



Facility Name & ID Number McAuley Residence

# 0045906 Report Period Beginning: July 1 2008 Ending: June 30, 2009

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	125	Skilled Pediatric (SNF/PED)	125	42,986	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	125	TOTALS	125	42,986	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	40,198	2,070	295	42,563	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,198	2,070	295	42,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.02%

D. How many bed-hold days during this year were paid by the Department? 718 (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? \_\_\_\_\_

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 11/03/2005

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: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number McAuley Residence # 0045906 Report Period Beginning: July 1 2008 Ending: June 30, 2009

**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
	<b>A. General Services</b>										
1	Dietary	99,668	37,736	6,531	143,935		143,935		143,935		1
2	Food Purchase		241,703		241,703		241,703	(78,579)	163,124		2
3	Housekeeping	267,749	62,533	138,514	468,796		468,796	(16,803)	451,993		3
4	Laundry	183,994	14,223		198,217		198,217		198,217		4
5	Heat and Other Utilities			612,393	612,393		612,393	(8,962)	603,431		5
6	Maintenance	195,998	56,017	292,246	544,261		544,261	(31,355)	512,906		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	747,409	412,212	1,049,684	2,209,305		2,209,305	(135,699)	2,073,606		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	94,378			94,378		94,378		94,378		9
10	Nursing and Medical Records	4,554,792	590,538	34,403	5,179,733		5,179,733	(3)	5,179,730		10
10a	Therapy	2,119,444	2,262	108,329	2,230,035		2,230,035	(7,352)	2,222,683		10a
11	Activities	29,430	330	17,584	47,344		47,344	(27,013)	20,331		11
12	Social Services	81,070	118		81,188		81,188		81,188		12
13	CNA Training	9,863	26		9,889		9,889		9,889		13
14	Program Transportation		27,761		27,761		27,761	(1,330)	26,431		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,888,977	621,035	160,316	7,670,328		7,670,328	(35,698)	7,634,630		16
	<b>C. General Administration</b>										
17	Administrative	117,526	274	6,455	124,255		124,255	(18,722)	105,533		17
18	Directors Fees										18
19	Professional Services			101,392	101,392		101,392	(7,053)	94,339		19
20	Dues, Fees, Subscriptions & Promotions			40,295	40,295		40,295	(4,828)	35,467		20
21	Clerical & General Office Expenses	491,222	28,448	30,475	550,145		550,145	(42,882)	507,263		21
22	Employee Benefits & Payroll Taxes			1,996,696	1,996,696		1,996,696	(98,025)	1,898,671		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,168	5,168		5,168	(894)	4,274		24
25	Other Admin. Staff Transportation			156	156		156	(156)			25
26	Insurance-Prop.Liab.Malpractice			53,868	53,868		53,868	(3,518)	50,350		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	608,748	28,722	2,234,505	2,871,975		2,871,975	(176,078)	2,695,897		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,245,134	1,061,969	3,444,505	12,751,608		12,751,608	(347,475)	12,404,133		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 &amp; ID Number

McAuley Residence

#0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			907,957	907,957		907,957	(41,002)	866,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,312	6,312		6,312	(6,312)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			914,269	914,269		914,269	(47,314)	866,955			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	430,568	6,098	30,591	467,257		467,257	(442,656)	24,601			39
40	Barber and Beauty Shops			452	452		452		452			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			460,902	460,902		460,902		460,902			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	430,568	6,098	491,945	928,611		928,611	(442,656)	485,955			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,675,702	1,068,067	4,850,719	14,594,488		14,594,488	(837,445)	13,757,043			45

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



McAuley ResidenceID# 0045906Report Period Beginning: July 1 2008Ending: June 30, 2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gain/Loss on disposal/consultant - IDPA portion	\$ (7,252)	6	1
2	Off-site recreational facility/non-care auto	(2,364)	30	2
3	Off-site recreational facility	(6,154)	17	3
4	Bank Fees and other misc fees-IDPA portion	(2,007)	20	4
5	Unallow Admin Fees-IDPA portion	(6,765)	17	5
6	Unallow program - religious	(27,013)	11	6
7	Governmental Sponsored Special Programs	(7,352)	10a	7
8	Expenses reimbursed from other sources:			8
9	Food Supplies	(0)	2	9
10	Housekeeping Wages	(12,511)	3	10
11	Housekeeping Supplies	(1,769)	3	11
12	Housekeeping Other	(2,523)	3	12
13	Heat and Other Utilities	(8,962)	5	13
14	Maintenance Wages	(11,872)	6	14
15	Maintenance Supplies	(2,428)	6	15
16	Maintenance Other	(9,803)	6	16
17	Nursing/Med records supplies	(3)	10	17
18	Program Transportation Other	(1,330)	14	18
19	Administrative Wages	(5,489)	17	19
20	Administrative Other	(314)	17	20
21	Professional Services	(5,067)	19	21
22	Dues, Fees, Subscriptions & Promotions	(2,821)	20	22
23	Clerical Wages	(29,908)	21	23
24	Clerical Supplies	(1,169)	21	24
25	Clerical Other	(1,883)	21	25
26	Employee Benefits & Payroll Taxes	(98,025)	22	26
27	Travel & Seminar	(894)	24	27
28	Other Admin Staff Transportation	(156)	25	28
29	Insurance	(3,518)	26	29
30	Depreciation	(49,276)	30	30
31	Interest	(330)	32	31
32	Ancillary Service Centers Supplies	(6,098)	39	32
33	Ancillary Service Centers Salaries	(405,967)	39	33
34	Ancillary Service Centers Other	(30,591)	39	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	<b>Total</b>	(751,614)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number McAuley Residence# 0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(78,579)	0	0	0	0	0	0	0	0	0	0	(78,579)	2
3	Housekeeping	(16,803)	0	0	0	0	0	0	0	0	0	0	(16,803)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,962)	0	0	0	0	0	0	0	0	0	0	(8,962)	5
6	Maintenance	(31,355)	0	0	0	0	0	0	0	0	0	0	(31,355)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(135,699)</b>	<b>0</b>	<b>(135,699)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3)	0	0	0	0	0	0	0	0	0	0	(3)	10
10a	Therapy	(7,352)	0	0	0	0	0	0	0	0	0	0	(7,352)	10a
11	Activities	(27,013)	0	0	0	0	0	0	0	0	0	0	(27,013)	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	(1,330)	0	0	0	0	0	0	0	0	0	0	(1,330)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(35,698)</b>	<b>0</b>	<b>(35,698)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	(18,722)	0	0	0	0	0	0	0	0	0	0	(18,722)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,053)	0	0	0	0	0	0	0	0	0	0	(7,053)	19
20	Fees, Subscriptions & Promotions	(4,828)	0	0	0	0	0	0	0	0	0	0	(4,828)	20
21	Clerical & General Office Expenses	(42,882)	0	0	0	0	0	0	0	0	0	0	(42,882)	21
22	Employee Benefits & Payroll Taxes	(98,025)	0	0	0	0	0	0	0	0	0	0	(98,025)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(894)	0	0	0	0	0	0	0	0	0	0	(894)	24
25	Other Admin. Staff Transportation	(156)	0	0	0	0	0	0	0	0	0	0	(156)	25
26	Insurance-Prop.Liab.Malpractice	(3,518)	0	0	0	0	0	0	0	0	0	0	(3,518)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(176,078)</b>	<b>0</b>	<b>(176,078)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(347,475)</b>	<b>0</b>	<b>(347,475)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name & ID Number McAuley Residence# 0045906

Report Period Beginning:

July 1 2008 Ending:

Summary B

June 30, 2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(41,002)	0	0	0	0	0	0	0	0	0	0	(41,002)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,312)	0	0	0	0	0	0	0	0	0	0	(6,312)	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	<b>TOTAL Ownership</b>	<b>(47,314)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(47,314)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(442,656)	0	0	0	0	0	0	0	0	0	0	(442,656)	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	<b>TOTAL Special Cost Centers</b>	<b>(442,656)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(442,656)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(837,445)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(837,445)</b>	<b>45</b>

Facility Name & ID Number

McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

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 2009						
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		\$	\$	1
2	V			be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to				2
3	V			these organizations on a pass-through basis, as part of our participation in collective purchasing				3
4	V			groups. Our share of costs are ultimately paid to external providers not related to us.				4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name &amp; ID Number

McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

## 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	40	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 McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008

Ending: ne 30, 2009

**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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

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

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.)





Facility Name & ID Number McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008 Ending:

June 30, 2009

**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 &amp; ID Number McAuley Residence

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	MC AULEY										9
10	FACILITY MANAGEMENT FEES		2006		3,154	79	40	79		269	10
11	general construction		2006		11,026	276	40	276		942	11
12	phone system		2006		3,286	93	40	93		303	12
13	Facility Management Fees		2006		421	28	15	28		94	13
14	Phone System Back Up		2006		1,904	190	10	190		651	14
15	Fence		2006		7,377	295	25	295		984	15
16	Plumbing Works		2006		13,381	669	20	669		2,007	16
17	Phone System		2006		7,461	746	10	746		2,549	17
18	Labor-Construction-Therapy Pool		2006		18,258	730	25	730		2,374	18
19	Facility Management Fees		2006		421	28	15	28		91	19
20	Paging System-Equipt and Labor		2006		248,670	12,434	20	12,434		37,301	20
21	Plaster Entrance		2006		2,979	248	12	248		765	21
22	Metal Door		2006		456	23	20	23		72	22
23	Labor		2006		158	11	15	11		33	23
24	Labor		2006		158	11	15	11		32	24
25	Facility Management Fees		2006		3,154	210	15	210		718	25
26	Install Tile		2006		7,278	728	10	728		1,880	26
27	Electrical Wiring		2006		4,764	238	20	238		595	27
28	Air Conditioning Improvement		2007		47,977	3,198	15	3,198		7,197	28
29	Phone System		2006		17,248	1,725	10	1,725		4,599	29
30	Facility Management Fees-Sensory Room		2006		600	40	15	40		110	30
31	Labor-Install-Sensory Room		2006		1,232	82	15	82		205	31
32	Facility anagement Fees-Sensory Room		2006		1,500	100	15	100		250	32
33	Labor-Install-Sensory Room		2007		1,694	113	15	113		273	33
34	Labor-Install-Sensory Room		2007		1,500	100	15	100		242	34
35	Labor-Install-Sensory Room		2007		960	64	15	64		149	35
36	Facility Management Fees		2007		66	4	15	4		10	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Facility anagement Fees-Sensory Room	2006	\$ 900	\$ 60	15	\$ 60	\$	\$ 160	37
38	Facility anagement Fees-Sensory Room	2006	300	20	15	20		52	38
39	Street Sign-McAuley	2007	4,465	447	10	447		819	39
40	Street Sign-McAuley	2007	2,125	212	10	212		389	40
41	Mc Auley Residence-Prior to 2006		17,260,535	431,820	40	431,820		1,592,585	41
42									42
43	Connolly Center Laundry allocated based on weight of laund		1,088,766	27,718	5 20	27,718	0	124,100	43
44	Resource Center allocated based on # of residents		35,303	2,427	5 25	2,427	0	8,411	44
45	Staff Development allocation based on # of emp trained		6,954	575	5 25	575		2,585	45
46	Food Services allocated based on # of meals		131,479	3,273	5 25	5,924	2,651	94,602	46
47	Building Operations allocation based on squ feet		3,208,387	114,267	5 25	115,068	801	1,814,740	47
48	Therapy dept allocation based on staff hours		209,805	10,833	5 25	10,833	0	100,439	48
49	MGA alloc based # of employees, direct exp and # of IT user accts.		789,917	35,185		42,370	7,185	434,193	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)		\$ 23,146,014	\$ 649,300		\$ 659,937	\$ 10,638	\$ 4,237,769	70

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

Facility Name & ID Number McAuley Residence

# 0045906

Report Period Beginning:

July 1 2008

Ending:

June 30, 2009

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	\$ 2,645,031	\$ 184,802	\$ 184,802	\$	10	\$ 1,316,129	71
72	Current Year Purchases	65,133	5,129	5,129		10	5,129	72
73	Fully Depreciated Assets	1,826,632					1,826,632	73
74								74
75	TOTALS	\$ 4,536,796	\$ 189,931	\$ 189,931	\$		\$ 3,147,890	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	residents	2002 Chevy van	1/1/2003	\$ 33,545	\$	\$	\$	4	\$ 33,545	76
77	residents	2005 Ford E450 van	11/8/2005	58,435	6,493	6,493		3	58,435	77
78	campus alloc from bldg ops-see attached listing of autos			130,628	10,594	10,594		3	103,546	78
79										79
80	TOTALS			\$ 222,608	\$ 17,087	\$ 17,087	\$		\$ 195,526	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)	\$ 27,905,419	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 856,318	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 866,955	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,638	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,581,185	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	\$ 6,302,144	\$ 417,240	\$ 4,404,953	86
87	Auto alloc to other prog	716,344	62,095	568,035	87
88	Bldg & Improv alloc to other prog	80,322,795	2,891,098	39,343,145	88
89	Land	401,707			89
90					90
91	TOTALS	\$ 87,742,990	\$ 3,370,433	\$ 44,316,133	91

G. Construction-in-Progress

	Description	Cost	
92	CILA	\$ 799,229	92
93	4 new homes on campus	3,418,581	93
94	various renovations on campus	295,693	94
95		\$ 4,513,503	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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 other staff 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. <u>CLASSROOM PORTION:</u></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. <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		26		26
3	Classroom Wages (a)		9,863		9,863
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 9,889	\$	\$ 9,889
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	9,889		

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 2008Ending: June 30, 2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2009 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 10,873,353	\$	1
2	Cash-Patient Deposits	425,258		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>35,000</u> )	10,589,969		3
4	Supply Inventory (priced at )	251,270		4
5	Short-Term Investments	7,260,486		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	53,314		7
8	Accounts Receivable (owners or related parties)	3,113,201		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 32,566,851	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	401,707		13
14	Buildings, at Historical Cost	103,468,809		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	11,777,892		16
17	Accumulated Depreciation (book methods)	(51,897,318)		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> )	4,513,504		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 68,264,594	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 100,831,445	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 815,084	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	409,964		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,533,758		30
31	Accrued Taxes Payable (excluding real estate taxes)	158,975		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Deferred Revenue</u>	181,068		36
37	<u>Other Liabilities and ARO</u>	1,816,462		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,915,311	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,915,311	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 94,916,134	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 100,831,445	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>92,453,897</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>92,453,897</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(4,661,401)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	14,408,467	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <u>Net Loss from North</u>	(8,703,708)	<b>15</b>
<b>16</b>	Other (describe) <u>Development &amp; Community Relations</u>	(1,959,956)	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (916,598)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<u>Changes in Temp Restricted Net Assets</u>	(13,220,334)	<b>18</b>
<b>19</b>	<u>Released from Restrictions</u>	16,499,210	<b>19</b>
<b>20</b>	<u>Investment activity/insurance proceeds</u>	325,255	<b>20</b>
<b>21</b>	<u>Net Asset Reclassification</u>	(225,296)	<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 3,378,835	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>94,916,134</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: July 1 2008Ending: June 30, 2009

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,383,848	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,383,848	3
<b>B. Ancillary Revenue</b>			
4	Day Care	549,239	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 549,239	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,933,087	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,209,305	31
32	Health Care	7,670,328	32
33	General Administration	2,871,975	33
<b>B. Capital Expense</b>			
34	Ownership	914,269	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	467,709	35
36	Provider Participation Fee	460,902	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,594,488	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(4,661,401)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (4,661,401)	43

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

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

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

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

Facility Name & ID Number **McAuley Residence**

# **0045906**

Report Period Beginning: **July 1 2008**

Ending:

**June 30, 2009**

**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	3,292	3,761	\$ 144,405	\$ 38.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,867	31,221	926,442	29.67	3
4	Licensed Practical Nurses	35,158	39,344	996,569	25.33	4
5	CNAs & Orderlies	164,430	180,157	2,442,248	13.56	5
6	CNA Trainees					6
7	Licensed Therapist	5,380	6,183	203,123	32.85	7
8	Rehab/Therapy Aides	16,333	18,885	322,082	17.05	8
9	Activity Director					9
10	Activity Assistants	1,417	1,610	29,430	18.28	10
11	Social Service Workers	3,356	3,813	81,070	21.26	11
12	Dietician	185	193	6,369	33.00	12
13	Food Service Supervisor	213	240	9,811	40.88	13
14	Head Cook	716	811	21,344	26.32	14
15	Cook Helpers/Assistants	2,654	2,885	45,159	15.65	15
16	Dishwashers	1,445	1,537	16,985	11.05	16
17	Maintenance Workers	8,295	9,278	195,998	21.13	17
18	Housekeepers	19,036	25,905	267,749	10.34	18
19	Laundry	12,577	14,132	183,994	13.02	19
20	Administrator	2,036	2,262	117,526	51.96	20
21	Assistant Administrator					21
22	Other Administrative	12,327	13,975	371,890	26.61	22
23	Office Manager					23
24	Clerical	6,508	7,680	119,332	15.54	24
25	Vocational Instruction	3,096	3,096	24,765	8.00	25
26	Academic Instruction	347	399	9,863	24.72	26
27	Medical Director	987	1,083	94,378	87.14	27
28	Qualified MR Prof. (QMRP)	17,807	20,511	452,464	22.06	28
29	Resident Services Coordinator	19,121	21,561	431,345	20.01	29
30	Habilitation Aides (DD Homes)	44,395	50,369	710,430	14.10	30
31	Medical Records	2,080	2,316	45,128	19.49	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Teacher</u>	17,172	19,905	405,803	20.39	33
34	TOTAL (lines 1 - 33)	428,230	483,112	\$ 8,675,702 *	\$ 17.96	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	194	\$ 6,531	1	35
36	Medical Director				36
37	Medical Records Consultant		1,543	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1,768	70,700	10a	41
42	Respiratory Therapy Consultant	84	3,360	10a	42
43	Speech Therapy Consultant	418	21,307	10a	43
44	Activity Consultant		3,808	11	44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>		332	10	46
47	<u>Doctor</u>		32,528	10	47
48	<u>Psych</u>		12,962	10a	48
49	TOTAL (lines 35 - 48)	2,464	\$ 153,071		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sr. Rosemary Connelly	Executive Director	N/A	\$ 14,721	Workers' Compensation Insurance	\$ 124,062	IDPH License Fee	\$	
Mary Pat O'Brien	Asst. Executive Director	N/A	16,572	Unemployment Compensation Insurance	22,698	Advertising: Employee Recruitment		
Denise Tigges	Admistrator	N/A	16,290	FICA Taxes	618,755	Health Care Worker Background Check		
Michael Diaz	Admistrator	N/A	7,350	Employee Health Insurance	611,216	(Indicate # of checks performed <u>220</u> )	7,709	
Lois Gates	Asst. Executive Director	N/A	16,538	Employee Meals		<u>Center for Disability and Elder Law successo</u>	750	
Chris Hegg/Joe Ferrera	Administrator	N/A	17,031	Illinois Municipal Retirement Fund (IMRF)*		<u>Membership Dues</u>	6,860	
Kevin Connelly/Fr. Jack Clair	CFO/Asst Exe Dir	N/A	29,024	<u>Emp Tuition Reimbursement/Other</u>	47,341	<u>Subscription</u>	492	
TOTAL (agree to Schedule V, line 17, col. 1)				<u>Dental Insurance</u>	44,001	<u>Recruiting Expense</u>	2,669	
(List each licensed administrator separately.)			\$ 117,526	<u>401K Match</u>	372,163	<u>Computer licensing</u>	10,342	
B. Administrative - Other				<u>Long-Term Disability and Life Insurance</u>	58,435	<u>Bank fees</u>	6,645	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
<u>Off-Site Recreational Facility-100% is unallowable and is adjuste</u>			\$ 6,455	\$ 1,898,671		\$ 35,467		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 6,455	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description		Line #	Amount	
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description		Line #	Amount	Description	Amount
Deloitte & Touche	Audit	\$ 47,276				\$	Out-of-State Travel	\$
ADP Processing	Payroll Service	36,345						
Burke, Warren, MacKay & Serr	Legal	3,396						
Ellison, Neilson, Zehe	Legal -Unallowable	2,126					In-State Travel	
Revere Group	Account Software Consultant	3,881						
Correll	Admin for 401K plan	8,368						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	4,274
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 101,392				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,274

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number McAuley Residence# 0045906Report Period Beginning: July 1 2008 Ending: June 30, 2008**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. 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? 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 221,157 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. \$ 460,902  
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. \$ No 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?  
**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? \_\_\_\_\_  
Firm Name: Deloitte and Touche
- (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.