06/30/06

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			669,027	669,027	(14,611)	654,416	(133,826)	520,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,594	4,594		4,594	(4,594)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			673,621	673,621	(14,611)	659,010	(138,420)	520,590			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	348,481	7,680		356,161	811,236	1,167,397	(356,161)	811,236			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			378,761	378,761		378,761		378,761			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	348,481	7,680	378,761	734,922	811,236	1,546,158	(356,161)	1,189,997			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,292,790	1,148,020	3,711,123	12,402,210		12,402,210	(941,061)	11,461,149			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning: 0701/05

Ending: 06/30/06

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	(70,398)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(313)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,346	30		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	(4,594)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(923)	25		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	(2,387)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,834)	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)	\$ (82,103)		\$	30

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))	\$ (82,103)		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	X		811,236	10, 30	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 811,236		47

BHF USE ONLY						
48		49		50		51
						52

McAuley Residence

ID# 0045906

Report Period Beginning: 0701/05

Ending: 06/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Loss on disposal	\$ (22,792)	6	1
2	Off-site recreational facility	(2,883)	17	2
3	Off-site recreational facility/non-care auto	(2,120)	30	3
4	Bank Service fees an other misc fees-Medicaid portion	(3,243)	20	4
5	Unallowable Admin costs	(4,794)	17	5
6	Unallowable Professional fees- Medicaid portion	(2,822)	19	6
7	Reimbursement for Hab-Aide training	(11,375)	10a	7
8	Expenses Reimbursed from other sources:			8
9	Housekeeping Wages	(11,082)	3	9
10	Housekeeping Supplies	(11,296)	3	10
11	Housekeeping Other	(2,924)	3	11
12	Heat and Other Utilities	(24,893)	5	12
13	Maintenance Wages	(18,123)	6	13
14	Maintenance Supplies	(19,073)	6	14
15	Maintenance Other	(23,485)	6	15
16	Nursing/Med Records Supplies	(2)	10	16
17	Program Transportation Other	(4,781)	14	17
18	Administrative Wages	(3,875)	17	18
19	Administrative Other	(195)	17	19
20	Professional Services	(4,474)	19	20
21	Dues, Fees, Subscriptions & Promotions	(780)	20	21
22	Clerical Wages	(58,972)	21	22
23	Clerical Supplies	(1,100)	21	23
24	Clerical Other	(5,851)	21	24
25	Employee Benefits & Payroll Taxes	(113,143)	22	25
26	Inservice and Education	(2)	23	26
27	Travel & Seminar	(268)	24	27
28	Other Admin Staff Transportation	(68)	25	28
29	Insurance	(15,329)	26	29
30	Depreciation	(133,052)	30	30
31	Ancillary Service Centers Salaries	-348481	39	31
32	Ancillary Service Centers Supplies	-7680	39	32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(858,958)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence# 0045906

Report Period Beginning:

0701/05

Ending:

06/30/06**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(70,398)	0	0	0	0	0	0	0	0	0	0	(70,398)	2
3	Housekeeping	(25,302)	0	0	0	0	0	0	0	0	0	0	(25,302)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(25,206)	0	0	0	0	0	0	0	0	0	0	(25,206)	5
6	Maintenance	(83,473)	0	0	0	0	0	0	0	0	0	0	(83,473)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(204,379)	0	0	0	0	0	0	0	0	0	0	(204,379)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2)	0	0	0	0	0	0	0	0	0	0	(2)	10
10a	Therapy	(11,375)	0	0	0	0	0	0	0	0	0	0	(11,375)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,781)	0	0	0	0	0	0	0	0	0	0	(4,781)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(16,158)	0	0	0	0	0	0	0	0	0	0	(16,158)	16
	C. General Administration													
17	Administrative	(11,747)	0	0	0	0	0	0	0	0	0	0	(11,747)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,683)	0	0	0	0	0	0	0	0	0	0	(9,683)	19
20	Fees, Subscriptions & Promotions	(4,023)	0	0	0	0	0	0	0	0	0	0	(4,023)	20
21	Clerical & General Office Expenses	(70,757)	0	0	0	0	0	0	0	0	0	0	(70,757)	21
22	Employee Benefits & Payroll Taxes	(113,143)	0	0	0	0	0	0	0	0	0	0	(113,143)	22
23	Inservice Training & Education	(2)	0	0	0	0	0	0	0	0	0	0	(2)	23
24	Travel and Seminar	(268)	0	0	0	0	0	0	0	0	0	0	(268)	24
25	Other Admin. Staff Transportation	(991)	0	0	0	0	0	0	0	0	0	0	(991)	25
26	Insurance-Prop.Liab.Malpractice	(15,329)	0	0	0	0	0	0	0	0	0	0	(15,329)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(225,943)	0	0	0	0	0	0	0	0	0	0	(225,943)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(446,480)	0	0	0	0	0	0	0	0	0	0	(446,480)	29

STATE OF ILLINOIS

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning:

0701/05 Ending:

Summary B

06/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(133,826)	0	0	0	0	0	0	0	0	0	0	(133,826)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,594)	0	0	0	0	0	0	0	0	0	0	(4,594)	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	(138,420)	0	(138,420)	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	(356,161)	0	0	0	0	0	0	0	0	0	0	(356,161)	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	(356,161)	0	(356,161)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(941,061)	0	(941,061)	45									

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning:

0701/05

Ending:

06/30/06

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 FY 2006						
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: 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		\$	\$
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 McAuley Residence # 0045906 Report Period Beginning: 0701/05 Ending: 06/30/06

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	\$ 13,112	17	1
2	Margaret Murphy	Co-Director of Development	Grants & Direct M	N/A	N/A	50+	100.00	Salary	0		2
3	Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is further allocated										3
4	between Misericordia North & McAuley). Also Margaret Murphy's salary is incurred to Development & Community Relations and is not reported										4
5	as an allowable expense on any Cost report.										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,112		13

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

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

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning: 0701/05

Ending: 06/30/06

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 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:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McAuley Residence COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045906

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(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 Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning:

0701/05 Ending:

06/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,145 B. General Construction Type: Exterior Brick Frame Solid Masonry Number of Stories 2+basement

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

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

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

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

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

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>Snf/Ped Long-term care, Developmental Training and School</u>			\$ <u>9,680</u>	1
2					2
3	TOTALS			\$ 9,680	3

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning:

0701/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	105		2005	2005	\$ 15,746,075	\$ 288,115	5-50yrs	\$ 288,115	\$	\$ 293,679	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	See Attached Schedule				5,444,351	95,169	5-50 yrs	96,515	1,346	3,543,018	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number McAuley Residence

0045906

Report Period Beginning:

0701/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 21,190,426	\$ 383,284		\$ 384,630	\$ 1,346	\$ 3,836,697	70

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: 0701/05 Ending: 06/30/06

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	\$ 409,528	\$ 72,422	\$ 57,810	\$ (14,612)	3-20 yrs	\$ 227,381	71
72	Current Year Purchases	1,109,765	53,327	53,327		3-20 yrs	60,182	72
73	Fully Depreciated Assets	353,158	2,301	2,301		3-20 yrs	353,129	73
74								74
75	TOTALS	\$ 1,872,451	\$ 128,050	\$ 113,438	\$ (14,612)		\$ 640,692	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				\$ 190,198	\$ 22,522	\$ 22,522		3 yrs	\$ 135,143	76
77										77
78										78
79										79
80	TOTALS			\$ 190,198	\$ 22,522	\$ 22,522			\$ 135,143	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 23,262,755	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 533,856	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 520,590	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (13,266)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,612,532	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	\$ 7,318,484	\$ 383,958	\$ 5,379,183	86
87	Auto alloc to other prog	584,348	27,240	552,050	87
88	Bldg & Improv. Alloc to other prog	66,196,324	3,072,035	32,816,058	88
89					89
90					90
91	TOTALS	\$ 74,099,156	\$ 3,483,233	\$ 38,747,291	91

G. Construction-in-Progress

	Description	Cost	
92	Chapel	\$ 2,101,593	92
93	CILA/Campus expansion	824,445	93
94	Technology	11,494	94
95		\$ 2,937,532	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

**

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number McAuley Residence# 0045906 Report Period Beginning:0701/05

Ending:

06/30/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		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	10, 30	27411	713,336			97,900	27,411	811,236	12
13	Other (specify):									13
14	TOTAL			\$ 713,336		\$	\$ 97,900	27,411	\$ 811,236	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: 0701/05

Ending:

06/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,875,252	\$	1
2	Cash-Patient Deposits	310,486		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	7,957,292		3
4	Supply Inventory (priced at)	140,823		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
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,283,853	\$	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	87,386,750		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,965,481		16
17	Accumulated Depreciation (book methods)	(43,359,823)		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)	2,937,532		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,939,620	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 67,223,473	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,348,192	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	296,986		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,005,004		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,724		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	56,212		36
37	Unearned Revenue/Construction payout	307,452		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,094,570	\$	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	289,325		43
44	Asset Retirement Obligation	331,839		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 621,164	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,715,734	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 62,507,739	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 67,223,473	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 68,455,849	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 68,455,849	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,575,275)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	12,213,327	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) <u>Net Loss from North campus</u>	(8,067,202)	15
16	Other (describe) <u>Development & Community Relations</u>	(2,391,365)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,820,515)	17
B. Transfers (Itemize):			
18	<u>Fixed Asset Additions</u>	7,456,292	18
19	<u>Funding of Depreciation</u>	(4,152,262)	19
20	<u>Transfer to Endowment/Contingency fund</u>	(6,142,639)	20
21	<u>Cummulative Effect of Change in Accounting Principle</u>	(288,986)	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3,127,595)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 62,507,739	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: 0701/05Ending: 06/30/06**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	\$ 7,202,236	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,202,236	3
B. Ancillary Revenue			
4	Day Care	624,699	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 624,699	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)	\$ 7,826,935	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,906,308	31
32	Health Care	6,599,970	32
33	General Administration	2,487,389	33
B. Capital Expense			
34	Ownership	673,621	34
C. Ancillary Expense			
35	Special Cost Centers	356,161	35
36	Provider Participation Fee	378,761	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,402,210	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,575,275)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,575,275)	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 McAuley Residence

0045906

Report Period Beginning:

0701/05

Ending:

06/30/06

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	1,998	2,081	\$ 95,718	\$ 46.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,012	25,950	710,707	27.39	3
4	Licensed Practical Nurses	27,512	30,870	757,345	24.53	4
5	CNAs & Orderlies	139,556	157,705	2,175,254	13.79	5
6	CNA Trainees					6
7	Licensed Therapist	4,445	5,034	176,033	34.97	7
8	Rehab/Therapy Aides	15,588	17,664	300,423	17.01	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	3,500	3,852	63,263	16.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,967	2,267	38,056	16.79	14
15	Cook Helpers/Assistants	3,878	4,544	53,377	11.75	15
16	Dishwashers	4,465	4,815	47,753	9.92	16
17	Maintenance Workers	8,088	9,031	176,300	19.52	17
18	Housekeepers	17,550	19,630	245,141	12.49	18
19	Laundry	10,992	12,527	183,092	14.62	19
20	Administrator	1,212	1,289	61,133	47.43	20
21	Assistant Administrator					21
22	Other Administrative	6,462	7,328	164,727	22.48	22
23	Office Manager					23
24	Clerical	11,780	13,167	208,231	15.81	24
25	Vocational Instruction	6,123	6,856	116,636	17.01	25
26	Academic Instruction	9,636	10,905	231,845	21.26	26
27	Medical Director	248	260	20,635	79.37	27
28	Qualified MR Prof. (QMRP)	16,342	18,118	337,277	18.62	28
29	Resident Services Coordinator	20,129	22,524	452,455	20.09	29
30	Habilitation Aides (DD Homes)	37,553	42,607	633,763	14.87	30
31	Medical Records	2,144	2,358	43,626	18.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	374,180	421,382	\$ 7,292,790 *	\$ 17.31	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	941	\$ 28,230	1	35
36	Medical Director				36
37	Medical Records Consultant		244	10	37
38	Nurse Consultant		9,821	10	38
39	Pharmacist Consultant		2,449	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,217	48,684	10a	41
42	Respiratory Therapy Consultant	303	12,110	10a	42
43	Speech Therapy Consultant	24	940	10a	43
44	Activity Consultant				44
45	Social Service Consultant		8,901	12	45
46	Other(specify)				46
47	Doctor		62,704	10	47
48					48
49	TOTAL (lines 35 - 48)	2,485	\$ 174,083		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	70	\$ 3,752	10	50
51	Licensed Practical Nurses	843	30,076	10	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	913	\$ 33,828		53

Facility Name & ID Number McAuley Residence**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 Assn \$5,244
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 105
- (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. \$ 160,222 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. \$ 378,761
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? 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? _____
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? _____
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? _____
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 \$5,000, 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.