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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0034975

Facility Name: Our Lady of Angels Ret Home

Address: 1201 Wyoming Ave (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: 8/10/62

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Diane Simon **Telephone Number:** (815) 553-4124
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 7/1/12 to 6/30/13 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) James Boyle
(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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	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		674	5,496	6,170	8
9	SNF/PED					9
10	ICF	11,318	10,565		21,883	10
11	ICF/DD					11
12	SC		12,263		12,263	12
13	DD 16 OR LESS					13
14	TOTALS	11,318	23,502	5,496	40,316	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.62%

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)
Independent Living

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 08/10/1962

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 5,496

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: 06/30/2013 Fiscal Year: 06/30/2013

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	457,176	21,212	9,840	488,228		488,228	(48,622)	439,606			1
2	Food Purchase		292,192		292,192		292,192	(56,589)	235,603			2
3	Housekeeping	217,563	41,630		259,193		259,193	(5,785)	253,408			3
4	Laundry	89,530	5,606		95,136		95,136	(2,380)	92,756			4
5	Heat and Other Utilities			202,045	202,045		202,045	(22,756)	179,289			5
6	Maintenance	219,330		153,244	372,574		372,574	(21,626)	350,948			6
7	Other (specify):*											7
8	TOTAL General Services	983,599	360,640	365,129	1,709,368		1,709,368	(157,758)	1,551,610			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,538,928	127,694	1,560	2,668,182		2,668,182		2,668,182			10
10a	Therapy											10a
11	Activities	157,517	7,479	2,048	167,044		167,044	(38,991)	128,053			11
12	Social Services	100,036		4,333	104,369		104,369	(1,740)	102,629			12
13	CNA Training											13
14	Program Transportation	21,112		6,982	28,094		28,094	(2,245)	25,849			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,817,593	135,173	38,923	2,991,689		2,991,689	(42,976)	2,948,713			16
	C. General Administration											
17	Administrative	78,861			78,861		78,861	(2,097)	76,764			17
18	Directors Fees											18
19	Professional Services			147,671	147,671		147,671	(2,777)	144,894			19
20	Dues, Fees, Subscriptions & Promotions			30,094	30,094		30,094	(23,116)	6,978			20
21	Clerical & General Office Expenses	293,630	23,486	127,277	444,393		444,393	(111,623)	332,770			21
22	Employee Benefits & Payroll Taxes			834,438	834,438		834,438	(22,208)	812,230			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,413	6,413		6,413	(282)	6,131			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,555	115,555		115,555	(9,494)	106,061			26
27	Other (specify):*											27
28	TOTAL General Administration	372,491	23,486	1,261,448	1,657,425		1,657,425	(171,597)	1,485,828			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,173,683	519,299	1,665,500	6,358,482		6,358,482	(372,331)	5,986,151			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.

Our Lady of Angels Retirement Home
Non-Allowable Expenses
Independent Living

Cost Centers	Allocation Basis	Independent Living	Facility Total	Factor	% IL to Facility	Salary / Expense	IL Total
Dietary	Meals Served	14,394	135,342	100.00%	10.64%	457,176	48,622
Food	Meals Served	14,394	135,342	100.00%	10.64%	292,192	31,075
Housekeeping	Census Factored	4,798	45,114	25.00%	2.66%	217,563	5,785
Laundry	Census Factored	4,798	45,114	25.00%	2.66%	89,530	2,380
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	182,045	22,756
Maintenance	Square Feet	1	8	100.00%	12.50%	219,330	27,416
Activities	Census	4,798	45,114	25.00%	2.66%	157,517	4,188
Social Services	Census	4,798	45,114	25.00%	2.66%	65,451	1,740
Program Transportation	Census	4,798	45,114	100.00%	10.64%	21,112	2,245
Administrative	Census	4,798	45,114	25.00%	2.66%	78,861	2,097
Professional Fees	Census	4,798	45,114	25.00%	2.66%	104,438	2,777
Dues, Fees, Subscriptions and Promotions	Census	4,798	45,114	25.00%	2.66%	293,630	7,807
Clerical and Office Expenses	Census	4,798	45,114	25.00%	2.66%	147,418	3,920
Travel and Seminar	Census	4,798	45,114	25.00%	2.66%	10,604	282
Insurance - Property	Square Feet	1	8	100.00%	12.50%	65,254	8,157
Insurance - Liability	Census	4,798	45,114	25.00%	2.66%	50,301	1,337
Depreciation	Square Feet	1	8	100.00%	12.50%	208,469	26,059
Equipment Rental	Census	4,798	45,114	25.00%	2.66%	21,446	570
Employee Benefits	Census	4,798	45,114	25.00%	2.66%	835,250	22,208
						3,517,587	221,421

Facility Name & ID Number Our Lady of Angels Ret Home #0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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			208,469	208,469		208,469	(26,836)	181,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,892	30,892		30,892	(2,752)	28,140			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,873	847,873		847,873	(847,873)				34
35	Rent-Equipment & Vehicles			21,446	21,446		21,446	(570)	20,876			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,108,680	1,108,680		1,108,680	(878,031)	230,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195,283	622,148	817,431		817,431		817,431			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,142	4,142		4,142		4,142			41
42	Provider Participation Fee			186,745	186,745		186,745		186,745			42
43	Other (specify):* **Devel/Chapel**			41,967	41,967		41,967	(43,680)	(1,713)			43
44	**TOTAL Special Cost Centers**		195,283	855,002	1,050,285		1,050,285	(43,680)	1,006,605			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,173,683	714,582	3,629,182	8,517,447		8,517,447	(1,294,042)	7,223,405			45

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

Our Lady of Angels Retirement Home
Line 43 -Other
Development & Chapel Expenses

Expense Type	Amount
Chapel Expenses	31,558
Fund Raising - Data Processing	2,721
Fund Raising - Advertising	849
Fund Raising - Public Relations	2,028
Fund Raising - Fundraiser Expenses	4,811
Total	**41,967**

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	(25,514)	02		4
5	Telephone, TV & Radio in Resident Rooms	(61,965)	21		5
6	Rented Facility Space	(39,113)			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	(2,752)	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	(8,652)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,000)	21		24
25	Fund Raising, Advertising and Promotional	(10,880)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,429)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (183,305)		$	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)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,305)		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

STATE OF ILLINOIS **Page 5A**

Our Lady of Angels Ret Home

ID# **0034975**

Report Period Beginning: **7/1/12**

Ending: **6/30/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Income	$ (34,803)	11	1
2	Bank Charges	(1,713)	43	2
3	Theft Loss	(845)	21	3
4	Board Gifts	(310)	21	4
5	Memorial Expense	(380)	21	5
6	Chapel Expense (Non-adjusted for Income)	(31,558)	43	6
7	Development Expenses	(10,409)	43	7
8	OLA Village - Cable	(5,551)	21	8
9	Capitalized Asset - Under $2,500 Threshold	5,790	06	9
10	Capitalized Asset - Depreciation ADJ	(777)	30	10
11				11
12	Independent Living Units (Allocated Costs)			12
13	Dietary	(48,622)	01	13
14	Food	(31,075)	02	14
15	Housekeeping	(5,785)	03	15
16	Laundry	(2,380)	04	16
17	Heat and Other Utilities	(22,756)	05	17
18	Maintenance	(27,416)	06	18
19	Activities	(4,188)	11	19
20	Social Services	(1,740)	12	20
21	Program Transportation	(2,245)	14	21
22	Administrative	(2,097)	17	22
23	Professional Fees	(2,777)	19	23
24	Dues, Fees, Subscriptions & Promotions	(7,807)	20	24
25	Clerical & Office Expense	(3,920)	21	25
26	Travel & Seminar	(282)	24	26
27	Insurance - Property	(8,157)	26	27
28	Insurance - Liabilitiy	(1,337)	26	28
29	Depreciation	(26,059)	30	29
30	**Equipment Rental**	(570)	35	30
31	Employee Benefits	-22208	22	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**	(301,977)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 **Report Period Beginning:** 7/1/12 **Ending:** 6/30/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(48,622)	0	0	0	0	0	0	0	0	0	0	(48,622)	1
2	Food Purchase	(56,589)	0	0	0	0	0	0	0	0	0	0	(56,589)	2
3	Housekeeping	(5,785)	0	0	0	0	0	0	0	0	0	0	(5,785)	3
4	Laundry	(2,380)	0	0	0	0	0	0	0	0	0	0	(2,380)	4
5	Heat and Other Utilities	(22,756)	0	0	0	0	0	0	0	0	0	0	(22,756)	5
6	Maintenance	(21,626)	0	0	0	0	0	0	0	0	0	0	(21,626)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(157,758)	0	0	0	0	0	0	0	0	0	0	(157,758)	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	(38,991)	0	0	0	0	0	0	0	0	0	0	(38,991)	11
12	Social Services	(1,740)	0	0	0	0	0	0	0	0	0	0	(1,740)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(42,976)	0	0	0	0	0	0	0	0	0	0	(42,976)	16
	C. General Administration													
17	Administrative	(2,097)	0	0	0	0	0	0	0	0	0	0	(2,097)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,777)	0	0	0	0	0	0	0	0	0	0	(2,777)	19
20	Fees, Subscriptions & Promotions	(23,116)	0	0	0	0	0	0	0	0	0	0	(23,116)	20
21	Clerical & General Office Expenses	(111,623)	0	0	0	0	0	0	0	0	0	0	(111,623)	21
22	Employee Benefits & Payroll Taxes	(22,208)	0	0	0	0	0	0	0	0	0	0	(22,208)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(282)	0	0	0	0	0	0	0	0	0	0	(282)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,494)	0	0	0	0	0	0	0	0	0	0	(9,494)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(171,597)	0	0	0	0	0	0	0	0	0	0	(171,597)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(372,331)	0	0	0	0	0	0	0	0	0	0	(372,331)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 **Report Period Beginning:** 7/1/12 **Ending:** 6/30/13

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	(26,836)	0	0	0	0	0	0	0	0	0	0	(26,836)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,752)	0	0	0	0	0	0	0	0	0	0	(2,752)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(847,873)	0	0	0	0	0	0	0	0	0	(847,873)	34
35	Rent-Equipment & Vehicles	(570)	0	0	0	0	0	0	0	0	0	0	(570)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,158)	(847,873)	0	0	0	0	0	0	0	0	0	(878,031)	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):*	(43,680)	0	0	0	0	0	0	0	0	0	0	(43,680)	43
44	TOTAL Special Cost Centers	(43,680)	0	0	0	0	0	0	0	0	0	0	(43,680)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(446,169)	(847,873)	0	0	0	0	0	0	0	0	0	(1,294,042)	45

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of St. Francis of Mary Immaculate	100					
The Congregation sponsors OLA as a non-profit organization						

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	34	Rent	$ 847,873	Sisters of St. Francis of Mary Immaculate	100.00%	$	$ (847,873)	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			$ 847,873			$	$ * (847,873)	14

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1		BOD						1
2	Richard Kasper	BOD						2
3	Kathy Birsa-Smith	BOD						3
4	Scott Czerkies	BOD						4
5	Fr. William Dewan	BOD						5
6	Sr. Mary Jane Griffin, OSF	BOD						6
7	Susan Martin	BOD						7
8	Kathryn Weigel	BOD						8
9	Sr. Dolores Zemont, OSF	BOD						9
10	Sr. Clarita Schumacher, OSF	BOD						10
11	George Block	BOD						11
12	Diane Habiger	BOD						12
13	Sr. Teresinha Del'Acqua, OSF	BOD						13
14	Melodee Easton	BOD						14
15	Lora McGuire	BOD						15
16	Sr. Mary Frances Seeley, OSF	BOD						16
17	Joseph Benson	BOD						17
18	Susan Parker	BOD						18
19	Steve Vanisko	BOD						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	Sr. Rita Vahling, OSF	Patoral Care Dir.	Administrative	See Below	0	36	100.00	Salary	$ 32,650	21 - 01	1
2	Sr. Donna Marie Baier, OSF	Volunteer Coord.	Administrative	See Below	0	35	100.00	Salary	23,274	11 - 01	2
3	Sr. Odelia Kloc, OSF	Enrichment Coord.	Administrative	See Below	0	40	100.00	Salary	26,700	11 - 01	3
4	Sr. Mary Ann Jerkofsky	Admissions Asst.	Administrative	See Below	0	25	100.00	Hourly	2,324	21 - 01	4
5											5
6	The Sisters are members of										6
7	the Sisters of St. Francis that										7
8	sponsors OLA as a non-profit										8
9	organization.										9
10											10
11											11
12											12
13								TOTAL	$ 84,948		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 Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank	X		Cash Flows	$3,870.00	6/26/12	200,000		6/26/17	5.7500	10,637	6
7	First Midwest Bank	X		Cash Flows	$1,250.00	1/1/13	500,000	300,000	12/31/13	4.5000	17,830	7
8	Christian Brothers	X		Insurance Policy Int Charges							2,425	8
9	TOTAL Facility Related				$5,120.00		$ 700,000	$ 300,000			$ 30,892	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 700,000	$ 300,000			$ 30,892	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 Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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:		
	2008	8
	2009	9
	2010	10
	2011	11
	2012	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Our Lady of Angels Ret Home COUNTY Will

FACILITY IDPH LICENSE NUMBER 0034975

CONTACT PERSON REGARDING THIS REPORT Diane M. Simon

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 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) 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 X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326 B. General Construction Type: Exterior BRICK Frame STEEL & BRICK Number of Stories 2

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).

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		1962	1962	$ 1,572,423	$	40	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	62593		15-40				9
10	Various			1993	149990		15-40				10
11	Various			1994	34476		15-40				11
12	Various			1995	89923		15-40				12
13	Various			1996	204209		15-40				13
14	Various			1997	365084		15-40				14
15	Various			1998	34996		15-40				15
16	Various			1999	5332		15-40				16
17	Various			2000	123450		15-40				17
18	Various			2001	54,577		15-40				18
19	Various			2002	398,917		15-40				19
20	Various			2003	83,462		15-40				20
21	Various			2004	133,665		15-40				21
22	Various			2005	80,832		15-40				22
23	Various			2006	78,669		15-40				23
24	Various			2007	3,208,187		15-40				24
25	Various			2008	73,616		15-40				25
26	Various			2009	65,296		15-40				26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	Various - Financial Statement Depreciation					112,535	15-40	112,535		1,391,367	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 Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	AC Compressor	2010	$ 29,546	$ 2,954	5 - 15	$ 2,954	$	$ 10,341	37
38	Wired Glass for Doors	2010	3,682	245	5 - 15	245		858	38
39	Wired Glass for Doors	2010	1,395	93	5 - 15	93		279	39
40	New Doors - IDPH Survey Finding with Wired Glass	2010	1,274	85	5 - 15	85		248	40
41	Parking Lot Reseal	2010	3,400	680	5 - 15	680		2,040	41
42	Kitchen Hood System and Alarms	2010	8,399	840	5 - 15	840		2,450	42
43	Walk In Freezer Condensing unit	2010	4,900	490	5 - 15	490		1,429	43
44	Activity Room - Paint, Cabinents, Countertop, and Blinds	2010	5,692	453	5 - 15	453		1,322	44
45	Therapy Room - Tile, Blinds, Cabinents, Cubicle Curtains	2010	10,873	725	5 - 15	725		2,054	45
46	Elevator Upgrades	2011	97,951	6,530	5 - 15	6,530		15,787	46
47	Driveway - Paving and Drainage	2011	118,504	10,154	5 - 15	10,154		21,267	47
48	Lobby Renovations	2011	23,975	1,199	5 - 15	1,199		2,370	48
49	Heat & Smoke Detectors	2011	4,324	432	5 - 15	432		772	49
50	Boiler Work	2011	12,566	2,513	5 - 15	2,513		4,116	50
51	Model Room Renovations	2011	2,836	435	5 - 15	435		747	51
52	Parking Lot Reseal	2011	3,265	653	5 - 15	653		1,088	52
53	Roof Repair	2012	5,000	250	5 - 15	250		344	53
54	Air Conditioning Work	2012	3,247	325	5 - 15	325		352	54
55	Fire Panel	2013	21,753	1,209	5 - 15	1,209		1,209	55
56	Air Conditioning Work	2013	7,269	545	5 - 15	545		545	56
57	Boiler Work	2013	3,368	168	5 - 15	168		168	57
58	Fire Detectors	2013	3,363	56	5 - 15	56		56	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,196,279	$ 143,568		$ 143,568	$	$ 1,461,209	70

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 419,463	$ 54,766	$ 54,766	$		$ 312,720	71
72	Current Year Purchases	35,166	3,494	3,494			3,494	72
73	Fully Depreciated Assets	651,567	6,079	6,079			651,567	73
74								74
75	TOTALS	$ 1,106,196	$ 64,339	$ 64,339	$		$ 967,781	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Freedom Van	1999	$ 35,909	$	$	$	5	$ 35,909	76
77	Facility	Ford Five Hundred	2006	21,359				5	21,359	77
78	Facility	Chevy Truck	1997	26,820				5	26,820	78
79	Facility	Repairs	2012	3,038	562	562		5	562	79
80	TOTALS			$ 87,126	$ 562	$ 562	$		$ 84,650	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)	$ 8,389,601	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,469	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 208,469	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)	$ 2,513,640	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	D2 Improvements	$ 6,872	92
93			93
94			94
95		$ 6,872	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 Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 [ ] 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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 21,446 Description: Copiers $20,277 and Postage Machine $1,169
    (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 Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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.

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	39-3	hrs	$		$ 216,008	$		$ 216,008	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			41,563			41,563	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			259,772			259,772	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				193,597		193,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39-2					2,310		2,310	12
13	Other (specify): See Supplemental	39-2					104,181		104,181	13
14	TOTAL			$		$ 517,343	$ 300,088		$ 817,431	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.

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Page 16 Line 12 Column 6: Other Ancillary Supplies

Feeding Tubes	624
Medical Supplies	1,686
Total	2,310

Page 16 Line 12 Column 6: Other Ancillary Expense

Laboratory	35,321
Radiology	30,851
Ambulance	331
Other Hospital Services	37,678
Total	104,181

STATE OF ILLINOIS

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13 (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	$ 322,924	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,205)	1,270,861		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	6,072		5
6	Prepaid Insurance	212,622		6
7	Other Prepaid Expenses	11,908		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,824,387	$	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	3,373,344		15
16	Equipment, at Historical Cost	1,211,192		16
17	Accumulated Depreciation (book methods)	(2,606,738)		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)**	$ 1,977,798	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,802,185	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 741,607	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	429,654		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,177		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)**	$ 1,173,438	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	665,343		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)**	$ 665,343	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,838,781	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,067,191	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,905,972	$	48

***(See instructions.)**

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,651,001	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,651,001	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	416,190	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)**	$ 416,190	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)**	$ 2,067,191	24 *

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

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,635,940	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,635,940	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	7,125	12
13	Barber and Beauty Care	11,439	13
14	Non-Patient Meals	25,514	14
15	Telephone, Television and Radio	1,550	15
16	Rental of Facility Space	39,113	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)**	$ 84,741	23
	D. Non-Operating Revenue		
24	Contributions	107,591	24
25	Interest and Other Investment Income***	2,752	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110,343	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	102,613	27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,613	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,933,637	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,709,368	31
32	Health Care	2,991,689	32
33	General Administration	1,657,425	33
	B. Capital Expense		
34	Ownership	1,108,680	34
	C. Ancillary Expense		
35	Special Cost Centers	863,540	35
36	Provider Participation Fee	186,745	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,517,447	40
41	**Income before Income Taxes (line 30 minus line 40)****	416,190	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 416,190	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,381,863	44
45	Private Pay - Net Inpatient Revenue	4,205,656	45
46	Medicare - Net Inpatient Revenue	2,613,328	46
47	Other-(specify) Independent Living	435,091	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,635,938	49

* **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.**

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Page 19 Line 28 Column 1: Other Miscellaneous Income

Laundry and Vending Commissions	384
Chapel Income (Adjusted Out Page 5)	34,803
Miscellaneous Income	24,325
Insurance Proceeds - Van	37,550
OLA Village (Adjusted Out Page 5)	5,551
Total	102,613

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	1,668	1,895	$ 71,871	$ 37.93	1
2	Assistant Director of Nursing	1,877	2,080	68,273	32.82	2
3	Registered Nurses	27,842	30,385	802,633	26.42	3
4	Licensed Practical Nurses	21,996	24,553	589,644	24.02	4
5	CNAs & Orderlies	71,455	79,009	849,937	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,991	6,665	83,769	12.57	8
9	Activity Director	1,735	2,096	39,431	18.81	9
10	Activity Assistants	9,137	10,151	118,086	11.63	10
11	Social Service Workers	5,591	6,218	100,036	16.09	11
12	Dietician					12
13	Food Service Supervisor	1,716	2,120	53,973	25.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,097	31,459	319,132	10.14	15
16	Dishwashers	9,450	9,690	84,071	8.68	16
17	Maintenance Workers	10,171	11,429	219,330	19.19	17
18	Housekeepers	18,553	20,829	217,563	10.45	18
19	Laundry	9,690	10,392	89,530	8.62	19
20	Administrator	1,432	1,630	78,861	48.38	20
21	Assistant Administrator					21
22	Other Administrative	1,853	2,080	62,260	29.93	22
23	Office Manager					23
24	Clerical	13,407	14,697	231,370	15.74	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	1,833	2,090	27,769	13.29	31
32	Other Health C: Central Supply Cl	1,903	2,160	45,032	20.85	32
33	Other(specify) Driver	1,870	1,983	21,112	10.65	33
34	TOTAL (lines 1 - 33)	247,267	273,611	$ 4,173,683 *	$ 15.25	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	Monthly	$ 9,840	01-03	35
36	Medical Director	Monthly	24,000	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	Quarterly	2,048	11-03	44
45	Social Service Consultant	Quarterly	4,333	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,781		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 Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Shaw-Burns	Administrator	0	$ 54,201
Dawn Disera	Administrator	0	5,460
James Boyle	Administrator	0	19,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,861

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	$ 41,667
SureQuest Systems	Data Processing	1,732
Helen Ross	Consultant	31,425
The Sheahen Group	Consultant	7,469
John M. Dudek	Consultant	4,045
Human Readiness Consulting LLC	Consultant	294
Telusys	Data Processing	838
NTT Data	Data Processing	22,251
Comcast	Internet Provider	5,578
Ability Network	Data Processing	3,311
Google Apps	Data Processing	350
See Supplemental Schedule		28,711
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 147,671

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 194,797
Unemployment Compensation Insurance	36,667
FICA Taxes	229,292
Employee Health Insurance	344,169
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Physicals	6,998
Pension	12,594
Other Employee Welfare	9,921
Pg 5A Non-Allowable IL Costs	(22,208)
TOTAL (agree to Schedule V, line 22, col.8)	$ 812,230

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	$
Advertising: Employee Recruitment	812
Health Care Worker Background Check	
(Indicate # of checks performed 47)	3,508
Patient Background Checks	
Dues - Associations	9,396
Licenses & Fees	1,069
Advertising & Promotion	15,309
Pg 5A Non-Allowable IL Costs	(7,807)
Less: Public Relations Expense	(3,823)
Non-allowable advertising	(7,057)
Yellow page advertising	(4,429)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,978

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,413
Pg 5A Non-Allowable IL Costs	(282)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,131

**See instructions.

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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
CareTracker	Data Processing	$ 10,296
Barracuda Networks	Data Processing	1,188
Qquest Software Systems	Data Processing	1,599
Blackbaud	Data Processing	635
CliftonLarson Allen	Accounting	9,230
George Bagley & Company	Accounting	1,368
Templin Healthcare Accounting	Accounting	2,250
Tracy, Johnson & Wilson	Legal	1,190
Personnel Planners	Unemployment Consult	1,700
Ruettiger, Tonelli & Associates	Engineers	(745)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 28,711

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)*	
Employee Physicals	
Pension	
Other Employee Welfare	
Pg 5A Non-Allowable IL Costs	
TOTAL (agree to Schedule V, line 22, col.8)	$

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	$
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)	$

**See instructions.

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Seminar Schedule

Seminar Title	Date	Location	Attendee	Attendee Title	Amount
Creative Intervention for Demtia	08/14/12	Joliet, IL	Dawn Disera	Social Services	179.00
Breaking Through Barriers - Change is	10/19/12	Chicago, IL	Alice Lagman	Dietary Director	110.00
How to Create Unstoppable Success Now	12/13/12	Joliet, IL	Carol Shaw-Burns	Administrator	20.00
ANFP - North Central Regional Meeting	4/18/13 - 4/19/13	Milwaukee, WI	Alice Lagman	Dietary Director	139.00
Spring 2013 IANFP Workshop	04/25/13	Geneva, IL	Alice Lagman	Dietary Director	50.00
Healthcare Seminar - Affordable Care Act	03/19/13	Joliet, IL	Martha Klima	Human Resources Director	30.00
Healthcare Seminar - Affordable Care Act	03/19/13	Joliet, IL	Diane Simon	Finance Manager	30.00
The Conference for Administrative Assistants	04/02/13	Chicago, IL	Gina Wysocki	Adminstrative Assistant	195.00
Corporate Compliance 2013	03/12/13	Webinar	Dawn Disera	Social Services / Administrator	168.00
Illinois' Move to Managed Care	03/05/13	Lisle, IL	Dawn Disera	Social Services / Administrator	114.00
Illinois' Move to Managed Care	03/05/13	Lisle, IL	Diane Simon	Finance Manager	114.00
CPR Training	4/24/13, 4/25/13 & 5/1/13	Joliet, IL	Nursing Staff	Nurses & CNAs	323.00

Healthcare Reform	04/17/13	Bolingbrook, IL	Martha Klima	Human Resources Director	179.00
Healthcare Reform	04/17/13	Bolingbrook, IL	Diane Simon	Finance Manager	179.00
A Matter of Balance - Managing Concerns about Falls	06/10/13	Joliet, IL	Odeila Kloc	Activities Coordinator	100.00
Training & Certification Program for Carpet Cleaning & Industry Professionals	04/03/12	Glen Ellyn, IL	Rick Butterfield	Asst. Maintenance Director	35.00
Leadership School	09/06/12	Joliet, IL	Martha Klima	Human Resources Director	295.00

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Seminar Schedule

Seminar Title	Date	Location	Attendee	Attendee Title	Amount
Employer's Guide to Healthcare Reform (Manual)			Martha Klima	Human Resources Director	298.09
Extinguishment Training	06/14/13	Joliet, IL	All Employees	All Departments	395.00
Managing an HR Department of One (manual)			Martha Klima	Human Resources Director	173.95
LSN Annual Conference	5/1/13 - 5/3/13	Chicago, IL	Numerous	All Departments	3,062.00
Dietary Program	03/07/13	Joliet, IL	Alice Lagman	Dietary Director	74.00
Dietary State Certification Renewal Program	01/02/13	Joliet, IL	Sherri Hannah	Dietary Supervisor	50.00
Zeroing in on the Needs of our Long Term Care Residents	06/20/13	Webinar	Denice Hlavacik	MDS	100.00
Pg 5A Non-Allowable IL Costs					(282.00)

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 Our Lady of Angels Ret Home **#** 0034975 **Report Period Beginning:** 7/1/12 **Ending:** 6/30/13

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. **LSN $8693**

(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? **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. $ **31,651** Line **10-2**

(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? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ 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. $ **186,745**
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? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **25,514**

(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? **Ln 14**
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? **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 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.