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.

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

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: 8/10/1962

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: **Telephone Number:** ( )
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 7/1/14 to 6/30/15 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: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 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		1,140	5,285	6,425	8
9	SNF/PED					9
10	ICF	10,551	10,263		20,814	10
11	ICF/DD					11
12	SC		11,995		11,995	12
13	DD 16 OR LESS					13
14	TOTALS	10,551	23,398	5,285	39,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.46%

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 5,285

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: 06/30/2015 Fiscal Year: 06/30/2015

* 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: 7/1/14 Ending: 6/30/15

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	396,716	34,855	10,440	442,011		442,011	(45,837)	396,174			1
2	Food Purchase		286,303		286,303		286,303	(53,425)	232,878			2
3	Housekeeping	177,755	46,672		224,427		224,427	(5,134)	219,293			3
4	Laundry	79,953	7,599	703	88,255		88,255	(2,309)	85,946			4
5	Heat and Other Utilities			229,469	229,469		229,469	(28,684)	200,785			5
6	Maintenance	278,193		192,772	470,965		470,965	(71,465)	399,500			6
7	Other (specify):*											7
8	**TOTAL General Services**	932,617	375,429	433,384	1,741,430		1,741,430	(206,854)	1,534,576			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,579,639	160,628	2,790	2,743,057		2,743,057		2,743,057			10
10a	Therapy											10a
11	Activities	153,420	14,546	512	168,478		168,478	(39,557)	128,921			11
12	Social Services	67,705		1,557	69,262		69,262	(1,956)	67,306			12
13	CNA Training											13
14	Program Transportation	20,785		10,217	31,002		31,002	(2,402)	28,600			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,821,549	175,174	39,076	3,035,799		3,035,799	(43,915)	2,991,884			16
	C. General Administration											
17	Administrative	85,920			85,920		85,920	(2,482)	83,438			17
18	Directors Fees											18
19	Professional Services			127,981	127,981		127,981	(3,697)	124,284			19
20	Dues, Fees, Subscriptions & Promotions			28,875	28,875		28,875	(5,100)	23,775			20
21	Clerical & General Office Expenses	313,317	23,017	165,211	501,545		501,545	(142,649)	358,896			21
22	Employee Benefits & Payroll Taxes			963,221	963,221		963,221	(27,823)	935,398			22
23	Inservice Training & Education			2,216	2,216		2,216		2,216			23
24	Travel and Seminar			2,224	2,224		2,224	(64)	2,160			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			121,115	121,115		121,115	(9,907)	111,208			26
27	Other (specify):*											27
28	**TOTAL General Administration**	399,237	23,017	1,410,843	1,833,097		1,833,097	(191,722)	1,641,375			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,153,403	573,620	1,883,303	6,610,326		6,610,326	(442,491)	6,167,835			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%	396,716	45,837
Food	Meals Served	14,580	126,189	100.00%	11.55%	286,303	33,080
Housekeeping	Census Factored	4,860	42,063	25.00%	2.89%	177,755	5,134
Laundry	Census Factored	4,860	42,063	25.00%	2.89%	79,953	2,309
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	229,469	28,684
Maintenance	Square Feet	1	8	100.00%	12.50%	278,193	34,774
Activities	Census	4,860	42,063	25.00%	2.89%	153,420	4,432
Social Services	Census	4,860	42,063	25.00%	2.89%	67,705	1,956
Program Transportation	Census	4,860	42,063	100.00%	11.55%	20,785	2,402
Administrative	Census	4,860	42,063	25.00%	2.89%	85,920	2,482
Professional Fees	Census	4,860	42,063	25.00%	2.89%	127,981	3,697
Dues, Fees, Subscriptions and Promotions	Census	4,860	42,063	25.00%	2.89%	28,875	834
Clerical and Office Expenses	Census	4,860	42,063	25.00%	2.89%	313,317	9,050
Travel and Seminar	Census	4,860	42,063	25.00%	2.89%	2,224	64
Insurance - Property	Square Feet	1	8	100.00%	12.50%	66,679	8,335
Insurance - Liability	Census	4,860	42,063	25.00%	2.89%	54,435	1,572
Depreciation	Square Feet	1	8	100.00%	12.50%	193,512	24,189
Equipment Rental	Census	4,860	42,063	25.00%	2.89%	20,258	585
Employee Benefits	Census	4,860	42,063	25.00%	2.89%	963,221	27,823
						3,546,722	237,239

Our Lady of Angels Retirement Home
Line 43 -Professional Service
Legal Expenses

Firm Name	Invoice Date	Expense Type	Allowable Amount
Tracy, Johnson & Wilson	9/9/2014	Estate/Trust Consultation	19
Tracy, Johnson & Wilson	11/11/2014	Estate/Trust Consultation	56
Polsinelli PC	6/28/2015	General Matters	419
Polsinelli PC	8/27/2014	General Matters	1,044
Polsinelli PC	12/31/2014	General Matters	116
Tracy, Johnson & Wilson	12/5/2014	State Filing - Annual Report	93
Polsinelli PC	9/19/2014	Bad Debt/Collections	360
Polsinelli PC	9/18/2014	Bad Debt/Collections	224
Polsinelli PC	10/10/2014	Bad Debt/Collections	154
Polsinelli PC	1/30/2015	Bad Debt/Collections	655
Polsinelli PC	2/19/2015	Bad Debt/Collections	798
Polsinelli PC	3/24/2015	Bad Debt/Collections	39
Polsinelli PC	4/23/2015	Bad Debt/Collections	1,470
Polsinelli PC	5/31/2015	Bad Debt/Collections	4,833
Polsinelli PC	6/15/2015	Bad Debt/Collections	2,737
Polsinelli PC	6/15/2015	Bad Debt/Collections	3,549
Polsinelli PC	6/19/2015	Bad Debt/Collections	637
Polsinelli PC	6/15/2015	Residency Contract Review/Update	4,238
		Total	**21,438**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME #0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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			193,512	193,512		193,512	(29,232)	164,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,219	17,219		17,219	(13,289)	3,930			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,873	847,873		847,873	(847,873)				34
35	Rent-Equipment & Vehicles			20,258	20,258		20,258	(585)	19,673			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,078,863	1,078,863		1,078,863	(890,979)	187,884			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,216	726,161	876,377		876,377		876,377			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,287	5,287		5,287		5,287			41
42	Provider Participation Fee			189,122	189,122		189,122		189,122			42
43	Other (specify):* DEVEL/CHAPEL			51,303	51,303		51,303	(53,069)	(1,766)			43
44	**TOTAL Special Cost Centers**		150,216	971,873	1,122,089		1,122,089	(53,069)	1,069,020			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,153,403	723,836	3,934,039	8,811,278		8,811,278	(1,386,539)	7,424,739			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	44,140
Fund Raising - Data Processing	2,376
Fund Raising - Public Relations	3,130
Fund Raising - Fundraiser Expenses	1,657
Total	**51,303**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(20,345)	02		4
5	Telephone, TV & Radio in Resident Rooms	(52,832)	21		5
6	Rented Facility Space	(38,895)	06		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	(13,289)	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	(20,521)	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	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,472)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(794)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (210,148)		$	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))**	$ (210,148)		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: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Income	$ (35,125)	11	1
2	Bank Charges	(1,766)	43	2
3	Theft Loss	(50)	21	3
4	Memorial Expenses	(196)	21	4
5	Chapel Expenses (Non-adjusted for Income)	(44,140)	43	5
6	Development Expenses	(7,163)	43	6
7	Capitalized Asset - Under $2500 Threshold	2,204	06	7
8	Capitalized Asset - Depreciation Adjustment	(5,043)	30	8
9	Independent Living (Allocated Costs)			9
10	Dietary	(45,837)	01	10
11	Food	(33,080)	02	11
12	Housekeeping	(5,134)	03	12
13	Laundry	(2,309)	04	13
14	Heat & Other Utilities	(28,684)	05	14
15	Maintenance	(34,774)	06	15
16	Activities	(4,432)	11	16
17	Social Services	(1,956)	12	17
18	Program Transportation	(2,402)	14	18
19	Administrative	(2,482)	17	19
20	Professional Fees	(3,697)	19	20
21	Dues, Fees, Subscriptions & Promotions	(834)	20	21
22	Clerical & Office Expenses	(9,050)	21	22
23	Travel & Seminar	(64)	24	23
24	Insurance - Property	(8,335)	26	24
25	Insurance - Liability	(1,572)	26	25
26	Depreciation	(24,189)	30	26
27	Equipment Rental	(585)	35	27
28	Employee Benefits	(27,823)	22	28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(328,518)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	(45,837)	0	0	0	0	0	0	0	0	0	0	(45,837)	1
2	Food Purchase	(53,425)	0	0	0	0	0	0	0	0	0	0	(53,425)	2
3	Housekeeping	(5,134)	0	0	0	0	0	0	0	0	0	0	(5,134)	3
4	Laundry	(2,309)	0	0	0	0	0	0	0	0	0	0	(2,309)	4
5	Heat and Other Utilities	(28,684)	0	0	0	0	0	0	0	0	0	0	(28,684)	5
6	Maintenance	(71,465)	0	0	0	0	0	0	0	0	0	0	(71,465)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(206,854)	0	0	0	0	0	0	0	0	0	0	(206,854)	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	(39,557)	0	0	0	0	0	0	0	0	0	0	(39,557)	11
12	Social Services	(1,956)	0	0	0	0	0	0	0	0	0	0	(1,956)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,402)	0	0	0	0	0	0	0	0	0	0	(2,402)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(43,915)	0	0	0	0	0	0	0	0	0	0	(43,915)	16
	C. General Administration													
17	Administrative	(2,482)	0	0	0	0	0	0	0	0	0	0	(2,482)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,697)	0	0	0	0	0	0	0	0	0	0	(3,697)	19
20	Fees, Subscriptions & Promotions	(5,100)	0	0	0	0	0	0	0	0	0	0	(5,100)	20
21	Clerical & General Office Expenses	(142,649)	0	0	0	0	0	0	0	0	0	0	(142,649)	21
22	Employee Benefits & Payroll Taxes	(27,823)	0	0	0	0	0	0	0	0	0	0	(27,823)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(64)	0	0	0	0	0	0	0	0	0	0	(64)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,907)	0	0	0	0	0	0	0	0	0	0	(9,907)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(191,722)	0	0	0	0	0	0	0	0	0	0	(191,722)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(442,491)	0	0	0	0	0	0	0	0	0	0	(442,491)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OUR LADY OF ANGELS RET HOME **#** 0034975 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

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	(29,232)	0	0	0	0	0	0	0	0	0	0	(29,232)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,289)	0	0	0	0	0	0	0	0	0	0	(13,289)	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	(585)	0	0	0	0	0	0	0	0	0	0	(585)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(43,106)	(847,873)	0	0	0	0	0	0	0	0	0	(890,979)	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):*	(53,069)	0	0	0	0	0	0	0	0	0	0	(53,069)	43
44	**TOTAL Special Cost Centers**	(53,069)	0	0	0	0	0	0	0	0	0	0	(53,069)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(538,666)	(847,873)	0	0	0	0	0	0	0	0	0	(1,386,539)	45

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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. [X] YES [ ] NO

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 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: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Kathryn Weigel	BOD						1
2	Donald Cordano	BOD						2
3	Scott Czerkies	BOD						3
4	Fr. William Dewan	BOD						4
5	Sr. Mary Jane Griffin, OSF	BOD						5
6	Sr. Dolores Zemont, OSF	BOD						6
7	Sr. Clarita Schumacher, OSF	BOD						7
8	Richard Kasper	BOD						8
9	Sara Leone	BOD						9
10	Thomas Grotovsky	BOD						10
11	Kathryn Giegerich	BOD						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: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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. Donna Marie Baier, OSF	Volunteer Coord.	Administrative	See Below	0	35	100.00	Salary	$ 22,161	11-01	1
2	Sr. Odelia Kloc, OSF	Enrichment Coord.	Administrative	See Below	0	40	100.00	Salary	34,472	11-01	2
3	Sr. Mary Ann Jerkofsky, OSF	Admissions Asst.	Administrative	See Below	0	25	100.00	Salary	17,290	21-01	3
4	Sr. Geri Podobnik, OSF	MDS Coord.	Nursing	See Below	0	20	100.00	Salary	1,995	10-01	4
5											5
6											6
7	The Sisters are members of										7
8	the Sisters of St. Francis that										8
9	sponsors OLA as a non-profit										9
10	organization.										10
11											11
12											12
13								TOTAL	$ 75,918		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: 7/1/14 Ending: 6/30/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 7/1/14 Ending: 6/30/15

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	284,466	12/26/18	4.5000	14,805	6
7	CHRISTIAN BROTHERS		X	INS POLICY INT CHARGES							2,414	7
8												8
9	TOTAL Facility Related				$7,341.78		$ 393,585	$ 284,466			$ 17,219	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 393,585	$ 284,466			$ 17,219	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:** 7/1/14 **Ending:** 6/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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: 7/1/14 Ending: 6/30/15

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			1993	139,145		15-40				9
10	VARIOUS			1994	34,476		15-40				10
11	VARIOUS			1995	89,923		15-40				11
12	VARIOUS			1996	188,236		15-40				12
13	VARIOUS			1997	365,084		15-40				13
14	VARIOUS			1998	34,996		15-40				14
15	VARIOUS			1999	5,332		15-40				15
16	VARIOUS			2000	123,450		15-40				16
17	VARIOUS			2001	54,577		15-40				17
18	VARIOUS			2002	398,917		15-40				18
19	VARIOUS			2003	83,462		15-40				19
20	VARIOUS			2004	119,197		15-40				20
21	VARIOUS			2005	54,148		15-40				21
22	VARIOUS			2006	72,931		15-40				22
23	VARIOUS			2007	3,208,187		15-40				23
24	VARIOUS			2008	73,616		15-40				24
25	VARIOUS			2009	65,296		15-40				25
26	VARIOUS			2010	69,161		15-40				26
27	VARIOUS			2011	263,421		15-40				27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36						177,399	15-40	177,399		2,811,975	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 # Report Period Beginning: Ending:

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	Roof Repair	2012	$ 5,000	$ 250	20	$ 250	$	$ 844	37
38	Air Conditioning Work	2012	3,247	325	10	325		1,002	38
39	Fire Panel	2013	21,753	1,450	15	1,450		3,591	39
40	Air Conditioning Work	2013	7,269	727	10	727		1,999	40
41	Boiler Work	2013	3,368	674	5	674		1,516	41
42	Fire Detectors	2013	3,363	673	5	673		1,402	42
43	Parking Lot Reseal	2013	5,665	1,133	5	1,133		1,982	43
44	Tuckpoint - Entrance	2013	3,312	221	15	221		350	44
45	A/C - B2 Dining Room	2013	11,227	1,122	10	1,122		1,871	45
46	Elevator Upgrades	2014	143,244	1,220	20	1,220		9,550	46
47	Laundry - Heating Line	2014	3,265	327	10	327		462	47
48	Exterior Lighting	2014	3,408	170	20	170		213	48
49	Cooling Tower	2015	44,823	139	15	139		139	49
50	Boiler - Tube	2015	9,355	520	15	520		520	50
51	Boiler - Main	2015	3,965	529	5	529		529	51
52	Room Improvements - Sheltered Care - Carpet & Painting	2015	9,471	789	5	789		789	52
53	Boiler	2015	4,161	347	5	347		347	53
54	Water Tank	2015	3,968	265	5	265		265	54
55	Sprinkler Repairs	2015	2,791	186	5	186		186	55
56	A & B Hallways - Fire Door Upgrade Project (IDPH Survey)	2015	260,982	2,610	25	2,610		2,610	56
57	Asbestos Removal, Replace Fire Doors & Ceilings								57
58	Elevator Pit Ladders	2015	7,780	195	10	195		195	58
59	A & B Hallways - Sprinkler, Alarms, Lighting & Electrical Work	2015	25,546	170	25	170		170	59
60	Fireproofing - Beams	2015	10,900		10			1,090	60
61	Nursing Equipment	2015	9,157		5				61
62	Refrigerator	2015	3,395		5				62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,626,393	$ 191,440		$ 191,440	$	$ 2,843,596	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: 7/1/14 Ending: 6/30/15

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	$ 319,190	$	$	$		$	71
72	Current Year Purchases	12,552						72
73	Fully Depreciated Assets	793,894						73
74								74
75	TOTALS	$ 1,125,636	$	$	$		$	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	Ford Five Hundred	2006	$ 21,359	$	$	$	5	$ 21,359	76
77	Facility	Repairs	2012	3,038	607	607		5	1,215	77
78	Facility	Tires & Suspension (Ford)	2015	2,965	346	346		5	1,215	78
79	Facility	Ford Bus	2015	53,798	1,120	1,120		5	1,120	79
80	TOTALS			$ 81,160	$ 2,073	$ 2,073	$		$ 24,909	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)	$	8,833,189	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	193,513	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	193,513	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)	$	2,868,505	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 20,258 Description: COPIERS $19,729 AND POSTAGE MACHINE $529
(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: 7/1/14 Ending: 6/30/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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: 7/1/14 Ending: 6/30/15

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	22-3	hrs	$		$ 278,261	$		$ 278,261	1
2	Licensed Speech and Language Development Therapist	22-3	hrs			39,872			39,872	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	22-3	hrs			316,951			316,951	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	22-2	# of prescrpts				147,071		147,071	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education	22-2	hrs							11
12	Other (specify): SEE SUPPLEMENTAL						3,145		3,145	12
13	Other (specify): SEE SUPPLEMENTA	22-3					91,077		91,077	13
14	TOTAL			$		$ 635,084	$ 241,293		$ 876,377	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
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Page 16 Line 12 Column 6: Other Ancillary Supplies

Medical Supplies	3,145
Total	3,145

Page 16 Line 13 Column 6: Other Ancillary Expense

Laboratory	36,140
Radiology	32,923
Ambulance	74
Other Hospital Services	21,940
Total	91,077

Facility Name & ID Number OUR LADY OF ANGELS RET HOME **#** 0034975 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/15 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 794,807	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,356,672		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	218,937		6
7	Other Prepaid Expenses	16,161		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,386,577	$	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	3,723,242		15
16	Equipment, at Historical Cost	1,243,502		16
17	Accumulated Depreciation (book methods)	(2,957,670)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,009,074	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,395,651	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 612,161	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	156,910		29
30	Accrued Salaries Payable	321,360		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	152,966		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,243,397	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	207,556		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)**	$ 207,556	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,450,953	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,132,406	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,583,359	$	48

***(See instructions.)**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME **#** 0034975 **Report Period Beginning:** 7/1/14 **Ending:** 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,366,057	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,366,057	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	766,349	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)**	$ 766,349	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)**	$ 3,132,406	24	*

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 9,050,077	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,050,077	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	5,825	12
13	Barber and Beauty Care	4,946	13
14	Non-Patient Meals	20,345	14
15	Telephone, Television and Radio	7,073	15
16	Rental of Facility Space	38,895	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	277	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 77,361	23
	D. Non-Operating Revenue		
24	Contributions	431,856	24
25	Interest and Other Investment Income***	13,289	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 445,145	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS REVENUE	5,044	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,044	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,577,627	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,741,430	31
32	Health Care	3,035,799	32
33	General Administration	1,833,097	33
	B. Capital Expense		
34	Ownership	1,078,863	34
	C. Ancillary Expense		
35	Special Cost Centers	932,967	35
36	Provider Participation Fee	189,122	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,811,278	40
41	**Income before Income Taxes (line 30 minus line 40)****	766,349	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 766,349	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,526,547	44
45	Private Pay - Net Inpatient Revenue	4,385,380	45
46	Medicare - Net Inpatient Revenue	2,607,688	46
47	Other-(specify) INDEPENDENT LIVING	530,462	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,050,077	49

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

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

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

******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: 7/1/14 Ending: 6/30/15

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	1,832	2,080	$ 76,976	$ 37.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,905	25,941	716,441	27.62	3
4	Licensed Practical Nurses	22,250	26,574	631,198	23.75	4
5	CNAs & Orderlies	83,273	88,911	1,020,311	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,533	4,092	57,505	14.05	8
9	Activity Director	3,644	4,024	74,592	18.54	9
10	Activity Assistants	5,175	5,365	55,774	10.40	10
11	Social Service Workers	3,163	3,415	90,759	26.58	11
12	Dietician					12
13	Food Service Supervisor	1,908	2,080	56,141	26.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,097	29,377	311,753	10.61	15
16	Dishwashers	3,227	3,372	28,822	8.55	16
17	Maintenance Workers	14,114	15,364	278,193	18.11	17
18	Housekeepers	17,915	19,730	177,755	9.01	18
19	Laundry	7,110	7,847	79,953	10.19	19
20	Administrator	2,000	2,080	85,920	41.31	20
21	Assistant Administrator					21
22	Other Administrative	1,870	2,080	62,588	30.09	22
23	Office Manager					23
24	Clerical	14,286	15,470	250,729	16.21	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	1,872	2,086	28,848	13.83	31
32	Other Health C: CENTRAL SUPPI	1,996	2,080	48,360	23.25	32
33	Other(specify) DRIVER	1,829	2,000	20,785	10.39	33
34	TOTAL (lines 1 - 33)	241,999	263,968	$ 4,153,403 *	$ 15.73	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	$ 10,440	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	Quarterly	390	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	512	11-03	44
45	Social Service Consultant	Monthly	1,557	12-03	45
46	Other(specify)				46
47	Management Consultant	Intermittent	11,379	19-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 48,278		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: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGE BLOCK	ADMINISTRATOR		$ 85,920
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,920

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
KAYLYNN WABICH-JINDRA	CONSULTANT	$ 5,918
QUALITY THERAPY & CONS	CONSULTANT	4,989
SOCIAL WORK CONS GROUP	CONSULTANT	473
DTW	COMPUTER CONS	30,919
SUREQUEST SYSTEMS	DATA PROCESSING	882
BARRACUDA NETWORKS	DATA PROCESSING	1,188
NTT DATA	DATA PROCESSING	22,941
COMCAST	DATA PROCESSING	4,327
TELUSYS, INC	DATA PROCESSING	935
NEBO SYSTEMS	DATA PROCESSING	240
ABILITY NETWORK	DATA PROCESSING	7,833
SEE SUPPLEMENTAL SCHEDULE		43,639
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 124,284

D. Employee Benefits and Payroll Taxes

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

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,409
Health Care Worker Background Check	
(Indicate # of checks performed 113)	3,955
Patient Background Checks	
DUES - ASSOCIATIONS	11,931
LICENSES & FEES	6,261
ADVERSTISING & PROMOTION	5,319
Less: Public Relations Expense	(834)
Non-allowable advertising	(3,472)
Yellow page advertising	(794)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,775

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.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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
QQEST SOFTWARE SYSTEMS	DATA PROCESSING	$ 900
GOOGLE APPS	DATA PROCESSING	1,718
CERNER	DATA PROCESSING	10,296
LEGAL EXP - SEE PG3 SUP B	LEGAL	21,438
PERSONNEL PLANNERS	UNEMP CONS	1,638
CLIFTON LARSON ALLEN LLP	ACCOUNTING	9,255
TEMPLIN HEALTHCAR ACCOU	ACCOUNTING	2,091
PAGE 5A NON ALLOWABLE		(3,697)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 43,639

D. Employee Benefits and Payroll Taxes

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

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

Description	Line #	Amount
		$
TOTAL		$

* 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.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/14 Ending: 6/30/15

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: 7/1/14 Ending: 6/30/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN $5,980 and Leading Age $3,043**

(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? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,689** 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.

(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. $ **189,122**
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. $ **20,345**

(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? **100**
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. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.