FOR BHF USE

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

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.

I. IDPH License ID Number: 0033761

Facility Name: Rose-Angela Hall

Address: 4200 North Austin (Number) Chicago (City) 60634 (Zip Code)

County: Cook

Telephone Number: 773-545-8300 **Fax #** 773-545-2984

HFS ID Number:

Date of Initial License for Current Owners: 08/19/88

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501c3

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) _____ Sept 28, 2010 (Date)

(Type or Print Name) Sr. Rita Butler

(Title)

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Beverly Sorensen **Telephone Number:** 773-545-8300
Email Address:

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**

Facility Name & ID Number Rose-Angela Hall # 0033761 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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD	80	28,947	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	80	28,947	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	27,383			27,383	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,383			27,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.60%

D. How many bed-hold days during this year were paid by the Department?
1,564 (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)

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/13/88

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 [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

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.

Facility Name & ID Number Rose-Angela Hall # 0033761 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	186,558	12,855	26,685	226,098		226,098	0	226,098			1
2	Food Purchase		94,380		94,380		94,380	0	94,380			2
3	Housekeeping	49,573	16,716		66,289		66,289	0	66,289			3
4	Laundry	16,843	5,771		22,614	0	22,614	0	22,614			4
5	Heat and Other Utilities			122,005	122,005		122,005	0	122,005			5
6	Maintenance	93,264	71,658	77,593	242,515		242,515	0	242,515			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	346,238	201,380	226,283	773,901	0	773,901	0	773,901			8
	B. Health Care and Programs											
9	Medical Director	30,600			30,600		30,600	0	30,600			9
10	Nursing and Medical Records	1,683,816	34,085	17,749	1,735,650		1,735,650	0	1,735,650			10
10a	Therapy	23,734		32,192	55,926		55,926	0	55,926			10a
11	Activities	34,508			34,508		34,508	0	34,508			11
12	Social Services	25,674			25,674		25,674	0	25,674			12
13	CNA Training	14,103			14,103		14,103	0	14,103			13
14	Program Transportation			8,852	8,852		8,852	0	8,852			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,812,435	34,085	58,793	1,905,313	0	1,905,313	0	1,905,313			16
	C. General Administration											
17	Administrative	94,757			94,757		94,757	0	94,757			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			45,727	45,727		45,727	(4,852)	40,875			19
20	Dues, Fees, Subscriptions & Promotions			5,710	5,710		5,710	0	5,710			20
21	Clerical & General Office Expenses	170,226	67,296	12,361	249,883		249,883	0	249,883			21
22	Employee Benefits & Payroll Taxes			331,938	331,938		331,938	0	331,938			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			690	690		690	0	690			24
25	Other Admin. Staff Transportation				1,562		1,562	0	1,562			25
26	Insurance-Prop.Liab.Malpractice			51,367	51,367		51,367	0	51,367			26
27	Other (specify):* a\Assessment Fee			10,000	10,000		10,000	(10,000)	0			27
28	**TOTAL General Administration**	264,983	67,296	457,793	791,634	0	791,634	(14,852)	776,782			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,423,656	302,761	742,869	3,470,848	0	3,470,848	(14,852)	3,455,996			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rose-Angela Hall #0033761 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			331,893	331,893		331,893	0	331,893			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			331,893	331,893	0	331,893	0	331,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			207,360	207,360		207,360	0	207,360			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	207,360	207,360	0	207,360	0	207,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,423,656	302,761	1,282,122	4,010,101	0	4,010,101	(14,852)	3,995,249			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 Rose-Angela Hall # 0033761 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	10,000	ine27c3		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	4,852	Li 19c3		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 14,852		$ 0	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 14,852		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

Rose-Angela Hall

ID# 0033761

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Fines,Penalty	$ 10,000	Line 27c3	1
2	Legal fee	4,852	Line 19c3	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**	14,852		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **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 A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,852)	0	0	0	0	0	0	0	0	0	0	(4,852)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,000)	0	0	0	0	0	0	0	0	0	0	(10,000)	27
28	**TOTAL General Administration**	(14,852)	0	0	0	0	0	0	0	0	0	0	(14,852)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,852)	0	0	0	0	0	0	0	0	0	0	(14,852)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **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 D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,852)	0	0	0	0	0	0	0	0	0	0	(14,852)	45

Facility Name & ID Number Rose-Angela Hall # 0033761 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
Daughters of St. Mary of Providence	100			St. Mary of Providence	Chicago, IL.	Operating Corp.

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

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			Rent Facility/	$ 66,000	Daughters of St. Mary of Providence	100.00%	$ 66,000	$	1
2	V			Bldgs., Grounds						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				$ 66,000			$ 66,000	$ *	14

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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 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									$		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 Rose-Angela Hall # 0033761 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 [X] NO [ ]

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

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

	1 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

Facility Name & ID Number Rose-Angela Hall # 0033761 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						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

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

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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).	$	0	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.	$	0	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

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 Rose-Angela Hall COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033761

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 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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,510 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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. [ ] (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).

Providence Center - Community Living Facility 13647 Sq. Ft. 16 beds
Rose Angela Hall - Day Training Facility 34671 Sq. Ft. 115 Day Units
Providence Center - Adult Work Activity (now part of DT) 6653 Sq. Ft. 115 Day Units

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	Residewntial	66,437	1925	$ 50,975	1
2	Improvements		Various	24,500	2
3	TOTALS	66,437		$ 75,475	3

Facility Name & ID Number Rose-Angela Hall # 0033761 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	80		1979	1980	$ 2,031,195	$ 17,314	30	$ 17,314	$	$ 1,937,184	4
5			1938	1938	73,366		60			73,366	5
6			1956	1956	259,122		25			259,122	6
7			1928	1928	104,867		45			104,867	7
8			1953	1953	71,484		45			71,484	8
	Improvement Type**										
9	Remodling, Painting, Drywall			1980	85,251		20			85,251	9
10	Repairs			1980	24,301		20			24,301	10
11	Roof/tuckpointing			1988	8,466		20			8,466	11
12	Repairs, Painting, Decorating			1955	41,231		10			41,231	12
13	Decorating			1990	3,836		10			3,836	13
14	Asphalt, Paving Lot			1990	16,650		15			16,650	14
15	Garage disposal			1990	24,862	995	25	995		20,892	15
16	Remodling, Painting, Drywall			1991	45,685	2,284	20	2,284		42,707	16
17	New boiler-Kitchen Bldg			1998	12,320	821	15	821		10,673	17
18	New boiler- Admin Bldg.			1998	5,320	355	15	355		4,615	18
19	Install Handicap Rramp/remodle front entrance			2001	140,185	7,010	20	7,010		66,595	19
20	Remove & Install new fence around perimeter & electronic gate			2001	106,000	5,300	20	5,300		50,350	20
21	Addl re electronic gate & fence			2002	19,421	971	20	971		8,739	21
22	New rooftop HVAC units to replace existing			2002	248,000	16,533	15	16,533		139,530	22
23	Addl re ramp & fence ICF			2003	103,055	5,153	15	5,153		38,647	23
24	Sidewalks, underground snowmelt			2004	41,354	2,067	20	2,067		13,436	24
25	Parking lot stone & asphalt			2004	35,732	2,382	15	2,382		15,483	25
26	Carpentry, shelving, gate			1988	44,779		15			44,779	26
27	Outdoor rec. area			1989	12,400		15			12,400	27
28	G. Hall windows, AC			1991	24,239	1,212	20	1,212		23,359	28
29	Roofing			1991	10,852		20			10,852	29
30	Remodling Nurses station, Adm BLdg			1991	156,249	7,112	20	7,112		156,249	30
31	Walk In cooler remodling			1991	44,095	2,205	20	2,205		41,246	31
32	remodle kitchen			1991	31,445	1,572	10	1,572		30,654	32
33	Roofing			1992	12,170		15			12,170	33
34	Plumbing, heating, ainting, tile art			1993	30,813		15			30,813	34
35	Painting decorative ile			1992	14,977		10			14,977	35
36	Alarm sysem			1994	10,837		15			10,837	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 Rose-Angela Hall # 0033761 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	Emergency lights, snow melt cables, roofiing	1995	$ 65,535	$	10	$	$	$ 65,535	37
38	Hanadicap Bath, Whirlpool	1996	19,365	1,291	15	1,291		18,558	38
39	Painting, Pataching, Decorating	1996	37,184		5			37,184	39
40	New Boiler #1-4	1996	32,273	1,614	20	1,614		23,269	40
41	Install Bath	1996	4,208	281	15	281		4,074	41
42	Repair glass, roofing	1996	2,996		15			2,996	42
43	Tuckpointing, roof repair	1997	6,428		10			6,428	43
44	Electrical re A/C	1997	2,460	164	15	164		2,296	44
45	Window replacement A/C installation	1997	23,947	1,198	20	1,198		16,173	45
46	Painting, wall covering	1997	1,462		5			1,462	46
47	Architectural re windows, rempdling	1998	930		10			930	47
48	Elevator door	1998	1,200	80	15	80		1,000	48
49	New roof Adm. Bldg	1998	13,968	698	20	698		8,725	49
50	Painting, decorating Adm. Bldg	1998	950		5			950	50
51	Guanella Hall boiler	1998	14,758	738	20	738		9,225	51
52	New door stops, exits	1998	15,989	1,066	15	1,066		13,325	52
53	Painting, decorating Adm. Bldg	1998	25,548		5			25,548	53
54	Handrails	1998	6,132	408	15	408		5,100	54
55	New boiler, ht. coils D#1	1998	53,531	2,676	20	2,676		33,506	55
56	Painting, decorating dorsms	1999	18,294		5			18,294	56
57	Handicap handrails installed	1999	14,174	945	15	945		10,867	57
58	Install Walk In kitchen freezer	1999	17,409	1,161	15	1,161		13,352	58
59	Reconfigure office & handicap ramp & washroom	1999	54,060	2,703	20	2,703		31,085	59
60	Replace broken sewer & sidewalk	1999	17,168	859	20	859		9,878	60
61	New wall covering and decoating G. Hall	1999	23,831	1,193	10	1,193		25,024	61
62	Installation of fire pump	1999	8,300	415	20	415		4,773	62
63	Pip in new heads re fire system	1999	2,060	137	15	137		1,576	63
64	Chapel roof repair & piping	1999	2,939	294	10	294		3,363	64
65	Carpeting chapel	2000	1,511		5			1,511	65
66	Psinting , wall covering re hallways	2000	1,742	174	10	174		1,827	66
67	Remodel Kitchen ramp	2000	656	44	15	44		484	67
68	Pavement repairs and replace	2000	35,464	1,773	20	1,773		19,487	68
69		2000	10,527	526	20	526		5,521	69
70	TOTAL (lines 4 thru 69)		$ 4,431,558	$ 93,724		$ 93,724	$ 0	$ 3,849,087	70

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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	
1	Totals from Page 12A, Carried Forward		$ 4,431,558	$ 93,724		$ 93,724	$	$ 3,849,087	1
2	Insatall water supply valves	2000	21,820	1,091	20	1,091		11,455	2
3	Windows replaced in dorms	2000	85,550	4,278	20	4,278		44,919	3
4	Roff repair dorms	2000	13,520	1,352	10	1,352		14,196	4
5	Replace kitchen windows	2000	10,553	528	20	528		5,808	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		4,462	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		33,605	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		6,836	8
9	New water line piping	2000	11,006	550	20	550		5,775	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		4,798	10
11	Asphalt paving lot	1001	5,141		5			5,141	11
12	Ife alarm system	2001	6,938	694	10	694		6,593	12
13	G. Hall decoarating hallways	2001	5,540		5			5,540	13
14	Remove asbestos tile/replace	2001	5,192	519	10	519		4,932	14
15	Firewall door framing	2001	22,631	1,508	15	1,508		14,326	15
16	New hot water tanks repiping	2001	24,801	1,654	15	1,654		15,746	16
17	Shower door, replace drain	2001	11,732	782	15	782		7,430	17
18	Outdoor pavillion, gazebos	2001	41,095	2,740	15	2,740		26,029	18
19	Balcony roof repair	2001	5,803		5			5,803	19
20	Fire alarm system	2001	4,496	450	10	450		3,825	20
21	Plumbing work	2002	42,173	4,217	10	4,217		35,844	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		13,039	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		8,891	23
24	Tucki pointing	2002	11,585	1,158	10	1,158		9,843	24
25	Doors re Chapel	2003	1,642	164	10	164		1,230	25
26	Plumbing-water tanks, sm. Basin	2003	16,551	1,655	10	1,655		12,413	26
27	Roof curbs	2003	12,430	829	10	829		6,217	27
28	Elec. Wiring & smoke detectors	2003	5,327	532	15	532		3,995	28
29	Insulate pipes, door	2003	4,378	438	10	438		3,285	29
30	Windows, tuckpinting, Nepco	2003	25,922	2,592	10	2,592		19,440	30
31	Gas generator	2004	189,933	12,662	10	12,662		82,303	31
32	Roof tiles, decorating	2004	21,956	4,391	5	4,391		28,543	32
33	New laundry ares	2004	17,227	1,148	15	1,148		7,462	33
34	TOTAL (lines 1 thru 33)		$ 5,187,959	$ 146,987		$ 146,987	$ 0	$ 4,308,811	34

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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	
1	Totals from Page 12B, Carried Forward		$ 5,187,959	$ 146,987		$ 146,987	$	$ 4,308,811	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		11,439	2
3	Base parking lot, underground melt	2004	52,967	5,296	10	5,296		34,229	3
4	New fire alarm system	2004	68,500	4,567	15	4,567		29,685	4
5	A/C kitchen	2004	9,890	989	10	989		6,429	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		29,470	6
7	Handicap ramp re gym	2004	34,730	1,736	20	1,736		12,152	7
8	Gym windows	2004	8,245	550	15	550		3,850	8
9	Gym roof	2004	17,997	3,600	5	3,600		25,200	9
10	Plumbing, washroom remodel	2004	6,468	647	10	647		4,529	10
11	Esterior masonry, joints	2004	32,686	2,180	15	2,180		14,144	11
12	Gas generator balance	2005	26,180	1,745	15	1,745		9,598	12
13	Complete roof replacement	2005	380,077	19,004	20	19,004		104,522	13
14	Installation Attic exhaust	205	99,968	4,998	20	4,998		27,489	14
15	Complete new fire system	2005	130,900	6,545	20	6,545		35,997	15
16	Sewer & gas lines	2005	47,795	2,390	20	2,390		13,945	16
17	Paving lot	2005	31,920	2,128	15	2,128		11,704	17
18	Wallcover, tiles, painting	205	69,115	6,911	10	6,911		38,011	18
19	Electrical repairs, security	2005	30,411	3,041	10	3,041		16,725	19
20	Laundry, Kitchen repairs	2005	30,103	2,007	15	2,007		10,684	20
21	Hot water gas line	2006	5,380	538	10	538		2,295	21
22	Painting, Caulking	2006	16,065	3,213	5	3,213		13,527	22
23	Generator adjust	2006	5,545	370	15	370		1,664	23
24	Pool house, camp	206	13,574	1,357	10	1,357		6,107	24
25	Replace tiles, Laudry	2006	4,900	490	10	490		2,205	25
26	Masonry repairs	2007	101,462	6,764	15	6,764		23,674	26
27	Bott roofing	2007	17,577	1,172	15	1,172		4,102	27
28	Painting Wall covering	2007	4,184	418	10	418		1,463	28
29	Air system gym	2007	19,381	1,292	15	1,292		4,525	29
30	Walk-in refrig. & painting	2007	12,200	2,440	5	2,440		8,540	30
31	Bott roof tiles	2007	28,526	1,902	15	1,902		6,657	31
32	Walk[in tubs installed	2007	67,631	3,382	20	3,382		11,829	32
33	Indoor & Outdoor filters & repairs	2007	83,721	8,372	10	8,372		29,302	33
34	TOTAL (lines 1 thru 33)		$ 6,756,372	$ 252,982		$ 252,982	$ 0	$ 4,864,503	34

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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	
1	Totals from Page 12C, Carried Forward		$ 6,756,372	$ 252,982		$ 252,982	$	$ 4,864,503	1
2	Gate Wallpack & fixtures	2008	7,322	388	10	388		970	2
3	Reinsulate pipes	2008	7,351	390	10	390		975	3
4	Install shirlpool, tubs	2008	32,157	1,608	20	1,608		4,020	4
5	Neww Boiler sys. Hydronic Piping	2008	134,986	6,749	20	6,749		16,873	5
6	Kitchen Air Handler	2008	29,500	1,967	15	1,967		4,917	6
7	New flooring & carpeting	2008	75,553	5,036	15	5,036		12,590	7
8	Roof	2009	9,789	978	10	978		1,255	8
9	Water pipe piping	2009	7,248	725	10	725		1,088	9
10	Wall covering dorms	2009	11,125	1,112	10	1,112		1,668	10
11	Tile Block wall	2009	37,896	2,526	15	2,526		3,789	11
12	New flooring and carpeting	2009	121,350	8,090	15	8,090		10,566	12
13	Sprinklers, valves	2010	9,311	465	10	465		465	13
14	Concrete masonry	2010	10,400	520	10	520		520	14
15	Water heater	2010	5,565	556	5	556		556	15
16	Exterior painting Lot and roof	2010	12,582	1,258	5	1,258		1,258	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	TOTAL (lines 1 thru 33)		$ 7,268,507	$ 285,350		$ 285,350	$ 0	$ 4,926,013	34

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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	$ 861,479	$ 45,416	$ 45,416	$ 0		$ 734,753	71
72	Current Year Purchases	11,279	1,127	1,127	0	5	1,127	72
73	Fully Depreciated Assets	138,169			0			73
74					0			74
75	TOTALS	$ 1,010,927	$ 46,543	$ 46,543	$ 0		$ 735,880	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	Patient Care	Windstar 2004	2004	$ 21,328	$	$	$ 0		$ 21,328	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 21,328	$ 0	$ 0	$ 0		$ 21,328	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)	$ 8,376,237	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 331,893	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 331,893	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,683,221	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.

Facility Name & ID Number Rose-Angela Hall # 0033761 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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Rose-Angela Hall # 0033761 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? [X] YES [ ] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)		4,696		4,696
4	Clinical Wages (b)		9,407		9,407
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 14,103	$ 0	$ 14,103
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,103			

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	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

(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.)

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Rose-Angela Hall **#** 0033761 **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	$	$ 2,022,217	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	551,855	939,696	3
4	Supply Inventory (priced at)		0	4
5	Short-Term Investments			5
6	Prepaid Insurance		24,792	6
7	Other Prepaid Expenses		14,084	7
8	Accounts Receivable (owners or related parties)	(2,319,456)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,767,601)	$ 3,000,789	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	2,964,433	6,578,154	15
16	Equipment, at Historical Cost	1,032,255	1,646,706	16
17	Accumulated Depreciation (book methods)	(2,145,419)	(5,111,345)	17
18	Deferred Charges	0		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)**	$ 1,851,269	$ 3,113,515	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 83,668	$ 6,114,304	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,815	$ 187,236	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,082	238,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,653	13,004	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 196,550	$ 438,814	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)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 196,550	$ 438,814	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (112,882)	$ 5,675,490	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 83,668	$ 6,114,304	48

***(See instructions.)**

Facility Name & ID Number Rose-Angela Hall # 0033761 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**	$ 74,697	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,697	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(187,579)	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)**	$ (187,579)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (112,882)	24 *

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

Facility Name & ID Number Rose-Angela Hall # 0033761 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	$ 3,785,467	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,785,467	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)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,103	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,103	23
	D. Non-Operating Revenue		
24	Contributions	8,100	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,100	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,807,670	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	773,901	31
32	Health Care	1,905,313	32
33	General Administration	776,782	33
	B. Capital Expense		
34	Ownership	331,893	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	207,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,995,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	(187,579)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (187,579)	43

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

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

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

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

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2,024	2,153	$ 68,398	$ 31.77	1
2	Assistant Director of Nursing	1,560	1,560	39,000	25.00	2
3	Registered Nurses	7,861	8,363	210,107	25.12	3
4	Licensed Practical Nurses	5,939	6,318	136,597	21.62	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,088	33,906	16.24	9
10	Activity Assistants	58	58	602	10.38	10
11	Social Service Workers	529	529	25,674	48.53	11
12	Dietician					12
13	Food Service Supervisor	1,955	2,080	51,599	24.81	13
14	Head Cook	649	649	8,883	13.69	14
15	Cook Helpers/Assistants	10,216	10,868	126,076	11.60	15
16	Dishwashers					16
17	Maintenance Workers	4,112	4,374	93,264	21.32	17
18	Housekeepers	4,685	4,980	49,573	9.95	18
19	Laundry	1,950	2,073	16,843	8.12	19
20	Administrator	1,961	2,086	51,071	24.48	20
21	Assistant Administrator	2,040	2,080	43,686	21.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,789	16,797	170,226	10.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	200	200	30,600	153.00	27
28	Qualified MR Prof. (QMRP)	10,708	10,617	179,310	16.89	28
29	Resident Services Coordinator	12,000	12,612	218,055	17.29	29
30	Habilitation Aides (DD Homes)	86,284	90,825	836,867	9.21	30
31	Medical Records	1,958	2,083	33,319	16.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,446	183,393	$ 2,423,656 *	$ 13.22	34

* 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	n/a	$ 4,937	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	n/a	2,864	Lin 10 C3	37
38	Nurse Consultant	n/a	1,485	Lin 10 C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	450	29,677	Lin 10a C3	40
41	Occupational Therapy Consultant	40	2,515	Lin 10a C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dentist	n/a	5,150	Lin 10 C3	46
47	Phychiatrist	36	8,250	Lin 10 C3	47
48	FoodServiceProfessional MgmtFee	n/a	21,748	Lin 1 C3	48
49	TOTAL (lines 35 - 48)	526	$ 76,626		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

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Zdanowski	Administrator		$ 51,071
Sr. Rita Butler	Asst. Administrator		43,686
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,757

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
BIK & Co., LLp		$ 40,875
HenehanDonovan&Isaacson,Ltd		4,852
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 45,727

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,337
Unemployment Compensation Insurance	1,626
FICA Taxes	153,239
Employee Health Insurance	82,050
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	60,686
TOTAL (agree to Schedule V, line 22, col.8)	$ 331,938

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,316
Health Care Worker Background Check (Indicate # of checks performed 27)	
Patient Background Checks	432
Dues, Fees	1,762
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Alzheimer Assoc.	280
Influenza&H1&N1+hearing Loss	410
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 690

**See instructions.

Facility Name & ID Number Rose-Angela Hall # 0033761 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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rose-Angela Hall # 0033761 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? _____
If YES, give association name and amount. NO

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 4,340 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? _____
If YES, give effective date of lease. NO

(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. $ 207,360
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. $ 0 Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 15
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BIK & CO. LLP

(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? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE VII -A- PAGE 24

NAME	OFFICE
Sr. Patricia McCafferty	President
Sr. Rita Butler (1)	Vice-President & Secretary
Sr. Mary Patricia Whyte	Treasurer
Sr. Barbara Moerman	Director
Sr. Ann Schaffer	Director

(1) The Facility pays rent to the religious order, The Daughters of St. Mary of Providence for use of the building and grounds.

SCHEDULE VIII - Allocation of the Indirect Costs - SEE ATTACHED WORKSHEETS