

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0029876

Facility Name: Misericordia Home-North

Address: 6300 North Ridge Avenue Chicago 60660
 Number City Zip Code

County: Cook

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

HFS ID Number: 362170153-002 thru 362170153-0013

Date of Initial License for Current Owners: varios

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 07/01/2006 to 06/30/2007 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 Misericordia Home-North

0029876 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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		Intermediate (ICF)			3
4	250	Intermediate/DD	250	91,250	4
5		Sheltered Care (SC)			5
6	27	ICF/DD 16 or Less	27	9,855	6
7	277	TOTALS	277	101,105	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	83,238	10		83,248
12	SC				12
13	DD 16 OR LESS	9,634	365		9,999
14	TOTALS	92,872	375		93,247

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.23%

D. How many bed-hold days during this year were paid by the Department? 7,757 (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, 6 CILA homes, CLF and CCI

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 Various-see attached

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

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/2007 Fiscal Year: 06/30/2007

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

Facility Name & ID Number Misericordia Home-North # 0029876 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	504,121	104,261	67,130	675,512		675,512	(190,777)	484,735		1
2	Food Purchase		1,354,644		1,354,644		1,354,644	(436,717)	917,927		2
3	Housekeeping	788,443	192,720	283,193	1,264,356		1,264,356	(589,166)	675,190		3
4	Laundry	162,522	54,848		217,370		217,370	(53,133)	164,237		4
5	Heat and Other Utilities			819,715	819,715		819,715	(446,084)	373,631		5
6	Maintenance	618,080	209,849	1,380,053	2,207,982		2,207,982	(1,121,804)	1,086,178		6
7	Other (specify):*										7
8	TOTAL General Services	2,073,166	1,916,322	2,550,091	6,539,579		6,539,579	(2,837,681)	3,701,898		8
	B. Health Care and Programs										
9	Medical Director	68,077			68,077		68,077	(20,814)	47,263		9
10	Nursing and Medical Records	1,972,416	518,209	47,792	2,538,417		2,538,417	(808,249)	1,730,168		10
10a	Therapy	12,726,879	5,659	56,636	12,789,174		12,789,174	(3,779,461)	9,009,713		10a
11	Activities	332,092	21,507	104,648	458,247		458,247	(159,405)	298,842		11
12	Social Services	265,285	186	14,160	279,631		279,631	(90,152)	189,479		12
13	CNA Training										13
14	Program Transportation		106,917		106,917		106,917	(62,771)	44,146		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	15,364,749	652,478	223,236	16,240,463		16,240,463	(4,920,852)	11,319,611		16
	C. General Administration										
17	Administrative	287,106		8,252	295,358		295,358	(128,985)	166,373		17
18	Directors Fees										18
19	Professional Services			207,919	207,919		207,919	(88,457)	119,462		19
20	Dues, Fees, Subscriptions & Promotions			65,828	65,828		65,828	(38,256)	27,572		20
21	Clerical & General Office Expenses	1,346,956	177,515	140,334	1,664,805		1,664,805	(716,883)	947,922		21
22	Employee Benefits & Payroll Taxes			5,802,695	5,802,695		5,802,695	(2,276,374)	3,526,321		22
23	Inservice Training & Education			209,286	209,286		209,286	(79,972)	129,314		23
24	Travel and Seminar			19,919	19,919		19,919	(7,504)	12,415		24
25	Other Admin. Staff Transportation		1,909	262,165	264,074		264,074	(1,876)	262,198		25
26	Insurance-Prop.Liab.Malpractice							(148,726)	(148,726)		26
27	Other (specify):*										27
28	TOTAL General Administration	1,634,062	179,424	6,716,398	8,529,884		8,529,884	(3,487,033)	5,042,851		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	19,071,977	2,748,224	9,489,725	31,309,926		31,309,926	(11,245,566)	20,064,360		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 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,848,880	2,848,880	2,848,880	(1,600,451)	1,248,429				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,392	25,392	25,392	(25,392)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,874,272	2,874,272	2,874,272	(1,625,843)	1,248,429				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,687,324	808,789	1,730	3,497,843	3,497,843	(3,570,555)	(72,712)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,120,176	1,120,176	1,120,176		1,120,176				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,687,324	808,789	1,121,906	4,618,019	4,618,019	(3,570,555)	1,047,464				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	21,759,301	3,557,013	13,485,903	38,802,217	38,802,217	(16,441,964)	22,360,253				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

0029876

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(121,521)	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	51,255	30		9
10	Interest and Other Investment Income	(25,392)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,142)	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	(4,097)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(956)	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)	\$ (101,853)		\$	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))	\$ (101,853)		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

BHF USE ONLY					
48		49		50	
				51	
					52

Misericordia Home-North

ID# 0029876

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gain/Loss on disposal - IDPA portion	\$ 69	6	1
2	Unallowable professional fees- IDPA portion	(32,148)	6	2
3	Off-site recreational facility/non-care auto	(5,979)	30	3
4	Off-site recreational facility	(5,089)	17	4
5	Bank Fees and other misc fees-IDPA portion	(4,057)	20	5
6	Unallow Admin Fees-IDPA portion	(10,670)	17	6
7	Expenses reimbursed from other sources:			7
8	Dietary wages	(134,987)	1	8
9	Dietary Supplies	(34,139)	1	9
10	Dietary Other	(21,651)	1	10
11	Food Supplies	(436,717)	2	11
12	Housekeeping Wages	(301,607)	3	12
13	Housekeeping Supplies	(113,215)	3	13
14	Housekeeping Other	(174,344)	3	14
15	Laundry Wages	(27,680)	4	15
16	Laundry Supplies	(25,453)	4	16
17	Heat and Other Utilities	(446,084)	5	17
18	Maintenance Wages	(297,263)	6	18
19	Maintenance Supplies	(115,332)	6	19
20	Maintenance Other	(677,130)	6	20
21	Medical Director	(20,814)	9	21
22	Nursing/Med Records Wages	(615,291)	10	22
23	Nursing/Med Records Supplies	(178,024)	10	23
24	Nursing/Med Records Other	(14,934)	10	24
25	Therapy Wages	(3,623,323)	10a	25
26	Therapy Supplies	(1,874)	10a	26
27	Therapy Other	(32,743)	10a	27
28	Activities Wages	(119,614)	11	28
29	Activities Supplies	(7,700)	11	29
30	Activities Other	(32,091)	11	30
31	Social Services Wages	-85527	12	31
32	Social Services Supplies	-60	12	32
33	Social Services Other	-4565	12	33
34	Program Transportation	-62771	14	34
35	Administrative Wages	-110062	17	35
36	Administrative Other	-3164	17	36
37	Professional Services	-84360	19	37
38	Dues, Fees, Subscriptions & Promotions	-34199	20	38
39	Clerical Wages	-533032	21	39
40	Clerical Supplies	-93691	21	40
41	Clerical Other	-89204	21	41
42	Employee Benefits & Payroll Taxes	-2276374	22	42
43	Inservice Training & Education	-79972	23	43
44	Travel & Seminar	-7504	24	44
45	Other Administrative Staff Transportation	-734	25	45
46	Insurance	-148726	26	46
47	Depreciation	-1645727	30	47
48	Ancillary Service Centers	-3570555	39	48
49	Total	(16,340,111)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Misericordia Home-North# 0029876

Report Period Beginning:

07/01/2006

Ending:

06/30/2007**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	(190,777)	0	0	0	0	0	0	0	0	0	0	(190,777)	1
2	Food Purchase	(436,717)	0	0	0	0	0	0	0	0	0	0	(436,717)	2
3	Housekeeping	(589,166)	0	0	0	0	0	0	0	0	0	0	(589,166)	3
4	Laundry	(53,133)	0	0	0	0	0	0	0	0	0	0	(53,133)	4
5	Heat and Other Utilities	(446,084)	0	0	0	0	0	0	0	0	0	0	(446,084)	5
6	Maintenance	(1,121,804)	0	0	0	0	0	0	0	0	0	0	(1,121,804)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,837,681)	0	0	0	0	0	0	0	0	0	0	(2,837,681)	8
	B. Health Care and Programs													
9	Medical Director	(20,814)	0	0	0	0	0	0	0	0	0	0	(20,814)	9
10	Nursing and Medical Records	(808,249)	0	0	0	0	0	0	0	0	0	0	(808,249)	10
10a	Therapy	(3,779,461)	0	0	0	0	0	0	0	0	0	0	(3,779,461)	10a
11	Activities	(159,405)	0	0	0	0	0	0	0	0	0	0	(159,405)	11
12	Social Services	(90,152)	0	0	0	0	0	0	0	0	0	0	(90,152)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(62,771)	0	0	0	0	0	0	0	0	0	0	(62,771)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,920,852)	0	0	0	0	0	0	0	0	0	0	(4,920,852)	16
	C. General Administration													
17	Administrative	(128,985)	0	0	0	0	0	0	0	0	0	0	(128,985)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(88,457)	0	0	0	0	0	0	0	0	0	0	(88,457)	19
20	Fees, Subscriptions & Promotions	(38,256)	0	0	0	0	0	0	0	0	0	0	(38,256)	20
21	Clerical & General Office Expenses	(716,883)	0	0	0	0	0	0	0	0	0	0	(716,883)	21
22	Employee Benefits & Payroll Taxes	(2,276,374)	0	0	0	0	0	0	0	0	0	0	(2,276,374)	22
23	Inservice Training & Education	(79,972)	0	0	0	0	0	0	0	0	0	0	(79,972)	23
24	Travel and Seminar	(7,504)	0	0	0	0	0	0	0	0	0	0	(7,504)	24
25	Other Admin. Staff Transportation	(1,876)	0	0	0	0	0	0	0	0	0	0	(1,876)	25
26	Insurance-Prop.Liab.Malpractice	(148,726)	0	0	0	0	0	0	0	0	0	0	(148,726)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,487,033)	0	0	0	0	0	0	0	0	0	0	(3,487,033)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,245,566)	0	0	0	0	0	0	0	0	0	0	(11,245,566)	29

STATE OF ILLINOIS

Facility Name & ID Number Misericordia Home-North

0029876

Report Period Beginning:

07/01/2006 Ending:

Summary B

06/30/2007

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	(1,600,451)	0	0	0	0	0	0	0	0	0	0	(1,600,451)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,392)	0	0	0	0	0	0	0	0	0	0	(25,392)	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	(1,625,843)	0	(1,625,843)	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	(3,570,555)	0	0	0	0	0	0	0	0	0	0	(3,570,555)	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	(3,570,555)	0	(3,570,555)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,441,964)	0	(16,441,964)	45									

Facility Name & ID Number Misericordia Home-North

0029876

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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 2007						
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 Misericordia Home-North # 0029876 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	\$	1
2	Margaret Murphy	Co-Director of Development	Grants & Direct M	N/A	N/A	50+	100.00	Salary		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 & McAuley). 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	\$	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

0029876 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

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

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Misericordia Home-North COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029876

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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Misericordia Home-North

0029876 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 504,692 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Day Training Facility - approximately 71,977 square feet with 300+ participants.

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

6 CILAs - approximately 19,226 square feet with 30 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

0029876

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	See attached schedule				25,108,631	997,238	5-50yrs	1,048,493	51,255	15,742,203	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 Misericordia Home-North

0029876

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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)	\$ 25,108,631	\$ 997,238		\$ 1,048,493	\$ 51,255	\$ 15,742,203	70

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

Facility Name & ID Number Misericordia Home-North # 0029876 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	\$ 2,186,265	\$ 184,956	\$ 184,956	\$	5-15 yrs	\$ 1,447,401	71
72	Current Year Purchases	68,659	4,270	4,270			4,270	72
73	Fully Depreciated Assets	1,459,632					1,459,632	73
74								74
75	TOTALS	\$ 3,714,556	\$ 189,226	\$ 189,226	\$		\$ 2,911,303	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	See Attached			\$ 241,025	\$ 10,709	\$ 10,709	\$	3 yrs	\$ 217,641	76
77										77
78										78
79										79
80	TOTALS			\$ 241,025	\$ 10,709	\$ 10,709	\$		\$ 217,641	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)	\$ 29,064,212	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,197,173	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,248,428	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 51,255	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,871,147	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 program	\$ 5,765,572	\$ 350,989	\$ 3,648,715	86
87	Auto alloc to other prog	578,635	52,694	508,326	87
88	Bldg & Improv alloc to other prog	61,422,544	2,194,009	21,555,963	88
89					89
90					90
91	TOTALS	\$ 67,766,751	\$ 2,597,692	\$ 25,713,004	91

G. Construction-in-Progress

	Description	Cost	
92	Chapel	\$ 7,891,064	92
93	CILA	516,638	93
94	Technology	11,493	94
95		\$ 8,419,195	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO 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 Misericordia Home-North# 0029876 Report Period Beginning:07/01/2006 Ending: 06/30/2007

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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									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.

Facility Name & ID Number Misericordia Home-North # 0029876 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2007 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,999,006	\$	1
2	Cash-Patient Deposits	317,122		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>35,000</u>)	10,313,394		3
4	Supply Inventory (priced at)	124,418		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)	\$ 12,753,940	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	86,531,174		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,299,789		16
17	Accumulated Depreciation (book methods)	(44,584,153)		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)	8,419,195		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 60,666,005	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 73,419,945	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,570,083	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	303,622		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,857,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	307,022		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Short-term benefits withheld/457</u>	83,003		36
37	<u>Unearned Revenue</u>	249,149		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,369,931	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Gift Annuity</u>	285,039		43
44	<u>Asset Retirement Obligation</u>	290,139		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 575,178	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,945,109	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 66,474,836	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 73,419,945	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 62,507,739	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 62,507,739	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,245,668)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	9,349,495	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 McAuley/South</u>	(3,761,398)	15
16	Other (describe) <u>Development & Community Relations</u>	(1,877,014)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,534,585)	17
	B. Transfers (Itemize):		
18	<u>Fixed Asset Additions</u>	8,312,142	18
19	<u>Funding of Depreciation</u>	(3,794,866)	19
20	<u>Transfer to Endowment Fund</u>	4,716,961	20
21	<u>Inter-Agency transfer</u>	(732,555)	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 8,501,682	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 66,474,836	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Misericordia Home-North# 0029876Report Period Beginning: 07/01/2006Ending: 06/30/2007**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	\$ 24,256,728	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 24,256,728	3
B. Ancillary Revenue			
4	Day Care	6,299,821	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,299,821	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)	\$ 30,556,549	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	6,539,579	31
32	Health Care	16,240,463	32
33	General Administration	8,529,884	33
B. Capital Expense			
34	Ownership	2,874,272	34
C. Ancillary Expense			
35	Special Cost Centers	3,497,843	35
36	Provider Participation Fee	1,120,176	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 38,802,217	40
41	Income before Income Taxes (line 30 minus line 40)**	(8,245,668)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (8,245,668)	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

0029876

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

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	1,750	2,080	\$ 77,071	\$ 37.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	42,235	47,741	1,391,178	29.14	3
4	Licensed Practical Nurses	17,010	19,047	483,981	25.41	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	8,903	10,073	305,028	30.28	7
8	Rehab/Therapy Aides	9,795	11,182	176,855	15.82	8
9	Activity Director	3,558	3,992	88,921	22.27	9
10	Activity Assistants	14,563	16,176	243,171	15.03	10
11	Social Service Workers	11,817	13,241	265,286	20.04	11
12	Dietician					12
13	Food Service Supervisor	2,326	2,699	121,561	45.04	13
14	Head Cook	3,624	4,160	112,150	26.96	14
15	Cook Helpers/Assistants	10,809	11,971	184,634	15.42	15
16	Dishwashers	7,017	7,368	85,776	11.64	16
17	Maintenance Workers	27,198	29,201	618,080	21.17	17
18	Housekeepers	54,764	60,444	788,443	13.04	18
19	Laundry	11,228	12,486	162,522	13.02	19
20	Administrator	4,861	5,028	240,317	47.80	20
21	Assistant Administrator	1,181	1,418	46,789	33.00	21
22	Other Administrative	20,211	22,507	647,403	28.76	22
23	Office Manager					23
24	Clerical	39,072	44,190	699,552	15.83	24
25	Vocational Instruction	133,824	145,270	2,687,324	18.50	25
26	Academic Instruction					26
27	Medical Director	710	770	68,077	88.41	27
28	Qualified MR Prof. (QMRP)	88,737	99,579	1,914,899	19.23	28
29	Resident Services Coordinator	69,555	81,964	1,665,012	20.31	29
30	Habilitation Aides (DD Homes)	578,862	650,817	8,665,084	13.31	30
31	Medical Records	1,434	1,696	20,187	11.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	1,165,044	1,305,100	\$ 21,759,301 *	\$ 16.67	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	2,036	\$ 67,130		35
36	Medical Director				36
37	Medical Records Consultant		2,866		37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,980		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	795	31,781		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	550	24,855		43
44	Activity Consultant				44
45	Social Service Consultant		11,294		45
46	Other(specify) <u>Doctor</u>		1,700		46
47	<u>Psychiatrist/Psychologist</u>		37,141		47
48	<u>Dentist</u>		971		48
49	TOTAL (lines 35 - 48)	3,381	\$ 185,718		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

0029876

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	\$ 44,186	Workers' Compensation Insurance	\$ 268,674	IDPH License Fee	\$ 1,495	
Mary Pat O'Brien	Administrators	N/A	46,242	Unemployment Compensation Insurance	72,358	Advertising: Employee Recruitment	7,553	
Denise Tigges	Administrators	N/A	46,559	FICA Taxes	966,426	Health Care Worker Background Check	9,806	
Betty Flynn	Administrators	N/A	58,712	Employee Health Insurance	1,096,177	(Indicate # of checks performed _____)		
Lois Gates	Asst. CEO	N/A	41,603	Employee Meals		Membership Dues	478	
Chris Hegg	Asst. Admin	N/A	27,962	Illinois Municipal Retirement Fund (IMRF)*		Subscription	885	
Kevin Connelly/Fr. Jack Clair	Asst. Admin	N/A	21,842	Pension	971,382	CARF-accreditation fee	5	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 287,106	Emp Tuition Reimburse	61,600	Computer licensing	7,146	
(List each licensed administrator separately.)				Dental Insurance	89,704	Dept of Financial & Professional Reg	204	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Off-Site Recreational Facility-100% is unallowable and is adjuster			\$ 8,252			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 8,252	TOTAL (agree to Schedule V, line 22, col.8)	\$ 3,526,321	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 27,572	
(Attach a copy of any management service agreement)								
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		\$ 45,757				Out-of-State Travel	\$
ADP Processing	Payroll Service		110,732					
Burke, Warren, MacKay & Serr	Legal		28,219					
Ellison, Neilson, Zehe	Legal Unallowable		7,196				In-State Travel	
Simon Consulting	Financial		815					
Law Offices of Denise Merch	Legal		3,300					
Law Offices of Kamin Memon	Legal		9,900					
Veralee Nathaniel	Legal Unallowable		2,000					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 207,919	TOTAL		\$	Seminar Expense	12,415
(If total legal fees exceed \$5,000, attach copy of invoices.)							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	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Misericordia Home-North

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 action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,603 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. \$ 1,120,176
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. \$ 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? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte & Touche 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? _____
Attach invoices and a summary of services for all architect and appraisal fees.