FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0034975

Facility Name: Our Lady of Angels Retirement Home

Address: 1201 Wyoming Avenue (Number) Joliet (City) 60435 (Zip Code)

County: Will

Telephone Number: (815) 725 - 6631 **Fax #** (815) 725 - 1451

HFS ID Number:

Date of Initial License for Current Owners: 08/10/62

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune **Telephone Number:** (815) 725 - 6631
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Carol Shaw-Burns
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5	50	Sheltered Care (SC)	50	18,250	5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,005	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		2,596	4,482	7,078	8
9	SNF/PED					9
10	ICF	12,114	11,326		23,440	10
11	ICF/DD					11
12	SC		15,290		15,290	12
13	DD 16 OR LESS					13
14	TOTALS	12,114	29,212	4,482	45,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.61%

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

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/10/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 37 and days of care provided 4,482

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/10 Fiscal Year: 06/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	424,747	19,420	8,380	452,547		452,547	(41,003)	411,544			1
2	Food Purchase		294,802		294,802		294,802	(49,581)	245,221			2
3	Housekeeping	178,189	27,632		205,821		205,821	(17,560)	188,261			3
4	Laundry	66,507	10,076		76,583		76,583	(545)	76,038			4
5	Heat and Other Utilities			259,867	259,867		259,867	(32,483)	227,384			5
6	Maintenance	226,317		188,101	414,418		414,418	(92,730)	321,688			6
7	Other (specify):*											7
8	**TOTAL General Services**	895,760	351,930	456,348	1,704,038		1,704,038	(233,902)	1,470,136			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,448,191	97,754	1,992	2,547,937		2,547,937	(827)	2,547,110			10
10a	Therapy	103,964			103,964		103,964		103,964			10a
11	Activities	205,161	16,344	7,177	228,682		228,682	(11,227)	217,455			11
12	Social Services	135,140		5,275	140,415		140,415	(6,361)	134,054			12
13	CNA Training											13
14	Program Transportation	21,181		10,204	31,385		31,385	(2,844)	28,541			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,913,637	114,098	42,648	3,070,383		3,070,383	(21,259)	3,049,124			16
	C. General Administration											
17	Administrative	154,917			154,917		154,917	(7,018)	147,899			17
18	Directors Fees											18
19	Professional Services			106,168	106,168		106,168	(7,324)	98,844			19
20	Dues, Fees, Subscriptions & Promotions			35,614	35,614		35,614	(16,080)	19,534			20
21	Clerical & General Office Expenses	326,821	28,261	142,001	497,083		497,083	(93,272)	403,811			21
22	Employee Benefits & Payroll Taxes			1,203,544	1,203,544		1,203,544	(22,434)	1,181,110			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,665	9,665		9,665	(438)	9,227			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			121,964	121,964		121,964	(10,501)	111,463			26
27	Other (specify):*											27
28	**TOTAL General Administration**	481,738	28,261	1,618,956	2,128,955		2,128,955	(157,067)	1,971,888			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,291,135	494,289	2,117,952	6,903,376		6,903,376	(412,228)	6,491,148			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Our Lady of Angels Retirement Home #0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			322,278	322,278		322,278	(40,285)	281,993			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,307	4,307		4,307	(4,307)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			873,737	873,737		873,737	(873,737)				34
35	Rent-Equipment & Vehicles			16,618	16,618		16,618	(753)	15,865			35
36	Other (specify):*											36
37	TOTAL Ownership			1,216,940	1,216,940		1,216,940	(919,082)	297,858			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		165,041	385,419	550,460		550,460		550,460			39
40	Barber and Beauty Shops			25,160	25,160		25,160	(25,160)				40
41	Coffee and Gift Shops			5,023	5,023		5,023	(5,023)				41
42	Provider Participation Fee			48,233	48,233		48,233	(922)	47,311			42
43	Other (specify):* Develop./Chapel	45,273		88,270	133,543		133,543	(133,543)				43
44	TOTAL Special Cost Centers	45,273	165,041	552,105	762,419		762,419	(164,648)	597,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,336,408	659,330	3,886,997	8,882,735		8,882,735	(1,495,958)	7,386,777			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,203)	02		4
5	Telephone, TV & Radio in Resident Rooms	(42,748)	21		5
6	Rented Facility Space	(37,021)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(545)	04		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,307)	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	(922)	42		18
19	Entertainment				19
20	Contributions	(1,400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(600)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,500)	21		24
25	Fund Raising, Advertising and Promotional	(8,103)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,650)	20		28
29	Other-Attach Schedule	(467,222)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (622,221)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	(873,737)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (873,737)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,495,958)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Our Lady of Angels Retirement Home

ID# 0034975

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee and Gift Shop Income (Extent of Expense)	$ (5,023)	41	1
2	Development Salary	(45,273)	43	2
3	Development Expenses	(63,254)	43	3
4	Chapel Expenses	(25,016)	43	4
5	Barber and Beauty	(25,160)	40	5
6	Bank Charges	(95)	21	6
7	Investment Expenses	(1,196)	21	7
8	Board Gifts	(56)	21	8
9	Womens Auxilliary	(131)	21	9
10	Food Rebates	(946)	02	10
11	Uniform Income	(221)	21	11
12	Copy Machine Income	(60)	21	12
13	Postage Income	(103)	21	13
14	Insurance Reimbursement	(3,158)	06	14
15	Legal Fees - Collection	(1,434)	19	15
16	Legal Fees - Retainer	(600)	19	16
17				17
18	OLA Village Income (Expense Reimbursement)			18
19	Housekeeping	(5,009)	03	19
20	Maintenance	(6,596)	06	20
21	Nursing	(827)	10	21
22	Activities	(908)	11	22
23				23
24	Independent Living Units (14 (Allocated Costs)			24
25	Dietary	(41,003)	01	25
26	Food	(24,432)	02	26
27	Housekeeping	(12,551)	03	27
28	Heat and Other Utilities	(32,483)	05	28
29	Maintenance	(45,955)	06	29
30	Activities	(10,319)	11	30
31	Social Services	(6,361)	12	31
32	Program Transportation	(2,844)	14	32
33	Administrative	(7,018)	17	33
34	Professional Fees	(4,690)	19	34
35	Dues, Fees, Subscriptions and Promotions	(927)	20	35
36	Clerical and Office Expense	(19,162)	21	36
37	Travel and Seminar	(438)	24	37
38	Insurance - Property	(7,804)	26	38
39	Insurance - Liability	(2,697)	26	39
40	Depreciation	(40,285)	30	40
41	Equipment Rental	(753)	35	41
42	Employee Benefits	(22,434)	22	42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(467,222)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Our Lady of Angels Retirement Home **#** 0034975 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(41,003)	0	0	0	0	0	0	0	0	0	0	(41,003)	1
2	Food Purchase	(49,581)	0	0	0	0	0	0	0	0	0	0	(49,581)	2
3	Housekeeping	(17,560)	0	0	0	0	0	0	0	0	0	0	(17,560)	3
4	Laundry	(545)	0	0	0	0	0	0	0	0	0	0	(545)	4
5	Heat and Other Utilities	(32,483)	0	0	0	0	0	0	0	0	0	0	(32,483)	5
6	Maintenance	(92,730)	0	0	0	0	0	0	0	0	0	0	(92,730)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(233,902)	0	0	0	0	0	0	0	0	0	0	(233,902)	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	(827)	0	0	0	0	0	0	0	0	0	0	(827)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(11,227)	0	0	0	0	0	0	0	0	0	0	(11,227)	11
12	Social Services	(6,361)	0	0	0	0	0	0	0	0	0	0	(6,361)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,844)	0	0	0	0	0	0	0	0	0	0	(2,844)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(21,259)	0	0	0	0	0	0	0	0	0	0	(21,259)	16
	C. General Administration													
17	Administrative	(7,018)	0	0	0	0	0	0	0	0	0	0	(7,018)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,324)	0	0	0	0	0	0	0	0	0	0	(7,324)	19
20	Fees, Subscriptions & Promotions	(16,080)	0	0	0	0	0	0	0	0	0	0	(16,080)	20
21	Clerical & General Office Expenses	(93,272)	0	0	0	0	0	0	0	0	0	0	(93,272)	21
22	Employee Benefits & Payroll Taxes	(22,434)	0	0	0	0	0	0	0	0	0	0	(22,434)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(438)	0	0	0	0	0	0	0	0	0	0	(438)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(10,501)	0	0	0	0	0	0	0	0	0	0	(10,501)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(157,067)	0	0	0	0	0	0	0	0	0	0	(157,067)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(412,228)	0	0	0	0	0	0	0	0	0	0	(412,228)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(40,285)	0	0	0	0	0	0	0	0	0	0	(40,285)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,307)	0	0	0	0	0	0	0	0	0	0	(4,307)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(873,737)	0	0	0	0	0	0	0	0	0	(873,737)	34
35	Rent-Equipment & Vehicles	(753)	0	0	0	0	0	0	0	0	0	0	(753)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(45,345)	(873,737)	0	0	0	0	0	0	0	0	0	(919,082)	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	(25,160)	0	0	0	0	0	0	0	0	0	0	(25,160)	40
41	Coffee and Gift Shops	(5,023)	0	0	0	0	0	0	0	0	0	0	(5,023)	41
42	Provider Participation Fee	(922)	0	0	0	0	0	0	0	0	0	0	(922)	42
43	Other (specify):*	(133,543)	0	0	0	0	0	0	0	0	0	0	(133,543)	43
44	**TOTAL Special Cost Centers**	(164,648)	0	0	0	0	0	0	0	0	0	0	(164,648)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(622,221)	(873,737)	0	0	0	0	0	0	0	0	0	(1,495,958)	45

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of St. Francis of Mary Immaculate	100%	N/A		N/A		

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. [X] 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	34	Rent	$ 873,737	Sisters of St. Francis of Mary Immaculate	100.00%	$	$ (873,737)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 873,737			$	$ * (873,737)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sisters of St. Francis								$		1
2	of Mary Immaculate	(See Attached)									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 Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Illinois Department of											10
11	Health and Family Services		X	Medicaid Integrity Audit				4,923				11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 4,923			$	14
15	TOTALS (line 9+line14)						$	$ 4,923			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Our Lady of Angels Retirement Home **#** 0034975 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Our Lady of Angels Retirement Home is not subject to real estate taxes.

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Our Lady of Angels Retirement Home COUNTY Will

FACILITY IDPH LICENSE NUMBER 0034975

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune

TELEPHONE (815) 725 - 6631 FAX #: (815) 725 - 1451

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326 B. General Construction Type: Exterior Brick Frame Steel and Brick Number of Stories Two

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

Independent Living - 14 Units (Represents 1 / 8 of the facility)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	609,840	1962	$	1
2					2
3	TOTALS	609,840		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	137		137	1962	$ 1,572,423	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	8,000						9
10	Various			1983	89,578						10
11	Various			1984	78,857						11
12	Various			1985	22,845						12
13	Various			1987	10,742						13
14	Various			1988	2,330						14
15	Various			1990	26,014						15
16	Various			1991	136,675						16
17	Various			1992	62,593						17
18	Various			1993	149,990						18
19	Various			1994	34,476						19
20	Various			1995	89,923						20
21	Various			1996	204,209						21
22	Various			1997	365,084						22
23	Various			1998	34,996						23
24	Various			1999	5,332						24
25	Various			2000	123,450						25
26	Various			2001	54,577						26
27	Various			2002	398,917						27
28	Various			2003	83,462						28
29	Various			2004	133,665						29
30	Various			2005	80,832						30
31	Various			2006	78,669						31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Activity Room / Auditorium Remodeling	2007	$ 86,934	$		$	$	$	37
38	Walkin Cooler Repairs / Updates	2007	5,200						38
39	Building Renovations	2007	3,107,313						39
40	Driveway Canopy	2007	8,740						40
41	Elevator Repairs	2008	2,310						41
42	Elevator Repairs	2008	4,290						42
43	IDPH Survey Modifications	2008	6,765						43
44	IDPH Survey Modifications	2008	2,032						44
45	Sidewalk	2008	3,000						45
46	Asbestos Removal	2008	5,000						46
47	Hot Water Heater Repair	2008	5,990						47
48	Boiler Repairs	2008	15,229						48
49	Handicap Ramp	2008	6,300						49
50	Exterior Lighting	2008	13,265						50
51	Exterior Lighting	2008	9,435						51
52	Construction Renovations	2009	2,450						52
53	Electrical Work	2009	4,423						53
54	Lighting Project - New Energy Efficient Fixtures	2009	58,423						54
55	AC Compressor	2010	29,546						55
56	Wired Glass for Doors - IDPH Survey Fire Rating	2010	3,682						56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			259,071		259,071		1,135,263	69
70	TOTAL (lines 4 thru 69)		$ 7,227,966	$ 259,071		$ 259,071	$	$ 1,135,263	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 976,404	$ 58,198	$ 58,198	$	10	$ 792,041	71
72	Current Year Purchases	8,826	738	738		10	738	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 985,230	$ 58,936	$ 58,936	$		$ 792,779	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Freedom Van	1999	$ 35,909	$	$	$	5	$ 35,909	76
77	Facility	Glaval Universal Bus	2002	54,750				5	54,750	77
78	Facility	Ford Five Hundred	2006	21,359	4,271	4,271		5	18,865	78
79										79
80	TOTALS			$ 112,018	$ 4,271	$ 4,271	$		$ 109,524	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)	$ 8,325,214	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 322,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 322,278	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,037,566	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	Chevy Truck - 1997	$ 26,820	$	$ 26,820	86
87	Deere Tractor - 2000	11,000		11,000	87
88					88
89					89
90					90
91	TOTALS	$ 37,820	$	$ 37,820	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.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sisters of St. Francis of Mary Immaculate

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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/10
Ending 06/30/15

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ $ 15,865 Description: Postage Machine = $1,335 / Copiers = $15,283 / Non-Allowable = ($753)
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 147,331	$		$ 147,331	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,482			21,482	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			177,779			177,779	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				162,812		162,812	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Medical Supplies	39 - 02					2,229		2,229	12
13	Other (specify): Lab / X-Ray / Other	39 - 03				38,827			38,827	13
14	TOTAL			$		$ 385,419	$ 165,041		$ 550,460	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10 (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	$ 741,026	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	951,916		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,737		5
6	Prepaid Insurance	209,797		6
7	Other Prepaid Expenses	26,947		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,935,423	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,014,687		15
16	Equipment, at Historical Cost	1,135,065		16
17	Accumulated Depreciation (book methods)	(2,075,385)		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):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,074,367	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,009,791	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 986,762	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,923		29
30	Accrued Salaries Payable	196,050		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued PTO and Payroll Taxes	263,058		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,450,793	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,450,793	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,558,998	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,009,791	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,757,073	1
2	Restatements (describe):		2
3	**Post PY Medicaid Cost Report Equity Adjustment**		3
4	**Related to OLA Village (No effect on allowable items)**	(41,602)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,715,471	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(156,474)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (156,474)	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)**	$ 2,558,998	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,351,829	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,351,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	6,988	12
13	Barber and Beauty Care	29,600	13
14	Non-Patient Meals	24,203	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	37,021	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	545	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 98,357	23
	D. Non-Operating Revenue		
24	Contributions	232,913	24
25	Interest and Other Investment Income***	19,882	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 252,795	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	23,281	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,281	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,726,261	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,704,038	31
32	Health Care	3,070,383	32
33	General Administration	2,128,955	33
	B. Capital Expense		
34	Ownership	1,216,940	34
	C. Ancillary Expense		
35	Special Cost Centers	714,186	35
36	Provider Participation Fee	48,233	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,882,735	40
41	**Income before Income Taxes (line 30 minus line 40)****	(156,474)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (156,474)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,080	$ 71,197	$ 34.23	1
2	Assistant Director of Nursing	412	600	12,946	21.58	2
3	Registered Nurses	20,560	22,157	631,216	28.49	3
4	Licensed Practical Nurses	25,587	28,137	639,879	22.74	4
5	CNAs & Orderlies	86,294	94,383	1,025,039	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,945	5,902	103,964	17.62	8
9	Activity Director	3,547	3,824	74,587	19.50	9
10	Activity Assistants	9,195	10,677	130,574	12.23	10
11	Social Service Workers	8,093	8,855	135,140	15.26	11
12	Dietician					12
13	Food Service Supervisor	1,792	2,080	55,092	26.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,722	29,188	316,769	10.85	15
16	Dishwashers	6,143	6,349	52,886	8.33	16
17	Maintenance Workers	9,920	11,622	226,317	19.47	17
18	Housekeepers	18,125	20,378	178,189	8.74	18
19	Laundry	5,598	6,177	66,507	10.77	19
20	Administrator	1,824	2,578	84,594	32.81	20
21	Assistant Administrator					21
22	Other Administrative	1,296	2,072	70,323	33.94	22
23	Office Manager					23
24	Clerical	16,353	18,360	348,001	18.95	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	1,774	1,932	26,847	13.90	31
32	Other Health C: Central Supply	1,649	1,731	41,068	23.73	32
33	Other(specify) Development	1,555	2,131	45,273	21.24	33
34	TOTAL (lines 1 - 33)	253,248	281,213	$ 4,336,408 *	$ 15.42	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,380	01 - 03	35
36	Medical Director	Monthly	18,000	09 - 03	36
37	Medical Records Consultant	Quarterly	1,560	10 - 03	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	Monthly	7,177	11 - 03	44
45	Social Service Consultant	Monthly	5,275	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 40,392		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Maria Pesavento	CEO	0	$ 70,323
Michelle Hart-Carlson	Administrator	0	79,044
(07/01/09 - 05/16/10)			
Sr. Mary Ujcik	Administrator	0	5,550
(05/17/10 - 06/30/10)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,917

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DTW	Computer Consultant	$ 23,715
Larson Allen	Accounting	1,831
Frost, Ruttenberg & Rothblatt	Accounting	9,000
Provena Senior Services	Other Administrative	10,200
Health Care Management	Other Administrative	15,000
Write Insights	Other Professional	150
Scott Czerkies	Other Professional	218
University of St. Francis	Other Professional	1,575
Tracy, Johnson & Wilson	Legal	4,164
Wessels Pautsch & Sherman	Legal (Monthly Retainer)	600
Duane Morris	Legal	13,168
See Supplemental Schedule		26,547
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 106,168

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 368,685
Unemployment Compensation Insurance	72,628
FICA Taxes	301,995
Employee Health Insurance	368,711
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,245
Pension Contributions	76,843
Uniforms	386
Employee Relations	12,051
Non-Allowable (IL Allocation)	(22,434)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,181,110

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,995
Health Care Worker Background Check	2,781
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	11,893
Licenses and Fees	1,792
Adertising, Promotions, Pub. Relations	13,753
Non-Allowable (IL Allocation)	(927)
Less: Public Relations Expense	(5,213)
Non-allowable advertising	(2,890)
Yellow page advertising	(5,650)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,665
Non-Allowable (IL Allocation)	(438)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,227

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consult.	$ 2,350
Ivans	Data Processing	3,379
Nebo Systems	Data Processing	265
Telusys, Inc.	Data Processing	660
Qqest	Data Processing	1,295
Keane Care	Data Processing	15,584
Barracuda	Data Processing	2,093
KPMG	Data Processing	475
LaCerte	Data Processing	446
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,547

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/09 Ending: 06/30/10

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. **ICLTC = $2,765 / LSN & AAHSA = $6,316**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,785** Line **10 - 02**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **47,633**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **24,203**

(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? **Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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.