

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	105	Skilled Pediatric (SNF/PED)	125	39,442	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	125	39,442	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	36,714	2,196	125	39,035	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,714	2,196	125	39,035	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.97%

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

538 (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 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 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: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1, 2007 Ending: June 30, 2008

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	162,899	49,672	15,955	228,526		228,526		228,526		1
2	Food Purchase		220,925		220,925		220,925	(68,839)	152,086		2
3	Housekeeping	263,579	95,648	150,548	509,775		509,775	(4,461)	505,314		3
4	Laundry	183,728	10,423		194,151		194,151		194,151		4
5	Heat and Other Utilities			429,088	429,088		429,088	(49,268)	379,820		5
6	Maintenance	213,757	49,353	298,162	561,272		561,272	(43,545)	517,727		6
7	Other (specify):*										7
8	TOTAL General Services	823,963	426,021	893,753	2,143,737		2,143,737	(166,113)	1,977,624		8
	B. Health Care and Programs										
9	Medical Director	82,373			82,373		82,373		82,373		9
10	Nursing and Medical Records	4,148,416	535,140	50,415	4,733,971		4,733,971		4,733,971		10
10a	Therapy	1,987,754	9,581	69,627	2,066,962		2,066,962		2,066,962		10a
11	Activities	12,588	521	26,094	39,203		39,203		39,203		11
12	Social Services	67,893	879	586	69,358		69,358		69,358		12
13	CNA Training	25,282	442		25,724		25,724		25,724		13
14	Program Transportation		33,301		33,301		33,301	(3,072)	30,229		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,324,306	579,864	146,722	7,050,892		7,050,892	(3,072)	7,047,820		16
	C. General Administration										
17	Administrative	121,520		2,258	123,778		123,778	(15,451)	108,327		17
18	Directors Fees										18
19	Professional Services			60,087	60,087		60,087	(14,322)	45,765		19
20	Dues, Fees, Subscriptions & Promotions			26,441	26,441		26,441	(5,071)	21,370		20
21	Clerical & General Office Expenses	440,047	34,370	52,365	526,782		526,782	(108,506)	418,276		21
22	Employee Benefits & Payroll Taxes			2,153,407	2,153,407		2,153,407	(152,962)	2,000,445		22
23	Inservice Training & Education			35	35		35		35		23
24	Travel and Seminar			5,395	5,395		5,395	(395)	5,000		24
25	Other Admin. Staff Transportation		331		331		331	(291)	40		25
26	Insurance-Prop.Liab.Malpractice			69,117	69,117		69,117	(8,542)	60,575		26
27	Other (specify):*										27
28	TOTAL General Administration	561,567	34,701	2,369,105	2,965,373		2,965,373	(305,540)	2,659,833		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,709,836	1,040,586	3,409,580	12,160,002		12,160,002	(474,725)	11,685,277		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: July 1, 2007 Ending:

June 30, 2008

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			915,426	915,426	915,426	(83,591)	831,835				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,388	4,388	4,388	(4,388)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			919,814	919,814	919,814	(87,979)	831,835				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	515,526	12,336		527,862	527,862	(527,862)					39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			466,870	466,870	466,870		466,870				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	515,526	12,336	466,870	994,732	994,732	(527,862)	466,870				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,225,362	1,052,922	4,796,264	14,074,548	14,074,548	(1,090,566)	12,983,982				45

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

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	(68,828)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,133	30		9
10	Interest and Other Investment Income	(4,388)	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	(255)	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	(3,277)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,230)	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 Investment Fees	(1,641)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (94,486)		\$	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))	\$ (94,486)		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.

		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						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

McAuley Residence

ID# 0045906

Report Period Beginning: July 1, 2007

Ending: June 30, 2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gain/Loss on disposal/consultant - IDPA portion	\$ (3,920)	6	1
2	Unallowable professional fees- IDPA portion	(444)	19	2
3	Off-site recreational facility/non-care auto	(2,817)	30	3
4	Off-site recreational facility	(2,013)	17	4
5	Bank Fees and other misc fees-IDPA portion	(3,250)	20	5
6	Unallow Admin Fees-IDPA portion	(4,135)	19	6
7	Expenses reimbursed from other sources:			7
8	Food Supplies	(11)	2	8
9	Housekeeping Supplies	(4)	3	9
10	Housekeeping Other	(4,457)	3	10
11	Heat and Other Utilities	(49,268)	5	11
12	Maintenance Wages	(14,700)	6	12
13	Maintenance Supplies	(4,125)	6	13
14	Maintenance Other	(20,800)	6	14
15	Program Transportation Other	(3,072)	14	15
16	Administrative Wages	(13,193)	17	16
17	Administrative Other	(245)	17	17
18	Professional Services	(6,466)	19	18
19	Dues, Fees, Subscriptions & Promotions	(1,821)	20	19
20	Clerical Wages	(78,642)	21	20
21	Clerical Supplies	(2,487)	21	21
22	Clerical Other	(5,147)	21	22
23	Employee Benefits & Payroll Taxes	(152,962)	22	23
24	Travel & Seminar	(395)	24	24
25	Other Admin Staff Transportation	(36)	25	25
26	Insurance	(8,542)	26	26
27	Depreciation	(86,907)	30	27
28	Ancillary Service Centers Salaries	(515,526)	39	28
29	Ancillary Service Centers Supplies	(12,336)	39	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(997,721)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence# 0045906

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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	(68,839)	0	0	0	0	0	0	0	0	0	0	(68,839)	2
3	Housekeeping	(4,461)	0	0	0	0	0	0	0	0	0	0	(4,461)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(49,268)	0	0	0	0	0	0	0	0	0	0	(49,268)	5
6	Maintenance	(43,545)	0	0	0	0	0	0	0	0	0	0	(43,545)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(166,113)	0	0	0	0	0	0	0	0	0	0	(166,113)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,072)	0	0	0	0	0	0	0	0	0	0	(3,072)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,072)	0	0	0	0	0	0	0	0	0	0	(3,072)	16
	C. General Administration													
17	Administrative	(15,451)	0	0	0	0	0	0	0	0	0	0	(15,451)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,322)	0	0	0	0	0	0	0	0	0	0	(14,322)	19
20	Fees, Subscriptions & Promotions	(5,071)	0	0	0	0	0	0	0	0	0	0	(5,071)	20
21	Clerical & General Office Expenses	(108,506)	0	0	0	0	0	0	0	0	0	0	(108,506)	21
22	Employee Benefits & Payroll Taxes	(152,962)	0	0	0	0	0	0	0	0	0	0	(152,962)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(395)	0	0	0	0	0	0	0	0	0	0	(395)	24
25	Other Admin. Staff Transportation	(291)	0	0	0	0	0	0	0	0	0	0	(291)	25
26	Insurance-Prop.Liab.Malpractice	(8,542)	0	0	0	0	0	0	0	0	0	0	(8,542)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(305,540)	0	0	0	0	0	0	0	0	0	0	(305,540)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(474,725)	0	0	0	0	0	0	0	0	0	0	(474,725)	29

STATE OF ILLINOIS

Facility Name & ID Number McAuley Residence

0045906 Report Period Beginning:

July 1, 2007 Ending:

Summary B
June 30, 2008

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	(83,591)	0	0	0	0	0	0	0	0	0	0	(83,591)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,388)	0	0	0	0	0	0	0	0	0	0	(4,388)	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	(87,979)	0	(87,979)	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	(527,862)	0	0	0	0	0	0	0	0	0	0	(527,862)	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	(527,862)	0	(527,862)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,090,566)	0	(1,090,566)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of Board of Directors during FY 2008						
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:

July 1, 2007

Ending:

June 30, 2008

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 and Margaret Murphy receive salaries for their Management positions at Misericordia and not for being a Board member. Sr. Rosemary									4
5	Connelly's salary is allocated between Development/Community Relations and MG&A (MG&A portion is further allocated between McAuley and North.									5
6	Also Margaret Murphy's salary is incurred to Development & Community Relations and is not reported 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 McAuley Residence

0045906 Report Period Beginning: July 1, 2007 Ending: ne 30, 2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

Facility Name & ID Number

McAuley Residence

0045906

Report Period Beginning:

July 1, 2007

Ending:

June 30, 2008

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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 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 2008 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:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

July 1, 2007 Ending:

June 30, 2008

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).

Day Training Facility - approximately 5,002 square feet.

School Facility - approximately 4,928 square feet.

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 McAuley Residence

0045906

Report Period Beginning:

July 1, 2007 Ending: June 30, 2008

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				22,835,760	617,636	5-50yrs	623,769	6,133	3,760,495	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:

July 1, 2007

Ending: June 30, 2008

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)	\$ 22,835,760	\$ 617,636		\$ 623,769	\$ 6,133	\$ 3,760,495	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,903,454	\$ 181,832	\$ 181,832	\$	3-20 yrs	\$ 674,864	71
72	Current Year Purchases	61,062	2,077	2,077		3-20 yrs	2,077	72
73	Fully Depreciated Assets	538,934					534,788	73
74								74
75	TOTALS	\$ 2,503,450	\$ 183,909	\$ 183,909	\$		\$ 1,211,729	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			\$ 217,222	\$ 24,157	\$ 24,157	\$	3	\$ 196,196	76
77										77
78										78
79										79
80	TOTALS			\$ 217,222	\$ 24,157	\$ 24,157	\$		\$ 196,196	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)		\$ 25,556,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 825,702	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 831,835	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 6,133	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,168,420	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Furn & Equip alloc to other program	\$ 7,415,617	\$ 334,580	\$ 5,861,435	86
87	Auto alloc to other prog	592,036	30,108	523,342	87
88	Bldg & Improv alloc to other prog	65,678,055	2,589,905	36,744,969	88
89					89
90					90
91	TOTALS	\$ 73,685,708	\$ 2,954,593	\$ 43,129,746	91

G. Construction-in-Progress

	Description	Cost	
92	Chapel	\$ 14,266,971	92
93	CILA	775,316	93
94	Technology	43,626	94
95		\$ 15,085,913	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

* 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>However DSPs were trained.</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 442	\$	\$ 442
2	Books and Supplies				
3	Classroom Wages (a)		25,282		25,282
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 25,724	\$	\$ 25,724
10	SUM OF line 9, col. 1 and 2 (e)	\$	25,724		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 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	5 Units 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	Other (specify):									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 McAuley Residence# 0045906Report Period Beginning: July 1, 2007

Ending:

June 30, 2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2008 (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	\$ 4,563,860	\$	1
2	Cash-Patient Deposits	346,398		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>35,000</u>)	11,676,471		3
4	Supply Inventory (priced at)	207,353		4
5	Short-Term Investments	15,521,055		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	343		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 32,315,480	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	88,513,935		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,728,205		16
17	Accumulated Depreciation (book methods)	(48,298,166)		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 <u>CIP</u>)	15,085,913		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 66,029,887	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 98,345,367	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,166,956	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	331,875		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,159,429		30
31	Accrued Taxes Payable (excluding real estate taxes)	338,539		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>Accrued Benefits and 457</u>	998,864		36
37	<u>Unearned Revenue/Purchasing Card paya</u>	272,883		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,268,546	\$	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 Annuities</u>	315,137		43
44	<u>Asset Retirement Obligation</u>	307,787		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 622,924	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,891,470	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 92,453,897	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 98,345,367	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 66,474,836	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 66,474,836	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(4,885,315)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	19,479,576	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</u>	(7,819,359)	15
16	Other (describe) <u>Development & Community Relations</u>	(2,086,928)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,687,974	17
B. Transfers (Itemize):			
18	<u>Changes in Temp Restricted Net Assets</u>	21,070,202	18
19	<u>Released from Restrictions</u>	447,370	19
20	<u>Investment activity/insurance proceeds</u>	657,750	20
21	<u>Net Asset Reclassification</u>	(884,235)	21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 21,291,087	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 92,453,897	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: July 1, 2007Ending: June 30, 2008**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	\$ 8,435,014	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,435,014	3
B. Ancillary Revenue			
4	Day Care	754,219	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 754,219	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)	\$ 9,189,233	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,143,737	31
32	Health Care	7,050,892	32
33	General Administration	2,965,373	33
B. Capital Expense			
34	Ownership	919,814	34
C. Ancillary Expense			
35	Special Cost Centers	527,862	35
36	Provider Participation Fee	466,870	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,074,548	40
41	Income before Income Taxes (line 30 minus line 40)**	(4,885,315)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (4,885,315)	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# 0045906Report Period Beginning: July 1, 2007Ending: June 30, 2008

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	3,406	3,727	\$ 140,019	\$ 37.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,309	26,333	786,613	29.87	3
4	Licensed Practical Nurses	32,149	35,207	896,764	25.47	4
5	CNAs & Orderlies	152,857	167,454	2,280,404	13.62	5
6	CNA Trainees					6
7	Licensed Therapist	5,645	6,489	219,330	33.80	7
8	Rehab/Therapy Aides	14,962	17,231	289,546	16.80	8
9	Activity Director	91	108	2,932	27.15	9
10	Activity Assistants	530	595	9,656	16.23	10
11	Social Service Workers	2,833	3,256	67,893	20.85	11
12	Dietician					12
13	Food Service Supervisor	150	150	6,914	46.09	13
14	Head Cook	1,880	2,080	43,005	20.68	14
15	Cook Helpers/Assistants	5,006	5,425	73,063	13.47	15
16	Dishwashers	3,319	3,530	39,917	11.31	16
17	Maintenance Workers	9,512	10,454	213,757	20.45	17
18	Housekeepers	18,229	20,420	263,579	12.91	18
19	Laundry	10,423	12,119	183,728	15.16	19
20	Administrator	1,770	2,058	121,520	59.05	20
21	Assistant Administrator					21
22	Other Administrative	10,005	11,544	296,166	25.66	22
23	Office Manager	854	1,004	20,241	20.16	23
24	Clerical	8,240	9,380	143,881	15.34	24
25	Vocational Instruction	8,706	10,504	192,479	18.32	25
26	Academic Instruction	14,641	16,187	348,329	21.52	26
27	Medical Director	918	988	82,373	83.37	27
28	Qualified MR Prof. (QMRP)	17,490	19,072	431,706	22.64	28
29	Resident Services Coordinator	18,160	21,125	452,610	21.43	29
30	Habilitation Aides (DD Homes)	32,531	36,499	531,377	14.56	30
31	Medical Records	2,008	2,319	44,616	19.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Respiratory Aide</u>	1,889	2,217	42,944	19.37	33
34	TOTAL (lines 1 - 33)	402,513	447,475	\$ 8,225,362 *	\$ 18.38	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	499	\$ 15,955	1	35
36	Medical Director				36
37	Medical Records Consultant		1,586	10	37
38	Nurse Consultant		125	10	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	998	45,710	10a	41
42	Respiratory Therapy Consultant	105	4,190	10a	42
43	Speech Therapy Consultant	407	19,727	10a	43
44	Activity Consultant				44
45	Social Service Consultant		586	12	45
46	Other(specify) <u>Dental</u>		296	10	46
47	<u>Doctor</u>		33,225	10	47
48	<u>Psychiatrist/Psychologist</u>		15,183	10	48
49	TOTAL (lines 35 - 48)	2,009	\$ 136,583		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

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 Assoc \$6555
- (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? 25
- (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. \$ 186,478 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. \$ 466,870
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? 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, program vehicles
- 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 unallow
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte and 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.