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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0034975

Facility Name: OUR LADY OF ANGELS RET HOME

Address: 1201 WYOMING AVENUE (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

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

HFS ID Number:

Date of Initial License for Current Owners: 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 7/1/13 to 6/30/14 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) George Block
(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: 7/1/13 Ending: 6/30/14

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		341	5,697	6,038	8
9	SNF/PED					9
10	ICF	10,441	10,349		20,790	10
11	ICF/DD					11
12	SC		10,375		10,375	12
13	DD 16 OR LESS					13
14	TOTALS	10,441	21,065	5,697	37,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.40%

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 5,697

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: 06/30/2014 Fiscal Year: 06/30/2014

* 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: 7/1/13 Ending: 6/30/14

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	422,540	23,250	9,540	455,330		455,330	(48,821)	406,509			1
2	Food Purchase		292,430		292,430		292,430	(54,777)	237,653			2
3	Housekeeping	227,103	42,613		269,716		269,716	(6,560)	263,156			3
4	Laundry	71,967	8,086		80,053		80,053	(2,079)	77,974			4
5	Heat and Other Utilities			250,221	250,221		250,221	(31,278)	218,943			5
6	Maintenance	221,924		179,488	401,412		401,412	(22,088)	379,324			6
7	Other (specify):*											7
8	TOTAL General Services	943,534	366,379	439,249	1,749,162		1,749,162	(165,603)	1,583,559			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,493,134	141,558	1,560	2,636,252		2,636,252		2,636,252			10
10a	Therapy											10a
11	Activities	152,105	9,712	1,312	163,129		163,129	(41,479)	121,650			11
12	Social Services	116,248		4,507	120,755		120,755	(3,358)	117,397			12
13	CNA Training											13
14	Program Transportation	20,096		8,167	28,263		28,263	(2,322)	25,941			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,781,583	151,270	39,546	2,972,399		2,972,399	(47,159)	2,925,240			16
	C. General Administration											
17	Administrative	102,938			102,938		102,938	(2,973)	99,965			17
18	Directors Fees											18
19	Professional Services			111,220	111,220		111,220	(3,213)	108,007			19
20	Dues, Fees, Subscriptions & Promotions			28,026	28,026		28,026	(9,755)	18,271			20
21	Clerical & General Office Expenses	328,282	25,598	292,799	646,679		646,679	(277,479)	369,200			21
22	Employee Benefits & Payroll Taxes			788,423	788,423		788,423	(22,774)	765,649			22
23	Inservice Training & Education			433	433		433		433			23
24	Travel and Seminar			2,043	2,043		2,043	(59)	1,984			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			119,800	119,800		119,800	(9,765)	110,035			26
27	Other (specify):*											27
28	TOTAL General Administration	431,220	25,598	1,342,744	1,799,562		1,799,562	(326,018)	1,473,544			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,156,337	543,247	1,821,539	6,521,123		6,521,123	(538,780)	5,982,343			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	14,580	126,189	100.00%	11.55%	422,540	48,821
Food	Meals Served	14,580	126,189	100.00%	11.55%	292,430	33,788
Housekeeping	Census Factored	4,860	42,063	25.00%	2.89%	227,103	6,560
Laundry	Census Factored	4,860	42,063	25.00%	2.89%	71,967	2,079
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	250,221	31,278
Maintenance	Square Feet	1	8	100.00%	12.50%	221,924	27,741
Activities	Census	4,860	42,063	25.00%	2.89%	152,105	4,394
Social Services	Census	4,860	42,063	25.00%	2.89%	116,248	3,358
Program Transportation	Census	4,860	42,063	100.00%	11.55%	20,096	2,322
Administrative	Census	4,860	42,063	25.00%	2.89%	102,938	2,973
Professional Fees	Census	4,860	42,063	25.00%	2.89%	111,220	3,213
Dues, Fees, Subscriptions and Promotions	Census	4,860	42,063	25.00%	2.89%	28,349	819
Clerical and Office Expenses	Census	4,860	42,063	25.00%	2.89%	328,282	9,483
Travel and Seminar	Census	4,860	42,063	25.00%	2.89%	2,043	59
Insurance - Property	Square Feet	1	8	100.00%	12.50%	65,595	8,199
Insurance - Liability	Census	4,860	42,063	25.00%	2.89%	54,206	1,566
Depreciation	Square Feet	1	8	100.00%	12.50%	201,403	25,175
Equipment Rental	Census	4,860	42,063	25.00%	2.89%	19,032	550
Employee Benefits	Census	4,860	42,063	25.00%	2.89%	788,423	22,774
						3,476,125	235,149

Facility Name & ID Number OUR LADY OF ANGELS RET HOME #0034975 **Report Period Beginning:** 7/1/13 **Ending:** 6/30/14

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			201,403	201,403		201,403	(30,986)	170,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,228	21,228		21,228	(26,781)	(5,553)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,873	847,873		847,873	(847,873)				34
35	Rent-Equipment & Vehicles			19,032	19,032		19,032	(550)	18,482			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,089,536	1,089,536		1,089,536	(906,190)	183,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		223,463	682,170	905,633		905,633		905,633			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,664	4,664		4,664		4,664			41
42	Provider Participation Fee			179,326	179,326		179,326		179,326			42
43	Other (specify):* DEVEL/CHAPEL			51,005	51,005		51,005	(52,576)	(1,571)			43
44	**TOTAL Special Cost Centers**		223,463	917,165	1,140,628		1,140,628	(52,576)	1,088,052			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,156,337	766,710	3,828,240	8,751,287		8,751,287	(1,497,546)	7,253,741			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	38,062
Fund Raising - Data Processing	3,946
Fund Raising - Public Relations	17
Fund Raising - Fundraiser Expenses	8,980
Total	**51,005**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	(20,989)	02		4
5	Telephone, TV & Radio in Resident Rooms	(58,829)	21		5
6	Rented Facility Space	(37,245)			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	(26,781)	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	(6,517)	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	(202,020)	21		24
25	Fund Raising, Advertising and Promotional	(5,364)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,572)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (361,317)		$	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))**	$ (361,317)		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

OUR LADY OF ANGELS RET HOME

ID# 0034975

Report Period Beginning: 7/1/13

Ending: 6/30/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Income	$ (37,085)	11	1
2	Bank Charges	(1,571)	43	2
3	Theft Loss	(300)	21	3
4	Board Gifts	(160)	21	4
5	Memorial Expense	(170)	21	5
6	Chapel Expense (Non-adjusted for Income)	(38,062)	43	6
7	Development Expenses	(12,943)	43	7
8	Capitalized Asset - Under $2,500 Threshold	5,653	06	8
9	Capitalized Asset - Depreciation Adjustment	(5,811)	30	9
10	Independent Living (Allocated Costs)			10
11	Dietary	(48,821)	01	11
12	Food	(33,788)	02	12
13	Housekeeping	(6,560)	03	13
14	Laundry	(2,079)	04	14
15	Heat and Other Utilities	(31,278)	05	15
16	Maintenance	(27,741)	06	16
17	Activities	(4,394)	11	17
18	Social Services	(3,358)	12	18
19	Program Transportation	(2,322)	14	19
20	Administrative	(2,973)	17	20
21	Professional Fees	(3,213)	19	21
22	Dues, Fees, Subscriptions & Promotions	(819)	20	22
23	Clerical & Office Expense	(9,483)	21	23
24	Travel & Seminar	(59)	24	24
25	Insurance - Property	(8,199)	26	25
26	Insurance - Liability	(1,566)	26	26
27	Depreciation	(25,175)	30	27
28	Equipment Rental	(550)	35	28
29	Employee Benefits	(22,774)	22	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**	(325,601)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 **Report Period Beginning:** 7/1/13 **Ending:** 6/30/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(48,821)	0	0	0	0	0	0	0	0	0	0	(48,821)	1
2	Food Purchase	(54,777)	0	0	0	0	0	0	0	0	0	0	(54,777)	2
3	Housekeeping	(6,560)	0	0	0	0	0	0	0	0	0	0	(6,560)	3
4	Laundry	(2,079)	0	0	0	0	0	0	0	0	0	0	(2,079)	4
5	Heat and Other Utilities	(31,278)	0	0	0	0	0	0	0	0	0	0	(31,278)	5
6	Maintenance	(22,088)	0	0	0	0	0	0	0	0	0	0	(22,088)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(165,603)	0	0	0	0	0	0	0	0	0	0	(165,603)	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	(41,479)	0	0	0	0	0	0	0	0	0	0	(41,479)	11
12	Social Services	(3,358)	0	0	0	0	0	0	0	0	0	0	(3,358)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,322)	0	0	0	0	0	0	0	0	0	0	(2,322)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(47,159)	0	0	0	0	0	0	0	0	0	0	(47,159)	16
	C. General Administration													
17	Administrative	(2,973)	0	0	0	0	0	0	0	0	0	0	(2,973)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,213)	0	0	0	0	0	0	0	0	0	0	(3,213)	19
20	Fees, Subscriptions & Promotions	(9,755)	0	0	0	0	0	0	0	0	0	0	(9,755)	20
21	Clerical & General Office Expenses	(277,479)	0	0	0	0	0	0	0	0	0	0	(277,479)	21
22	Employee Benefits & Payroll Taxes	(22,774)	0	0	0	0	0	0	0	0	0	0	(22,774)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(59)	0	0	0	0	0	0	0	0	0	0	(59)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,765)	0	0	0	0	0	0	0	0	0	0	(9,765)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(326,018)	0	0	0	0	0	0	0	0	0	0	(326,018)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(538,780)	0	0	0	0	0	0	0	0	0	0	(538,780)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OUR LADY OF ANGELS RET HOME **#** 0034975 **Report Period Beginning:** 7/1/13 **Ending:** 6/30/14

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	(30,986)	0	0	0	0	0	0	0	0	0	0	(30,986)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,781)	0	0	0	0	0	0	0	0	0	0	(26,781)	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	(550)	0	0	0	0	0	0	0	0	0	0	(550)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(58,317)	(847,873)	0	0	0	0	0	0	0	0	0	(906,190)	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):*	(52,576)	0	0	0	0	0	0	0	0	0	0	(52,576)	43
44	**TOTAL Special Cost Centers**	(52,576)	0	0	0	0	0	0	0	0	0	0	(52,576)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(649,673)	(847,873)	0	0	0	0	0	0	0	0	0	(1,497,546)	45

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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: 7/1/13 Ending: 6/30/14

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	Richard Kasper	BOD						1
2	Kathy Birsa-Smith	BOD						2
3	Scott Czerkies	BOD						3
4	Fr. William Dewan	BOD						4
5	Sr. Mary Jane Griffin, OSF	BOD						5
6	Susan Martin	BOD						6
7	Kathyn Weigel	BOD						7
8	Sr. Dolores Zemont, OSF	BOD						8
9	Sr. Clarita Schumacher, OSF	BOD						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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	Pastoral Care Dir.	Administrative	See Below	0	36	100.00	Salary	$ 32,339	21-01	1
2	Sr. Donna Marie Baier, OSF	Volunteer Coord.	Administrative	See Below	0	35	100.00	Salary	24,020	11-01	2
3	Sr. Odelia Kloc. OSF	Enrichment Coord.	Administrative	See Below	0	40	100.00	Salary	28,829	11-01	3
4	Sr. Mary Ann Jerkofsky, OSF	Admissions Asst.	Administrative	See Below	0	25	100.00	Hourly	17,456	21-01	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 102,644		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: 7/1/13 Ending: 6/30/14

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: 7/1/13 Ending: 6/30/14

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	$7,341.78	1/3/14	393,585	357,761	12/26/18	4.5000	8,658	6
7	FIRST MIDWEST BANK	X		CASH FLOWS			500,000				10,176	7
8	CHRISTIAN BROTHERS	X		INS POLICY INT CHARGES							2,394	8
9	TOTAL Facility Related				$7,341.78		$ 893,585	$ 357,761			$ 21,228	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 893,585	$ 357,761			$ 21,228	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: 7/1/13 Ending: 6/30/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 7/1/13 Ending: 6/30/14

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. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

INDEPENDENT LIVING - 14 UNITS (REPRESENTS 1/8 OF THE FACILITY)

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	609,840	1962	$	1
2					2
3	TOTALS	609,840		$	3

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	61,156		15-40				9
10	VARIOUS			1993	139,145		15-40				10
11	VARIOUS			1994	34,476		15-40				11
12	VARIOUS			1995	89,923		15-40				12
13	VARIOUS			1996	188,236		15-40				13
14	VARIOUS			1997	365,084		15-40				14
15	VARIOUS			1998	34,996		15-40				15
16	VARIOUS			1999	5,332		15-40				16
17	VARIOUS			2000	123,450		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	119,197		15-40				21
22	VARIOUS			2005	54,148		15-40				22
23	VARIOUS			2006	72,931		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	VARIOUS			2010	69,161		15-40				27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	VARIOUS - FINANCIAL STATEMENT DEPRECIATION					121,303	15-40	121,303		1,656,246	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: 7/1/13 Ending: 6/30/14

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	Elevator Upgrades	2011	$ 97,951	$ 6,530	15	$ 6,530	$	$	37
38	Driveway - Paving and Drainage	2011	118,504	10,154	15	10,154			38
39	Lobby Renovations	2011	23,975	1,199	20	1,199			39
40	Heat & Smoke Detectors	2011	4,324	432	10	432			40
41	Boiler Work	2011	12,566	2,513	5	2,513			41
42	Model Room Renovations	2011	2,836	435	5	435			42
43	Parking Lot Reseal	2011	3,265	653	5	653			43
44	Roof Repair	2012	5,000	250	20	250			44
45	Air Conditioning Work	2012	3,247	325	10	325			45
46	Fire Panel	2013	21,753	1,191	15	1,191			46
47	Air Conditioning Work	2013	7,269	727	10	727			47
48	Boiler Work	2013	3,368	674	5	674			48
49	Fire Detectors	2013	3,363	673	5	673			49
50	Parking Lot Reseal	2013	5,665	850	5	850			50
51	Tuckpoint - Entrance	2013	3,312	128	15	128			51
52	A/C - B2 Dining Room	2013	11,227	748	10	748			52
53	Elevator Upgrades	2014	143,244	406	20	406			53
54	Laundry - Heating Line	2014	3,265	136	10	136			54
55	Exterior Lighting	2014	3,408	42	20	42			55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,291,255	$ 149,369		$ 149,369	$	$ 1,656,246	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: 7/1/13 Ending: 6/30/14

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	$ 328,172	$ 38,091	$ 38,091	$		$ 225,063	71
72	Current Year Purchases	2,695	270	270			270	72
73	Fully Depreciated Assets	779,993	13,065	13,065			793,874	73
74							1,170	74
75	TOTALS	$ 1,110,860	$ 51,426	$ 51,426	$		$ 1,020,376	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	608	608		5		79
80	TOTALS			$ 87,126	$ 608	$ 608	$		$ 84,088	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)	$ 8,489,241	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,403	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,403	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)	$ 2,760,710	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: 7/1/13 Ending: 6/30/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 19,031 Description: COPIERS $17,962 AND POSTAGE MACHINE $1,070
    (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: 7/1/13 Ending: 6/30/14

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: 7/1/13 Ending: 6/30/14

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		hrs	$		$ 252,719	$		$ 252,719	1
2	Licensed Speech and Language Development Therapist		hrs			40,197			40,197	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			273,593			273,593	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				221,670		221,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): SEE SUPPLEMENTAL						1,794		1,794	12
13	Other (specify): SEE SUPPLEMENTAL						115,661		115,661	13
14	TOTAL			$		$ 566,508	$ 339,125		$ 905,633	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.

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 16 Supplemental
07/01/13 - 06/30/14

Page 16 Line 12 Column 6: Other Ancillary Supplies

Feeding Tubes	348
Medical Supplies	1,446
Total	1,794

Page 16 Line 12 Column 6: Other Ancillary Expense

Laboratory	44,536
Radiology	37,107
Ambulance	602
Other Hospital Services	33,416
Total	115,661

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/14 (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	$ 610,285	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,423,619		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	202,747		6
7	Other Prepaid Expenses	22,717		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,259,368	$	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	3,531,895		15
16	Equipment, at Historical Cost	1,110,860		16
17	Accumulated Depreciation (book methods)	(2,808,142)		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)**	$ 1,834,613	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,093,981	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 800,911	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	308,391		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	164,648		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,273,950	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	557,761		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)**	$ 557,761	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,831,711	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,366,057	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,197,768	$	48

***(See instructions.)**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,067,191	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,067,191	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	298,866	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)**	$ 298,866	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)**	$ 2,366,057	24	*

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	$ 8,522,774	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,522,774	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,389	12
13	Barber and Beauty Care	4,521	13
14	Non-Patient Meals	20,989	14
15	Telephone, Television and Radio	6,856	15
16	Rental of Facility Space	37,244	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	789	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 76,788	23
	D. Non-Operating Revenue		
24	Contributions	416,342	24
25	Interest and Other Investment Income***	26,781	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 443,123	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS REVENUE	7,468	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,468	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,050,153	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,749,162	31
32	Health Care	2,972,399	32
33	General Administration	1,799,562	33
	B. Capital Expense		
34	Ownership	1,089,536	34
	C. Ancillary Expense		
35	Special Cost Centers	961,302	35
36	Provider Participation Fee	179,326	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,751,287	40
41	**Income before Income Taxes (line 30 minus line 40)****	298,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 298,866	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,335,902	44
45	Private Pay - Net Inpatient Revenue	3,936,631	45
46	Medicare - Net Inpatient Revenue	2,770,303	46
47	Other-(specify) INDEPENDENT LIVING	479,938	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,522,774	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.**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	1,724	2,032	$ 71,534	$ 35.20	1
2	Assistant Director of Nursing	1,192	1,336	41,588	31.13	2
3	Registered Nurses	23,924	26,040	688,240	26.43	3
4	Licensed Practical Nurses	24,269	26,861	669,667	24.93	4
5	CNAs & Orderlies	72,172	77,712	886,199	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,320	4,752	63,368	13.34	8
9	Activity Director	1,868	2,048	41,289	20.16	9
10	Activity Assistants	8,827	9,497	110,816	11.67	10
11	Social Service Workers	5,145	5,621	116,248	20.68	11
12	Dietician					12
13	Food Service Supervisor	1,780	2,032	51,602	25.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,506	28,645	295,624	10.32	15
16	Dishwashers	8,112	8,396	75,314	8.97	16
17	Maintenance Workers	10,416	11,696	221,924	18.97	17
18	Housekeepers	22,381	24,618	227,103	9.23	18
19	Laundry	6,537	7,530	71,967	9.56	19
20	Administrator	1,784	1,800	102,938	57.19	20
21	Assistant Administrator					21
22	Other Administrative	1,880	176	59,904	340.36	22
23	Office Manager					23
24	Clerical	10,336	11,004	268,378	24.39	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	1,796	2,040	26,297	12.89	31
32	Other Health C: Central Supply Cl	1,899	2,113	46,241	21.88	32
33	Other(specify) DRIVER	1,845	1,920	20,096	10.47	33
34	TOTAL (lines 1 - 33)	238,713	257,869	$ 4,156,337 *	$ 16.12	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	$ 9,540	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	1,312	11-03	44
45	Social Service Consultant	Monthly	4,507	12-03	45
46	Other(specify)				46
47	Management Consultant	Intermittent	15,269	19-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 56,188		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: 7/1/13 Ending: 6/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Boyle	Administrator	0	$ 59,525
George Block	Administrator	0	43,413
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 102,938

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 CONSULTAN	$ 33,369
SHEAHAN GROUP	MANAGEMENT CONSULTAN	7,997
JOHN DUDEK	MANAGEMENT CONSULTAN	2,023
HUMAN READINESS	MANAGEMENT CONSULTAN	824
PROFESSIONAL MEDICAL	MANAGEMENT CONSULTAN	3,000
KAYLYNN WABICH-JINDRA	MANAGEMENT CONSULTAN	1,425
TELUSYS	DATA PROCESSING	759
NTT DATA	DATA PROCESSING	18,549
COMCAST	DATA PROCESSING	4,910
ABILITY	DATA PROCESSING	6,457
GOOGLE APPS	DATA PROCESSING	3,380
SEE SUPPLEMENTAL SCHEDULE		25,314
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 108,007

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,643
Unemployment Compensation Insurance	27,411
FICA Taxes	290,162
Employee Health Insurance	355,945
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
EMPLOYEE PHYSICALS	6,735
PENSION	80,575
OTHER EMPLOYEE WELFARE	5,952
PG 5A NON-ALLOWABLE COSTS	(22,774)
TOTAL (agree to Schedule V, line 22, col.8)	$ 765,649

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	829
Health Care Worker Background Check	3,670
(Indicate # of checks performed 49)	
Patient Background Checks	
DUES - ASSOCIATIONS	10,487
LICENSES & FEES	4,105
ADVERTISING AND PROMOTION	9,258
Less: Public Relations Expense	(1,605)
Non-allowable advertising	(4,578)
Yellow page advertising	(3,572)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,594

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,043
PG 5A NON-ALLOWABLE COSTS	(59)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,984

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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	$ 10,239
BARRACUDA NETWORK	DATA PROCESSING	1,188
QQUEST	DATA PROCESSING	1,792
SUSAN CHAVEZ	DATA PROCESSING	100
SUREQUEST	DATA PROCESSING	588
NEBO SYSTEMS	DATA PROCESSING	385
CLIFTON LARSON ALLEN	ACCOUNTING	9,021
TEMPLIN HEALTHCARE ACCT	ACCOUNTING	2,265
TRACY, JOHNSON & WILSON	LEGAL	761
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	2,188
PAGE 5A NON ALLOWABLE		(3,213)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 25,314

D. Employee Benefits and Payroll Taxes

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

* Attach copy of IMRF notifications

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

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

G. Schedule of Travel and Seminar**

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

**See instructions.

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 21 Supplemental
07/01/13 - 06/30/14

Seminar Schedule

Seminar Title	Date	Location	Attendee	Attendee Title	Amount
Dementia: Challenges and Barriers	09/19/13	Joliet, IL	April Brownlee	Activities Director	50.00
Multi-Dimensional Functional Screening and Assessment for	09/20/13	Joliet, IL	Kayla Euler	Nursing Supervisor	149.00
Multi-Dimensional Functional Screening and Assessment for	09/20/13	Joliet, IL	Dawn Disera	Social Services Director	149.00
Multi-Dimensional Functional Screening and Assessment for	09/20/13	Joliet, IL	Paula Hargis	Admissions Director	149.00
Riding the Wave of Change: CMS Final Rule 2014	09/20/13	Webinar	Diane Simon	Finance Manager	100.00
Pain & the Older Adult	10/16/13	Joliet, IL	Kayla Euler	Nursing Supervisor	129.00
Pain & the Older Adult	10/16/13	Joliet, IL	Maribeth Wunderlich	ADON	129.00
RUGS IV- 48 and Getting Credit for What You Do	10/15/13	Woodridge, IL	Denice Hlavacik	MDS Coordinator	95.00
RUGS IV- 48 and Getting Credit for What You Do	10/15/13	Woodridge, IL	James Boyle	Administrator	95.00
Home Infusion Nursing Program	09/07/13	Des Plaines, IL	Maribeth Wunderlich	ADON	195.00
CPR Training	03/06/14	Joliet, IL	Nursing Staff	Nurses & Staff	425.00
Payroll Law	08/26/14	Joliet, IL	Jeni Rock	Payroll Clerk	199.00

New Dining Practice Standards	10/29/13	Schaumburg, IL	Alice Lagman	Dietary Director	179.00
Pg 5A Non-Allowable Costs					(59.00)

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/13 Ending: 6/30/14

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: 7/1/13 Ending: 6/30/14

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 $5787**

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

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

(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? **15 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,010** 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 ____ 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. $ **179,326**
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. $ **20,989**

(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? **0**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.