

		FOR BHF USE					

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**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0042879</u></p> <p>Facility Name: <u>PRESENCE MCAULEY MANOR</u></p> <p>Address: <u>400 WEST SULLIVAN RD</u> <u>AURORA</u> <u>60506</u> <small>Number City Zip Code</small></p> <p>County: <u>KANE</u></p> <p>Telephone Number: <u>630-859-3700</u> Fax # <u>630-264-1862</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12-01-97</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501C3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>GEORGE VIEU</u> Telephone Number: <u>708-478-7943</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/15</u> to <u>12/31/15</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MICHAEL R. GORDON</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CFO, VICE PRESIDENT OF FINANCE</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) () () Fax # () ()</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MICHAEL R. GORDON</u> (Date) _____		(Title) <u>CFO, VICE PRESIDENT OF FINANCE</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) () () Fax # () ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																			
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Paid Preparer	(Signed) _____																																				
	(Date) _____																																				
	(Print Name and Title) _____																																				
	(Firm Name & Address) _____																																				
	(Telephone) () () Fax # () ()																																				

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	6,185	4,509	8,579	19,273	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,185	4,509	8,579	19,273	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.69%

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 87 and days of care provided 6,525

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: 12-31-15 Fiscal Year: 12-31-15

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

Facility Name & ID Number

PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		18,831	479,800	498,631	498,631		498,631			1
2	Food Purchase		211,411		211,411	211,411	(784)	210,627			2
3	Housekeeping	74,700	28,909	3,090	106,699	106,699		106,699			3
4	Laundry	5,706	3,566	37,745	47,017	47,017		47,017			4
5	Heat and Other Utilities			215,375	215,375	215,375	1,729	217,104			5
6	Maintenance	102,866	104,982	157,408	365,256	365,256	24,692	389,948			6
7	Other (specify):* Pastoral	22,207	2,338	9,227	33,772	33,772		33,772			7
8	TOTAL General Services	205,479	370,037	902,645	1,478,161	1,478,161	25,637	1,503,798			8
	B. Health Care and Programs										
9	Medical Director			24,989	24,989	24,989		24,989			9
10	Nursing and Medical Records	1,649,751	195,111	190,502	2,035,364	2,035,364		2,035,364			10
10a	Therapy	261,057		497,876	758,933	758,933		758,933			10a
11	Activities	58,769	432	5,915	65,116	65,116	413	65,529			11
12	Social Services	43,994	30	1,335	45,359	45,359		45,359			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,013,571	195,573	720,617	2,929,761	2,929,761	413	2,930,174			16
	C. General Administration										
17	Administrative	355,620	14,076	723,333	1,093,029	1,093,029	206,871	1,299,900			17
18	Directors Fees										18
19	Professional Services			23,794	23,794	23,794	31,069	54,863			19
20	Dues, Fees, Subscriptions & Promotions			59,835	59,835	59,835	(441)	59,394			20
21	Clerical & General Office Expenses			19,726	19,726	19,726	304	20,030			21
22	Employee Benefits & Payroll Taxes			695,037	695,037	695,037	98,562	793,599			22
23	Inservice Training & Education			1,050	1,050	1,050	865	1,915			23
24	Travel and Seminar			238	238	238	1,046	1,284			24
25	Other Admin. Staff Transportation			2,511	2,511	2,511		2,511			25
26	Insurance-Prop.Liab.Malpractice			155,433	155,433	155,433	33,765	189,198			26
27	Other (specify):*										27
28	TOTAL General Administration	355,620	14,076	1,680,957	2,050,653	2,050,653	372,041	2,422,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,574,670	579,686	3,304,219	6,458,575	6,458,575	398,091	6,856,666			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			311,715	311,715	311,715	(47,347)	264,368				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			181,499	181,499	181,499	85,733	267,232				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						34,474	34,474				34
35	Rent-Equipment & Vehicles			30,128	30,128	30,128	589	30,717				35
36	Other (specify):*											36
37	TOTAL Ownership			523,342	523,342	523,342	73,449	596,791				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			402,150	402,150	402,150		402,150				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,166	121,166	121,166		121,166				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			523,316	523,316	523,316		523,316				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,574,670	579,686	4,350,877	7,505,233	7,505,233	471,540	7,976,773				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: 1/01/15

Ending: 12/31/15

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	(1,907)	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	(57)	30		9
10	Interest and Other Investment Income	(3,664)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(837)	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	(2,766)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,231)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,231)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

PRESENCE MCAULEY MANOR

ID# 0042879

Report Period Beginning: 1/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ (2,766)	21	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				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	Total		(2,766)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,907)	1,123	0	0	0	0	0	0	0	0	0	(784)	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	1,729	0	0	0	0	0	0	0	0	0	1,729	5
6	Maintenance	0	2,751	21,941	0	0	0	0	0	0	0	0	24,692	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,907)	5,603	21,941	0	25,637	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	413	0	0	0	0	0	0	0	0	0	413	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	TOTAL Health Care and Programs	0	413	0	0	0	0	0	0	0	0	0	413	16
	C. General Administration													
17	Administrative	0	(85,182)	292,053	0	0	0	0	0	0	0	0	206,871	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	31,069	0	0	0	0	0	0	0	0	0	31,069	19
20	Fees, Subscriptions & Promotions	(837)	396	0	0	0	0	0	0	0	0	0	(441)	20
21	Clerical & General Office Expenses	(2,766)	3,070	0	0	0	0	0	0	0	0	0	304	21
22	Employee Benefits & Payroll Taxes	0	36,066	62,496	0	0	0	0	0	0	0	0	98,562	22
23	Inservice Training & Education	0	865	0	0	0	0	0	0	0	0	0	865	23
24	Travel and Seminar	0	1,046	0	0	0	0	0	0	0	0	0	1,046	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	33,765	0	0	0	0	0	0	0	0	0	33,765	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,603)	21,095	354,549	0	372,041	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,510)	27,111	376,490	0	398,091	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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)	
	D. Ownership													
30	Depreciation	(57)	0	(47,290)	0	0	0	0	0	0	0	0	(47,347)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,664)	0	89,397	0	0	0	0	0	0	0	0	85,733	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	34,474	0	0	0	0	0	0	0	0	34,474	34
35	Rent-Equipment & Vehicles	0	0	589	0	0	0	0	0	0	0	0	589	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,721)	0	77,170	0	73,449	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(9,231)	27,111	453,660	0	0	0	0	0	0	0	0	471,540	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 Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	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	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)	
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 1,123	\$ 1,123	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,729	1,729	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	2,751	2,751	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	413	413	4
5	V	17 Admin - Misc. Other	275,504	Presence Life Connections	100.00%	10,375	(265,129)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	179,947	179,947	6
7	V	19 Professional Services		Presence Life Connections	100.00%	31,069	31,069	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	396	396	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	3,070	3,070	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	36,066	36,066	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	865	865	11
12	V	24 Travel		Presence Life Connections	100.00%	1,046	1,046	12
13	V	26 Insurance		Presence Life Connections	100.00%	33,765	33,765	13
14	Total		\$ 275,504			\$ 302,615	\$ * 27,111	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%	\$ 3,232	\$	3,232	15
16	V	32 Interest		Presence Life Connections	100.00%	0			16
17	V	34 Rent - Facility		Presence Life Connections	100.00%	16,165		16,165	17
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	589		589	18
19	V	17 Admin Salaries		Presence Health	100.00%	103,038		103,038	19
20	V	22 Employee Benefits		Presence Health	100.00%	62,496		62,496	20
21	V	30 Depreciation	101,080	Presence Health	100.00%	50,558		(50,522)	21
22	V	34 Rent Facility		Presence Health	100.00%	18,309		18,309	22
23	V	17 Admin Consulting,Other	447,832	Presence Health	100.00%	380,164		(67,668)	23
24	V	17 Information Systems Salaries		Presence Health	100.00%	36,537		36,537	24
25	V	17 Information Systems - Other		Presence Health	100.00%	130,546		130,546	25
26	V	17 Admin Salaries		Presence Health	100.00%	30,198		30,198	26
27	V	17 Information Systems Salaries		Presence Health	100.00%	41,638		41,638	27
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	21,941		21,941	28
29	V	17 Admin Consulting,Other		Presence Health	100.00%	17,764		17,764	29
30	V	32 Admin - Interest Expense		Presence Health	100.00%	89,397		89,397	30
31	V	39 Ancillary Services - Other	402,150	Presence Senior Services Pharmacy	100.00%	402,150			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 951,062			\$ 1,404,722	\$ *	453,660	39

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

Facility Name & ID Number

PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy Dowd	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	James Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6	Joseph Hugar	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	John Larson	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8	Sr Marie Mason	BOD			Presence St. Vincent	Freeport	Community Living	8
9	Sallie Miller	BOD			Presence Behavioral H	Broadview	Parent	9
10	Phyllis Nichols	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Lawrence Pankau, MD	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Tim Phillippe	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Thomas Smith	BOD			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 Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Est	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	NA								\$	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:

1/01/15

Ending: 12/31/15

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	Management Fee Income 7,761,581	27	\$ 31,634		275,504	\$ 1,123	1
2	5	Utilities	Management Fee Income 7,761,581	27	48,706		275,504	1,729	2
3	6	Maintenance - Other	Management Fee Income 7,761,581	27	77,498		275,504	2,751	3
4	11	Activities-Special Events	Management Fee Income 7,761,581	27	11,644		275,504	413	4
5	17	Admin - Misc. Other	Management Fee Income 7,761,581	27	292,301		275,504	10,375	5
6	17	Administrative Salaries	Management Fee Income 7,761,581	27	5,069,517	5,069,517	275,504	179,947	6
7	19	Professional Services	Management Fee Income 7,761,581	27	875,274		275,504	31,069	7
8	20	Dues,Subscriptions	Management Fee Income 7,761,581	27	11,166		275,504	396	8
9	21	Clerical Supplies	Management Fee Income 7,761,581	27	86,492		275,504	3,070	9
10	22	Employee Benefits	Management Fee Income 7,761,581	27	1,016,065		275,504	36,066	10
11	23	Education/Conference	Management Fee Income 7,761,581	27	24,366		275,504	865	11
12	24	Travel	Management Fee Income 7,761,581	27	29,466		275,504	1,046	12
13	26	Insurance	Management Fee Income 7,761,581	27	951,237		275,504	33,765	13
14	30	Depreciation	Management Fee Income 7,761,581	27	91,051		275,504	3,232	14
15	32	Interest	Management Fee Income 7,761,581	27	0		275,504	0	15
16	34	Rent - Facility	Management Fee Income 7,761,581	27	455,407		275,504	16,165	16
17	35	Rent - Equipment	Management Fee Income 7,761,581	27	16,606		275,504	589	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 9,088,430	\$ 5,069,517		\$ 322,601	25

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending: 12/31/15

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	5,977,354	17	\$ 1,375,283	\$ 1,375,283	447,832	\$ 103,038	1
2	22	Employee Benefits	Operating Expense	5,977,354	17	834,149		447,832	62,496	2
3	30	Depreciation	Operating Expense	1,607,196	17	803,889		101,080	50,558	3
4	34	Rent Facility	Operating Expense	5,977,354	17	244,378		447,832	18,309	4
5	17	Admin Consulting,Other	Operating Expense	5,977,354	17	5,074,164		447,832	380,164	5
6	17	Information Systems Salaries	Operating Expense	5,977,354	17	487,675	487,675	447,832	36,537	6
7	17	Information Systems - Other	Operating Expense	5,977,354	17	1,742,443		447,832	130,546	7
8	17	Admin Salaries	Direct Cost	5,977,354	17	403,064	403,064	447,832	30,198	8
9	17	Information Systems Salaries	Direct Cost	5,977,354	17	555,758	555,758	447,832	41,638	9
10	6	Information Systems - Equip Mai	Direct Cost	5,977,354	17	292,852		447,832	21,941	10
11	17	Admin Consulting,Other	Direct Cost	5,977,354	17	237,106		447,832	17,764	11
12	32	Admin - Interest Expense	Direct Cost	5,977,354	17	1,193,207		447,832	89,397	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					\$ 13,243,968	\$ 2,821,780		\$ 982,586	25

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 60614
 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		\$	\$		\$ 402,150	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				\$	\$		\$ 402,150	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		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			
	A. Directly Facility Related															
	Long-Term															
1	Home Office Allocation						\$	\$			\$ 89,397	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$	\$			\$ 89,397	9				
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$	\$			\$ 89,397	15				

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2014 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 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		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.

2014 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 2014 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 2014.

	(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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

1/01/15 Ending:

12/31/15

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	VARIOUS		1987	9,470		15			9,450	9
10	VARIOUS		1994	18,925		8			18,925	10
11	VARIOUS		1995	4,742		8			4,742	11
12	VARIOUS		1996	1,683		5			1,683	12
13	VARIOUS		1997	5,525		5			5,525	13
14	VARIOUS		1999	2,941		5			2,941	14
15	VARIOUS		2000	1,200		5			1,200	15
16	VARIOUS		2001	62,210		9			62,210	16
17	VARIOUS		2003	76,245		9			76,245	17
18	VARIOUS		2004	104,667	4,997	12	4,997		97,420	18
19	VARIOUS		2005	236,034	9,330	11	9,330		186,260	19
20	VARIOUS		2006	44,405	2,925	14	2,925		31,467	20
21	VARIOUS		2007	368,343	26,250	13	26,250		233,829	21
22	VARIOUS		2008	110,916	9,467	10	9,467		89,545	22
23	VARIOUS		2009	111,052	10,577	11	10,577		70,795	23
24	VARIOUS		2010	155,845	12,361	10	12,361		91,486	24
25	VARIOUS		2011	86,281	9,838	11	9,838		43,941	25
26										26
27	HVAC		2012	16,220	1,081	15	1,081		3,777	27
28	PAINT 1ST AND 2ND FLOOR HALLWA		2012	5,650	1,130	5	1,130		4,944	28
29	PAINT 2ND FLOOR CORRIDOR		2012	6,862	1,372	5	1,372		4,938	29
30	RADIATOR		2012	5,964	398	15	398		1,391	30
31	VINYL FLOORING 2ND FLOOR		2012	19,788	1,979	10	1,979		8,853	31
32										32
33	TEKNOFLOR SHEET VINYL 2ND FLOOR		2013	25,250	2,525	10	2,525		8,780	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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	ARCRYLIC SHOWER FLOOR ACRYLIC	2014	\$ 33,916	\$ 3,392	10	\$ 3,392	\$	\$ 5,109	37
38	DOOR RESTRICTORS ON 3 ELEVATOR	2014	6,567	657	10	657		981	38
39	HEATING UNIT	2014	9,003	600	15	600		903	39
40	PANIC DEVICES ON DOUBLE DOORS	2014	6,541	654	10	654		985	40
41	PARKING LOT LIGHTING	2014	7,791	390	20	390		582	41
42	NEW PARKING LOT	2014	25,725	1,715	15	1,715		2,559	42
43	WANDER GUARD SYSTEM FOR SECOND	2014	2,977	595	5	595		893	43
44									44
45	CEILING TILE INSTALLATION	2015	2,153	163	20	108	(55)	163	45
46	CORNER GUARDS HIGH IMPACT WALL	2015	12,928	1,898	10	1,293	(605)	1,898	46
47	DESIGN FEE AND FLOOR PLAN FOR	2015	3,600	268	20	180	(88)	268	47
48	EXTERIOR PAINTING	2015	3,100	517	5	620	103	517	48
49	ICE WATER DISPENSER	2015	3,440	328	7	491	164	328	49
50	FLOORING IN LOWER LVL HALLS/BREAK RM/THERAPY R	2015	58,345	5,789	15	3,890	(1,900)	5,789	50
51	LABOR FOR INSTALLATION OF LIGH	2015	401	30	20	20	(10)	30	51
52	NEW MATTRESSES FOR 86 BEDS	2015	19,986	1,999	5	3,997	1,999	1,999	52
53	PAINT MAIN CORRIDOR ELEVATOR C	2015	12,380	3,619	5	2,476	(1,143)	3,619	53
54	PAINTING LOWER LEVEL HALLWAY	2015	4,965	497	5	993	497	497	54
55	PARKING LOT AND DRIVEWAY	2015	14,845	557	20	742	186	557	55
56	PATIENT TRANSPORTATION SLINGS	2015	2,769	207	20	138	(68)	207	56
57	PAVE PARKING LOT AND DRIVEWAY	2015	11,687	1,217	8	1,461	243	1,217	57
58	PAVING OVERLAY MAIN PARKING LO	2015	18,250	2,091	8	2,281	190	2,091	58
59	WALL COVERINGS/CORNERGUARDS IN RESIDENT ROOM	2015	27,840	4,126	10	2,784	(1,342)	4,126	59
60	INSTALLATION OF NEW ROOF FOR ENTIRE BUILDING	2015	21,320	1,066	10	2,132	1,066	1,066	60
61	REPLACE 5 CONCRETE SECTIONS OF	2015	4,200	35	20	210	175	35	61
62	WALL PROTECTORS FOR DAY ROOMS AND HALLWAYS	2015	25,539	1,064	10	2,554	1,490	1,064	62
63	WARMING DRAWER AND PLATE WARME	2015	5,841	195	10	584	389	195	63
64									64
65	DEDUCTION FOR NON-CARE ASSETS	2010	(10,064)		-5			(10,064)	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,035,225	\$ 127,895		\$ 129,185	\$ 1,290	\$ 5,306,921	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	\$ 730,798	\$ 67,425	\$ 67,425	\$	10	\$ 432,204	71
72	Current Year Purchases	181,903	14,945	13,598	(1,347)	13	14,945	72
73	Fully Depreciated Assets	316,541	369	369		7	316,541	73
74	Home Office Allocation		101,080	101,080				74
75	TOTALS	\$ 1,229,242	\$ 183,820	\$ 182,473	\$ (1,347)		\$ 763,690	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)	\$ 7,306,728	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 311,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,658	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (57)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,112,872	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				34,474			5
6								6
7	TOTAL				\$ 34,474			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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 30,717 Description: Administration 4245, Nursing 25517, Home Office

(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.

Facility Name & ID Number PRESENCE MCAULEY MANOR # 0042879 Report Period Beginning: 1/01/15 Ending: 12/31/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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, 1&3	2721	hrs	\$ 110,010	3,180	\$ 193,529	\$	5,901	\$ 303,539	1
2	Licensed Speech and Language Development Therapist	10a, 1&3	467	hrs	19,601	419	26,646		886	46,247	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 1&3	2777	hrs	98,156	4,419	268,473		7,196	366,629	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				121,166		121,166	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): DIRECTOR		724		33,290				724	33,290	12
13	Other (specify):										13
14	TOTAL				\$ 261,057	8,018	\$ 488,648	\$ 121,166	14,707	\$ 870,871	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: **1/01/15**

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/15** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,116,271	\$	1
2	Cash-Patient Deposits	142,276		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	38,985,402		3
4	Supply Inventory (priced at)	1,405,559		4
5	Short-Term Investments	1,530,325		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,822,954		7
8	Accounts Receivable (owners or related parties)	2,119,287		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 61,122,074	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,185,056		12
13	Land	17,252,477		13
14	Buildings, at Historical Cost	235,676,159		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,751,494		16
17	Accumulated Depreciation (book methods)	(179,552,982)		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 (specify):	397,300		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,709,504	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 217,831,578	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 13,801,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,484,204		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,921,984		32
33	Accrued Interest Payable	6,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Third Parties</u>	(1,674,742)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 40,542,848	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,286,073		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>	99,654		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,385,727	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 41,928,575	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 175,903,003	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 217,831,578	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,167,735	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	104,250,146	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 177,417,881	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,981,330)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,437,836	11
12	Expenditures for Specific Purposes	(971,384)	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)	\$ (1,514,878)	17
B. Transfers (Itemize):			
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)	\$ 175,903,003	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,905,063	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,905,063	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,820,933	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,820,933	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,907	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	766,939	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 768,846	23
D. Non-Operating Revenue			
24	Contributions	25,397	24
25	Interest and Other Investment Income***	3,664	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,061	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,523,903	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,478,161	31
32	Health Care	2,929,761	32
33	General Administration	2,050,653	33
B. Capital Expense			
34	Ownership	523,342	34
C. Ancillary Expense			
35	Special Cost Centers	402,150	35
36	Provider Participation Fee	121,166	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,505,233	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,981,330)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,981,330)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 880,100	44
45	Private Pay - Net Inpatient Revenue	359,525	45
46	Medicare - Net Inpatient Revenue	1,222,417	46
47	Other-(specify) <u>Insurance</u>	443,021	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,905,063	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:

1/01/15

Ending:

12/31/15

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	1,806	1,891	\$ 69,348	\$ 36.67	1
2	Assistant Director of Nursing	804	835	31,752	38.03	2
3	Registered Nurses	32,794	34,174	854,099	24.99	3
4	Licensed Practical Nurses	3,433	3,507	74,834	21.34	4
5	CNAs & Orderlies	45,674	47,962	574,098	11.97	5
6	CNA Trainees					6
7	Licensed Therapist	6,376	6,689	261,057	39.03	7
8	Rehab/Therapy Aides	3,786	3,988	64,788	16.25	8
9	Activity Director	1,943	2,049	38,837	18.95	9
10	Activity Assistants	1,494	1,591	20,881	13.12	10
11	Social Service Workers	1,627	1,701	30,510	17.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,206	11,532	163,611	14.19	17
18	Housekeepers	550	572	8,070	14.11	18
19	Laundry	1,118	1,137	11,678	10.27	19
20	Administrator	2,081	2,174	92,523	42.56	20
21	Assistant Administrator	1,299	1,394	41,737	29.94	21
22	Other Administrative	1,561	1,631	41,306	25.33	22
23	Office Manager	1,245	1,400	33,357	23.83	23
24	Clerical	6,842	7,902	98,227	12.43	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	169	183	3,066	16.75	31
32	Other Health C: Admissions	1,684	1,759	38,683	21.99	32
33	Other(specify) Pastoral	880	990	22,208	22.43	33
34	TOTAL (lines 1 - 33)	127,372	135,061	\$ 2,574,670 *	\$ 19.06	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			35	
36	Medical Director	Monthly	24,989	9,3	36
37	Medical Records Consultant	43	2,626	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	16	1,056	11,3	44
45	Social Service Consultant	20	1,100	12,3	45
46	Other(specify)				46
47	MDS Coordinator	221	29,795	10,3	47
48					48
49	TOTAL (lines 35 - 48)	300	\$ 59,566		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	644	\$ 40,791	10,2	50
51	Licensed Practical Nurses	826	38,419	10,2	51
52	Certified Nurse Assistants/Aides	1,095	27,484	10,2	52
53	TOTAL (lines 50 - 52)	2,565	\$ 106,694		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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number PRESENCE MCAULEY MANOR

0042879

Report Period Beginning:

1/01/15

Ending:

12/31/15

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. LEADING AGE \$5119.98
- (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? 13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,712 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. \$ 121,166
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. \$ 1,907
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.