



Facility Name & ID Number PRESENCE MCAULEY MANOR

# 0042879 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,755	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	2,641	7,618	12,826	23,085	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,641	7,618	12,826	23,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.70%

D. How many bed-hold days during this year were paid by the Department? 0 (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)  
N/A-NONE

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 12/01/97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/01/97 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 78 and days of care provided 9,629

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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	232,000	19,539	7,461	259,000		259,000		259,000		1
2	Food Purchase		156,746		156,746		156,746	(5,519)	151,227		2
3	Housekeeping	141,487	29,670		171,157		171,157		171,157		3
4	Laundry	13,282	3,596	67,906	84,784		84,784		84,784		4
5	Heat and Other Utilities			166,160	166,160		166,160	2,198	168,358		5
6	Maintenance	84,330	50,506	84,973	219,809		219,809	32,766	252,575		6
7	Other (specify):* <b>Pastoral Care</b>	23,787	2,382	19,253	45,422		45,422		45,422		7
8	<b>TOTAL General Services</b>	494,886	262,439	345,753	1,103,078		1,103,078	29,445	1,132,523		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,245	30,245		30,245		30,245		9
10	Nursing and Medical Records	2,357,310	290,625	30,249	2,678,184		2,678,184	(5,462)	2,672,722		10
10a	Therapy			910,425	910,425		910,425		910,425		10a
11	Activities	56,059	894	19,545	76,498		76,498	(18,865)	57,633		11
12	Social Services	52,514	186	1,109	53,809		53,809		53,809		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,465,883	291,705	991,573	3,749,161		3,749,161	(24,327)	3,724,834		16
	<b>C. General Administration</b>										
17	Administrative	329,454	17,156	629,591	976,201		976,201	(175,193)	801,008		17
18	Directors Fees										18
19	Professional Services			7,497	7,497		7,497	8,536	16,033		19
20	Dues, Fees, Subscriptions & Promotions			14,100	14,100		14,100	4,745	18,845		20
21	Clerical & General Office Expenses			12,700	12,700		12,700	(3,564)	9,136		21
22	Employee Benefits & Payroll Taxes			964,337	964,337		964,337	97,715	1,062,052		22
23	Inservice Training & Education							652	652		23
24	Travel and Seminar			5,648	5,648		5,648	2,035	7,683		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			110,116	110,116		110,116	145	110,261		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	329,454	17,156	1,743,989	2,090,599		2,090,599	(64,929)	2,025,670		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,290,223	571,300	3,081,315	6,942,838		6,942,838	(59,811)	6,883,027		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 PRESENCE MCAULEY MANOR

#0042879

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## 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			244,750	244,750		244,750	(5,721)	239,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			170,700	170,700		170,700	104,224	274,924			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							32,965	32,965			34
35	Rent-Equipment & Vehicles			65,016	65,016		65,016	883	65,899			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			480,466	480,466		480,466	132,351	612,817			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,155,514		1,155,514		1,155,514	(466,703)	688,811			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,260	130,260		130,260		130,260			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,155,514	130,260	1,285,774		1,285,774	(466,703)	819,071			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,290,223	1,726,814	3,692,041	8,709,078		8,709,078	(394,163)	8,314,915			45

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

Facility Name & ID Number PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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				3
4	Non-Patient Meals	(6,500)	2		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	3,593	30		9
10	Interest and Other Investment Income	(11,422)	32		10
11	Discounts, Allowances, Rebates & Refunds	(466,703)	39		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	(3,326)	30		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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,071)	20		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	(164,466)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (649,895)</b>		<b>\$</b>	<b>30</b>

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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (649,895)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

PRESENCE MCAULEY MANOR

ID# 0042879

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEVELOPMENT MISC	\$ (5,949)	21	1
2	BEAUTY AND BARBER	(19,523)	11	2
3	RADIOLOGY AND XRAY	(5,462)	10	3
4	Merger Related Home Office Allocation	(133,532)	17	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				25
26				26
27				27
28				28
29				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	<b>Total</b>	(164,466)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(6,500)	981	0	0	0	0	0	0	0	0	0	(5,519)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,198	0	0	0	0	0	0	0	0	0	2,198	5
6	Maintenance	0	892	31,874	0	0	0	0	0	0	0	0	32,766	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,500)</b>	<b>4,071</b>	<b>31,874</b>	<b>0</b>	<b>29,445</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	(5,462)	0	0	0	0	0	0	0	0	0	0	(5,462)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(19,523)	658	0	0	0	0	0	0	0	0	0	(18,865)	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	0	0	0	0	0	0	0	0	0	0	0	0	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>(24,985)</b>	<b>658</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>(24,327)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(133,532)	36,638	(78,299)	0	0	0	0	0	0	0	0	(175,193)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,536	0	0	0	0	0	0	0	0	0	8,536	19
20	Fees, Subscriptions & Promotions	(1,071)	5,816	0	0	0	0	0	0	0	0	0	4,745	20
21	Clerical & General Office Expenses	(5,949)	2,385	0	0	0	0	0	0	0	0	0	(3,564)	21
22	Employee Benefits & Payroll Taxes	0	25,482	72,233	0	0	0	0	0	0	0	0	97,715	22
23	Inservice Training & Education	0	652	0	0	0	0	0	0	0	0	0	652	23
24	Travel and Seminar	0	2,035	0	0	0	0	0	0	0	0	0	2,035	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	145	0	0	0	0	0	0	0	0	0	145	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(140,552)</b>	<b>81,689</b>	<b>(6,066)</b>	<b>0</b>	<b>(64,929)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(172,037)</b>	<b>86,418</b>	<b>25,808</b>	<b>0</b>	<b>(59,811)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE MCAULEY MANOR# 0042879

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

## 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	267	0	(5,988)	0	0	0	0	0	0	0	0	(5,721)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,422)	0	115,646	0	0	0	0	0	0	0	0	104,224	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	32,965	0	0	0	0	0	0	0	0	32,965	34
35	Rent-Equipment & Vehicles	0	0	883	0	0	0	0	0	0	0	0	883	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(11,155)</b>	<b>0</b>	<b>143,506</b>	<b>0</b>	<b>132,351</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	(466,703)	0	0	0	0	0	0	0	0	0	0	(466,703)	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>(466,703)</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>(466,703)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(649,895)	86,418	169,314	0	0	0	0	0	0	0	0	(394,163)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Vill	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Cai	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 981	\$ 981	1
2	V	5 Utilities		Presence Life Connections	100.00%	2,198	2,198	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	892	892	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	658	658	4
5	V	17 Admin - Misc. Other	230,352	Presence Life Connections	100.00%	132,920	(97,432)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	134,070	134,070	6
7	V	19 Professional Services		Presence Life Connections	100.00%	8,536	8,536	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	5,816	5,816	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	2,385	2,385	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	25,482	25,482	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	652	652	11
12	V	24 Travel		Presence Life Connections	100.00%	2,035	2,035	12
13	V	26 Insurance		Presence Life Connections	100.00%	145	145	13
14	Total		\$ 230,352			\$ 316,770	\$ * 86,418	14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 1,626	\$ 1,626
16	V	32 Interest		Presence Life Connections	100.00%	3	3
17	V	34 Rent - Facility		Presence Life Connections	100.00%	10,809	10,809
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	883	883
19	V	17 Admin Salaries		Presence Health	100.00%	88,514	88,514
20	V	22 Employee Benefits		Presence Health	100.00%	72,233	72,233
21	V	30 Depreciation	43,183	Presence Health	100.00%	35,569	(7,614)
22	V	34 Rent Facility		Presence Health	100.00%	22,156	22,156
23	V	17 Admin Consulting,Other	399,239	Presence Health	100.00%	39,210	(360,029)
24	V	17 Information Systems Salaries		Presence Health	100.00%	26,527	26,527
25	V	17 Information Systems - Other		Presence Health	100.00%	104,183	104,183
26	V	17 Admin Salaries		Presence Health	100.00%	24,890	24,890
27	V	17 Information Systems Salaries		Presence Health	100.00%	37,370	37,370
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	31,874	31,874
29	V	17 Admin Consulting,Other		Presence Health	100.00%	246	246
30	V	32 Admin - Interest Expense		Presence Health	100.00%	115,643	115,643
31	V	39 Ancillary Services - Other	1,155,514	Presence Senior Services Pharmacy	100.00%	1,155,514	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 1,597,936			\$ 1,767,250	\$ * 169,314

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

Facility Name & ID Number

PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compat	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Ca	Northlake	Independent Living	13
14					Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JO-ANN COSTANTINO	BOD						1
2	NANCY T. DOWD	BOD						2
3	FLORIDA FREEMAN	BOD						3
4	PATRICIA GOMEZ	BOD						4
5	JAMES C. HAGEN	BOD						5
6	LUCIA JONES	BOD						6
7	TERESA (TESS) KWIATKOWSKI	BOD						7
8	CONNIE S. MARCH	BOD						8
9	SR. MARIE MASON	BOD						9
10	SALLIE MILLER	BOD						10
11	PHYLLIS NICHOLS	BOD						11
12	LAWRENCE R. PANKAU	BOD						12
13	PAUL SKIEM	BOD						13
14	THOMAS E. SMITH	BOD						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

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										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 PRESENCE MCAULEY MANOR

# 0042879 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Presence Life Connections  
 Street Address 18927 Hickory Creek Dr, Ste 300  
 City / State / Zip Code Mokena, IL 60448  
 Phone Number (708)478-7900  
 Fax Number (708)478-5387

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	2	Food	7,173,919	29	\$ 30,538		230,352	\$ 981	1
2	5	Utilities	7,173,919	29	68,461		230,352	2,198	2
3	6	Maintenance - Other	7,173,919	29	27,769		230,352	892	3
4	11	Activities-Special Events	7,173,919	29	20,505		230,352	658	4
5	17	Admin - Misc. Other	7,173,919	29	4,139,560		230,352	132,920	5
6	17	Administrative Salaries	7,173,919	29	4,175,380	4,175,380	230,352	134,070	6
7	19	Professional Services	7,173,919	29	265,828		230,352	8,536	7
8	20	Dues,Subscriptions	7,173,919	29	181,120		230,352	5,816	8
9	21	Clerical Supplies	7,173,919	29	74,289		230,352	2,385	9
10	22	Employee Benefits	7,173,919	29	793,578		230,352	25,482	10
11	23	Education/Conference	7,173,919	29	20,317		230,352	652	11
12	24	Travel	7,173,919	29	63,365		230,352	2,035	12
13	26	Insurance	7,173,919	29	4,528		230,352	145	13
14	30	Depreciation	7,173,919	29	50,634		230,352	1,626	14
15	32	Interest	7,173,919	29	87		230,352	3	15
16	34	Rent - Facility	7,173,919	29	336,621		230,352	10,809	16
17	35	Rent - Equipment	7,173,919	29	27,511		230,352	883	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 10,280,091	\$ 4,175,380		\$ 330,091	25

Facility Name & ID Number PRESENCE MCAULEY MANOR

# 0042879 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Presence Health  
 Street Address 100 North River Road  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number (815)806-2327  
 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	17	Admin Salaries	Operating Expense	4,947,793	17	\$ 1,096,956	\$ 1,096,956	399,239	\$ 88,514	1
2	22	Employee Benefits	Operating Expense	4,947,793	17	895,186		399,239	72,233	2
3	30	Depreciation	Operating Expense	535,127	17	440,774		43,183	35,569	3
4	34	Rent Facility	Operating Expense	4,947,793	17	274,581		399,239	22,156	4
5	17	Admin Consulting,Other	Operating Expense	4,947,793	17	485,930		399,239	39,210	5
6	17	Information Systems Salaries	Operating Expense	4,947,793	17	328,752	328,752	399,239	26,527	6
7	17	Information Systems - Other	Operating Expense	4,947,793	17	1,291,143		399,239	104,183	7
8	17	Admin Salaries	Direct Cost	4,947,793	17	308,463	308,463	399,239	24,890	8
9	17	Information Systems Salaries	Direct Cost	4,947,793	17	463,127	463,127	399,239	37,370	9
10	6	Information Systems - Equip Mai	Direct Cost	4,947,793	17	395,016		399,239	31,874	10
11	17	Admin Consulting,Other	Direct Cost	4,947,793	17	3,054		399,239	246	11
12	32	Admin - Interest Expense	Direct Cost	4,947,793	17	1,433,168		399,239	115,643	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					\$ 7,416,150	\$ 2,197,298		\$ 598,415	25

Facility Name & ID Number PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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 Presence Senior Services Pharmacy  
 Street Address 670 North Convent Street  
 City / State / Zip Code Bourbonnais, Illinois 60914  
 Phone Number ( 815)936-3644  
 Fax Number ( 815)936-3238

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 1,155,514	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				\$	\$		\$ 1,155,514	25

Facility Name & ID Number

PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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		3	4	5	6		8	9	10					
		Related**					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	Home Office Allocation						\$	\$			\$ 115,646					
2																
3																
4																
5																
	<b>Working Capital</b>															
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 115,646					
	<b>B. Non-Facility Related*</b>															
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 115,646					

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 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 2013 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2008	_____	8	<b>FOR BHF USE ONLY</b>		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE MCAULEY MANOR COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0042879

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 2012 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 2012.

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

**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 and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 PRESENCE MCAULEY MANOR

# 0042879 Report Period Beginning:

01/01/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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).

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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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	87	1986	1986	\$ 4,218,962	\$	25	\$	\$	\$ 4,218,962
5									
6									
7									
8									
	Improvement Type**								
9	VARIOUS		1987	9,470		15			9,450
10	VARIOUS		1988	18,530		15			18,530
11	VARIOUS		1989	7,670		15			7,670
12	VARIOUS		1990	2,400		15			2,400
13	VARIOUS		1991	8,900		15			8,900
14	VARIOUS		1992	1,500		10			1,500
15	VARIOUS		1996	7,744		9			7,744
16	VARIOUS		1994	18,925		8			18,925
17	VARIOUS		1995	4,742		8			4,742
18	VARIOUS		1996	1,683		5			1,683
19	VARIOUS		1997	5,525		5			5,525
20	VARIOUS		1999	2,941		5			2,941
21	VARIOUS		2000	1,200		5			1,200
22	VARIOUS		2001	62,210		9			62,210
23	VARIOUS		2002	45,675		8			45,675
24	VARIOUS		2003	57,530	3,326	11	3,326		48,543
25	VARIOUS		2004	75,363	5,568	12	5,568		69,615
26	VARIOUS		2005	238,378	17,708	11	17,708		160,504
27	VARIOUS		2006	59,391	4,757	13	4,757		35,796
28	VARIOUS		2007	428,047	33,341	13	33,341		217,275
29	VARIOUS		2008	36,226	3,623	10	3,623		19,355
30	VARIOUS		2009	111,052	10,917	11	10,917		49,073
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	NEW WINDOW TREATMENTS	2010	\$ 4,279	\$ 856	5	\$ 856	\$	\$ 2,995	37
38	DINING ROOM FLOORING AND WALL COVERINGS	2010	20,223	2,022	10	2,022		8,089	38
39	PATIENT ROOM WALL COVERINGS AND PAINT	2010	22,899	2,290	10	2,290		8,015	39
40	HVAC REPAIRS	2010	20,877	2,982	7	2,982		10,438	40
41	NEW WINDOW FRAMES & WINDOWS	2010	36,723	1,836	20	1,836		6,426	41
42	PAINTING OF HALLWAYS AND CONVENT	2010	10,064	2,013	5	2,013		7,044	42
43	NEW CARPETING IN COMMUNITY	2010	8,849	1,770	5	1,770		6,194	43
44	INSTALL NEW ELECTRONIC DOOR EDGE	2010	5,060	506	10	506		1,771	44
45	DX-9100 BASE AND TEMPERATURE CONTROL	2010	3,991	399	10	399		1,397	45
46	LEAK REPAIRS \ DUCTWORK INSULATION AND FLASHING	2010	9,757	650	15	650		2,277	46
47	DEDUCTION OF NON-CARE ASSETS	2010	(10,064)	(2,013)	-5	(2,013)		(7,044)	47
48									48
49	CHAPEL CARPETING & PAINT	2011	9,530	1,906	5	1,906		4,765	49
50	SPRINKLER ELEVATOR PIT	2011	2,722	109	25	109		272	50
51	CEILING TILE	2011	2,792	349	8	349		873	51
52	FLOORING	2011	3,905	391	10	391		976	52
53	DIESEL TANK FOR GENERATORS	2011	4,950	990	5	990		2,475	53
54	NEW ROOF	2011	19,900	1,990	10	1,990		4,975	54
55	75 NEW PELLA WINDOWS	2011	41,084	4,108	10	4,108		9,533	55
56	CALL LIGHT	2011	1,398	93	15	93		233	56
57	VINYL FLOORING 2ND FLOOR	2011	19,788	1,979	10	1,979		4,947	57
58	PAINT 1ST AND 2ND FLOOR HALLWAYS	2011	5,650	1,130	5	1,130		2,825	58
59	PAINT 2ND FLOOR CORRIDOR	2011	6,862	1,372	5	1,372		2,059	59
60									60
61	RADIATOR REPAIR	2012	5,964	398	15	398		596	61
62	HVAC	2012	16,220	1,081	15	1,081		1,622	62
63	TEKNOFLOR SHEET VINYL 2ND FLOOR RESIDENT CORRI	2012	25,250	2,525	10	2,525		3,788	63
64									64
65	N/A	2013							65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,722,737	\$ 110,972		\$ 110,972	\$	\$ 5,105,759	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 798,519	\$ 83,676	\$ 83,676	\$	11	\$ 431,438	71
72	Current Year Purchases	74,096	3,593	7,186	3,593	11	3,593	72
73	Fully Depreciated Assets	175,365				8	175,365	73
74	Home Office Allocation		37,195	37,195				74
75	TOTALS	\$ 1,047,980	\$ 124,464	\$ 128,057	\$ 3,593		\$ 610,396	75

D. Vehicle Costs. (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	PLANT ENGINEERING	1999 FORD ELDORADO -15 CA	1999	\$ 42,261	\$	\$	\$	8	\$ 42,261	76
77										77
78										78
79										79
80	TOTALS			\$ 42,261	\$	\$	\$		\$ 42,261	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)	\$ 6,812,978	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,436	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 239,029	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,593	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,758,416	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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	Home Office Allocation				32,965			5
6								6
7	TOTAL				\$ 32,965			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 65,899 Description: Nursing \$57453, Plant Operations \$1008, Administration \$6555, Home office \$883

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10a, 3	hrs	\$	7,039	\$	411,797	\$	7,039	\$	411,797	1	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		916		53,611		916		53,611	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a, 3	hrs		7,599		445,017		7,599		445,017	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39, 3	# of prescripts					1,155,514			1,155,514	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>			\$	15,554	\$	910,425	\$	1,155,514	15,554	\$	2,065,939	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 **PRESENCE MCAULEY MANOR**# **0042879**Report Period Beginning: **01/01/2013**

Ending:

**12/31/2013****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(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	\$ 13,661,975	\$	1
2	Cash-Patient Deposits	68,270		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	15,696,287		3
4	Supply Inventory (priced at )	800,313		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	385,660		7
8	Accounts Receivable (owners or related parties)	147,435		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 30,759,940</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,299,457		12
13	Land	4,046,124		13
14	Buildings, at Historical Cost	99,124,432		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	23,581,218		16
17	Accumulated Depreciation (book methods)	(69,655,808)		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 (spec <u>Deferred Comp</u> )	333,555		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 69,728,978</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 100,488,918</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 8,064,524	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,175,855		28
29	Short-Term Notes Payable	73,289		29
30	Accrued Salaries Payable	3,854,754		30
31	Accrued Taxes Payable (excluding real estate taxes)	164,651		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,706,940		32
33	Accrued Interest Payable	10,831		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	8,866,479		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 23,917,323</b>	<b>\$</b>	<b>38</b>
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	894,135		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	510,572		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	438,744		43
44	<u>Deferred Lease Payable</u>	32,265		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 1,875,716</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 25,793,039</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 74,695,879</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 100,488,918</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 77,050,086	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(4,370,200)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,574,718	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,254,604	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	184,124	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	496,473	11
12	Expenditures for Specific Purposes	(239,322)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 441,275	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 74,695,879	24 *

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

**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		
<b>I. Revenue</b>		<b>Amount</b>		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 5,069,344	1	
2	Discounts and Allowances for all Levels	( )	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,069,344	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,623,230	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,623,230	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	19,523	13	
14	Non-Patient Meals	6,500	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,658,043	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	5,462	20	
21	Other Medical Services		21	
22	Laundry	7,432	22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,696,960	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions	24,815	24	
25	Interest and Other Investment Income***	11,422	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 36,237	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Purchase Rebates</b>	466,703	28	
28a	<b>Other Misc Income</b>	728	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 467,431	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,893,202	30	

		2		
<b>II. Expenses</b>		<b>Amount</b>		
<b>A. Operating Expenses</b>				
31	General Services	1,103,078	31	
32	Health Care	3,749,161	32	
33	General Administration	2,090,599	33	
<b>B. Capital Expense</b>				
34	Ownership	480,466	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,155,514	35	
36	Provider Participation Fee	130,260	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,709,078	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	184,124	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 184,124	43	

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 561,161	44
45	Private Pay - Net Inpatient Revenue	1,889,612	45
46	Medicare - Net Inpatient Revenue	1,836,676	46
47	Other-(specify) <u>Insurance</u>	781,895	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,069,344	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 **PRESENCE MCAULEY MANOR**

# **0042879**

Report Period Beginning: **01/01/2013**

Ending:

**12/31/2013**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,867	2,160	\$ 86,817	\$ 40.19	1
2	Assistant Director of Nursing	1,840	2,000	71,766	35.88	2
3	Registered Nurses	30,020	32,581	1,022,480	31.38	3
4	Licensed Practical Nurses	8,361	8,719	264,432	30.33	4
5	CNAs & Orderlies	51,371	55,685	778,694	13.98	5
6	CNA Trainees					6
7	Licensed Therapist	604	609	9,896	16.25	7
8	Rehab/Therapy Aides	4,353	5,222	84,662	16.21	8
9	Activity Director	1,482	1,560	29,088	18.65	9
10	Activity Assistants	2,431	2,590	26,677	10.30	10
11	Social Service Workers	2,887	3,019	52,203	17.29	11
12	Dietician	1,017	1,107	31,968	28.88	12
13	Food Service Supervisor	1,464	1,560	35,232	22.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,515	16,372	160,616	9.81	15
16	Dishwashers					16
17	Maintenance Workers	3,937	4,252	85,853	20.19	17
18	Housekeepers	11,902	13,230	142,717	10.79	18
19	Laundry	1,095	1,214	14,353	11.82	19
20	Administrator	1,864	2,080	82,897	39.85	20
21	Assistant Administrator	1,536	1,664	47,701	28.67	21
22	Other Administrative	4,431	4,713	80,475	17.08	22
23	Office Manager	856	1,040	25,127	24.16	23
24	Clerical	112	112	5,510	49.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,689	1,860	30,470	16.38	31
32	Other Health C: Admissions	4,517	4,968	93,253	18.77	32
33	Other(specify) <u>Pastoral Care</u>	1,156	1,288	27,336	21.22	33
34	TOTAL (lines 1 - 33)	156,307	169,605	\$ 3,290,223 *	\$ 19.40	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	88	\$ 5,550	1,3	35
36	Medical Director	Monthly	30,245	9,3	36
37	Medical Records Consultant	30	2,088	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	1,276	11,3	44
45	Social Service Consultant	20	1,100	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	150	\$ 40,259		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	201	\$ 12,530	10,3	50
51	Licensed Practical Nurses	100	4,079	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	301	\$ 16,609		53



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number PRESENCE MCAULEY MANOR

# 0042879

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

## 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. Life Services Network \$4549
- (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? N/A
- (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? N/A
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,058 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,260  
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? No 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? No 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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,500
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG
- (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.