FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0033761

Facility Name: Rose Angela Hall

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 8/19/88

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- **IRS Exemption Code** 501c3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

In the event there are further questions about this report, please contact:
Name: Beverly Sorensen **Telephone Number:** 773-545-8300
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) 10/23/15 (Date)
(Type or Print Name) Sr. Rita Butler
(Title) Director

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 Rose Angela Hall # 0033761 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD	80	29,200	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	26,703			26,703	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,703			26,703	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.45%

D. How many bed-hold days during this year were paid by the Department?
1,796 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

Facility Name & ID Number Rose Angela Hall # 0033761 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	205,010	12,332	29,691	247,033		247,033		247,033			1
2	Food Purchase		139,958		139,958		139,958		139,958			2
3	Housekeeping	50,352	30,846		81,198		81,198		81,198			3
4	Laundry	21,830	7,533		29,363		29,363		29,363			4
5	Heat and Other Utilities			160,202	160,202		160,202		160,202			5
6	Maintenance	113,140	43,132	152,840	309,112		309,112		309,112			6
7	Other (specify):*											7
8	TOTAL General Services	390,332	233,801	342,733	966,866		966,866		966,866			8
	B. Health Care and Programs											
9	Medical Director	30,600			30,600		30,600		30,600			9
10	Nursing and Medical Records	2,036,345	43,764	48,866	2,128,975		2,128,975		2,128,975			10
10a	Therapy	30,503			30,503		30,503		30,503			10a
11	Activities	34,679			34,679		34,679		34,679			11
12	Social Services	33,068			33,068		33,068		33,068			12
13	CNA Training	18,900			18,900		18,900		18,900			13
14	Program Transportation			10,419	10,419		10,419		10,419			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,184,095	43,764	59,285	2,287,144		2,287,144		2,287,144			16
	C. General Administration											
17	Administrative	97,718			97,718		97,718		97,718			17
18	Directors Fees											18
19	Professional Services			25,656	25,656		25,656		25,656			19
20	Dues, Fees, Subscriptions & Promotions			3,651	3,651		3,651		3,651			20
21	Clerical & General Office Expenses	273,557	61,705	17,093	352,355		352,355		352,355			21
22	Employee Benefits & Payroll Taxes			349,897	349,897		349,897		349,897			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,839	1,839		1,839		1,839			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,911	47,911		47,911		47,911			26
27	Other (specify):*											27
28	TOTAL General Administration	371,275	61,705	446,047	879,027		879,027		879,027			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,945,702	339,270	848,065	4,133,037		4,133,037		4,133,037			29

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

Facility Name & ID Number Rose Angela Hall #0033761 **Report Period Beginning:** 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			436,003	436,003		436,003		436,003			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			436,003	436,003		436,003		436,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,528	225,528		225,528		225,528			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			225,528	225,528		225,528		225,528			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,945,702	339,270	1,509,596	4,794,568		4,794,568		4,794,568			45

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	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))**	$		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

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Rose Angela Hall

ID# 0033761

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rose Angela Hall # 0033761 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rose Angela Hall **#** 0033761 **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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent Facility/	$ 90,000		100.00%	$ 90,000	$	1
2	V		Building, Grounds						2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 90,000			$ 90,000	$ *	14

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

Facility Name & ID Number Rose Angela Hall # 0033761 **Report Period Beginning:** 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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rose Angela Hall # 0033761 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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 [X] NO [ ]

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

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

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Rose Angela Hall **#** 0033761 **Report Period Beginning:** 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 Rose Angela Hall COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033761

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 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 Rose Angela Hall # 0033761 Report Period Beginning: 7/1/14 Ending: 6/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 514,510 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential	66,437	1925	$ 50,975	1
2	Improvements		Various	24,500	2
3	TOTALS	66,437		$ 75,475	3

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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			1979	1980	$ 2,031,195	$ 16,592	30	$ 16,592	$	$ 2,020,144	4
5			1968	1938	73,366		60			73,366	5
6			1956	1956	259,122		25			259,122	6
7			1928	1928	104,867		45			104,867	7
8			1953	1953	71,484		45			71,484	8
	Improvement Type**										
9	Remodling, Painting,Drywall			1980	85,251		20			85,251	9
10	Repairs			1980	24,301		20			24,301	10
11	Roof/tuckpointing			1988	8,466		20			8,466	11
12	Repairs, Painting Decorating			1955	41,231		10			41,231	12
13	Decorating			1990	3,836		10			3,836	13
14	Asphalt, Paving lot			1990	16,650		15			16,650	14
15	Garbage Disposal			1990	24,862	(10)	25	(10)		24,862	15
16	Remodling, Painting, Drywall			1991	45,685		20			45,685	16
17	New Boiler-Kitchen building			1998	12,320		15			12,320	17
18	New Boiler- Admin Building			1998	5,320		15			5,320	18
19	Install Handicap Ramp			2001	140,185	7,010	20	7,010		101,645	19
20	fence around perimeter & Elec. Gate			2001	106,000	5,300	20	5,300		76,850	20
21	Addl re electronic Gate & Fence			2002	19,421	971	20	971		13,594	21
22	New rooftop HVAC units to replace existing			2002	248,000	16,533	15	16,533		222,195	22
23	Addl re ramp & fence			2003	103,055	5,153	15	5,153		64,412	23
24	Side walk underground melt			2004	41,354	2,067	20	2,067		23,771	24
25	Parking lot stone and asphalt			2004	35,732	2,382	15	2,382		27,393	25
26	Carpentry, shelving, gate			1988	44,779		15			44,779	26
27	Outdoor Rec. area			1989	12,400		15			12,400	27
28	G. Hall windows, AC			1991	24,239		20			24,239	28
29	Roofing			1991	10,852		20			10,852	29
30	Remodel nurses station, Adm Bldg			1991	156,249		20			156,249	30
31	Walk-in-cooler remodel			1991	44,095		20			44,095	31
32	Remodel kitchen			1991	31,445		10			31,445	32
33	Roofing			1992	12,170		15			12,170	33
34	Plumbing, heating, painting, tile art			1993	30,813		15			30,813	34
35	Painting, decorative tile			1993	14,977		10			14,977	35
36	Alarm system readd 2842 left off prior yr			1994	13,679		15			13,679	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Emergency lights, snow melt cables, roofing	1995	$ 65,535	$	10	$	$	$ 65,535	37
38	Handicap Bath, whirlpool	1996	19,365		15			19,365	38
39	Painting, Patching, decorating	1996	37,184		5			37,184	39
40	New Boiler #1-4	1996	32,273	1,614	20	1,614		31,339	40
41	Install bath	1996	4,208		15			4,208	41
42	Repair glass, roofing	1996	2,996		15			2,996	42
43	Tuckpointing, roof repair	1997	6,428		10			6,428	43
44	Electrical re AC	1997	2,460		15			2,460	44
45	Window replacement A/C installation	1997	23,947	1,198	20	1,198		22,163	45
46	P ainting, wallcovering	1997	1,462		5			1,462	46
47	Architectural re windows, remodling	1998	930		10			930	47
48	Elevator door	1998	1,200		15			1,200	48
49	New roof Admin bldg	1998	13,968	698	20	698		12,215	49
50	Painting, decorating Adm Bldg	1998	950		5			950	50
51	Guanella Hall Boiler	1998	14,758	738	20	738		12,915	51
52	New door stops, exits	1998	15,989		15			15,989	52
53	Painting, decorating Adm Bldg	1998	25,548		5			25,548	53
54	Handrails	1998	6,132		15			6,132	54
55	New boiler, ht coils ,D. #1	1999	53,531	2,676	20	2,676		46,886	55
56	Painting decorating Dorms	1999	18,294		5			18,294	56
57	Handicap handrails installed	1999	14,174		15			14,174	57
58	Install walk-in kitchen freezer	1999	17,409	(587)	15	(587)		17,409	58
59	Recofigure office & handicap ramp & washroom	1999	54,060	2,703	20	2,703		44,600	59
60	Replace broken sewer & sidewalk	1999	17,168	859	20	859		14,173	60
61	New wall covering and decorating G. Hall	1999	23,831		10			23,831	61
62	Installation of fire pump	1999	8,300	415	20	415		6,848	62
63	Pip in new heads re fire system	1999	2,060		15			2,060	63
64	Chapel roof repair and Piping	1999	2,939		10			2,939	64
65	Carpeting chapel	200	1,511		5			1,511	65
66	Painting , wall covering re hallways	2000	1,742		10			1,742	66
67	New heaters hallways	2000	656		15			656	67
68	Remodel ramp, kitchen windows	2000	35,464	1,773	20	1,773		28,352	68
69	Pavement repair and replace	2000	10,527	526	20	526		8,151	69
70	TOTAL (lines 4 thru 69)		$ 4,434,400	$ 68,611		$ 68,611	$	$ 4,223,108	70

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,434,400	$ 68,611		$ 68,611	$	$ 4,223,108	1
2	Install water supply valves	2000	21,820	1,091	20	1,091		16,910	2
3	Windows replaced in dorms	2000	85,550	4,278	10	4,278		66,309	3
4	Roof repair dorms	2000	13,520		20			13,520	4
5	Replace kitchen windows	2000	10,553	528	20	528		8,448	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		6,682	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		49,600	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		10,091	8
9	New water line piping	2000	11,006	550	20	550		8,525	9
10	Electric outlets emergency lights	2000	6,858	232	15	232		6,858	10
11	Asphalt paving lot	2001	5,141		5			5,141	11
12	Fire alarm system	2001	6,938		10			6,938	12
13	G. Hall decorating hallways	2001	5,540		5			5,540	13
14	remove asbestos tile/replace	2001	5,192		10			5,192	14
15	Fire wall door framing	2001	22,631	1,508	15	1,508		21,866	15
16	new hot water tanks re piping	2001	24,801	1,654	15	1,654		24,016	16
17	Shower door, replace drain	2001	11,732	782	15	782		11,340	17
18	Outdoor Pavillion, gazebo	2001	41,095	2,740	15	2,740		39,729	18
19	Balcony roof repair	2001	5,803		5			5,803	19
20	Fire alarm system	2001	4,496		10			4,496	20
21	Plumbing work	2002	42,173	(2,112)	10	(2,112)		42,173	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		20,709	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		14,121	23
24	Tuckpointing	2002	11,585		10			11,585	24
25	Doors re Chapel	2003	1,642		10			1,642	25
26	Plumbing, water tanks, sm. Basin	2003	16,551		10			16,551	26
27	Roof curbs	2003	12,430	829	10	829		10,362	27
28	Elec. Wiring and smoke detectors	2003	5,327		15			5,327	28
29	Insuylate pipes, dooor	2003	4,378	655	10	655		4,378	29
30	Window, tuckpointing, Nepco	2003	25,922		10			25,922	30
31	Gas generator	2004	189,933	12,662	10	12,662		145,613	31
32	Roof times, decorating	2004	21,956		5			21,956	32
33	New laundry area	2004	17,227	1,148	15	1,148		13,202	33
34	TOTAL (lines 1 thru 33)		$ 5,190,801	$ 102,030		$ 102,030	$	$ 4,873,653	34

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,190,801	$ 102,030		$ 102,030	$	$ 4,873,653	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		20,144	2
3	Base parking lot, undergrou;nd melt	2004	52,967		10			52,967	3
4	New fire alarm system	2004	68,500	4,567	15	4,567		52,520	4
5	A/C kitchen	2004	9,890	40	10	40		9,890	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		50,520	6
7	Handcap ramp re Gym	2004	34,730	1,736	25	1,736		20,832	7
8	Gym windows	2004	8,245	550	15	550		6,600	8
9	Gym roof	2004	17,997		5			25,200	9
10	Pluming, washroom remodel	2004	6,468		10			6,468	10
11	Exterior masonry, joints	2004	32,686	2,180	15	2,180		25,044	11
12	Gas generator balance	2005	26,180	1,745	15	1,745		18,323	12
13	Complete roof replacement	2005	380,077	19,004	20	19,004		180,538	13
14	Installation attic exhaust	2005	99,968	4,998	20	4,998		52,479	14
15	Complete new fire alarm system	2005	130,900	6,545	20	6,545		68,722	15
16	Sewer & gas lines	2005	47,795	2,390	20	2,390		25,895	16
17	Paving lit	2005	31,920	2,128	15	2,128		22,344	17
18	Wsll coverings,tiles,painting	2005	69,115	3,460	10	3,460		69,115	18
19	Electrical repqair, security	2005	30,411	1,512	10	1,512		30,411	19
20	Laundry, Kitdhen repairs	2005	30,103	2,007	15	2,007		20,719	20
21	Hot water gas line	2006	5,380	538	10	538		4,985	21
22	Painting, caulking	2006	16,065		5			16,065	22
23	Generator adjustment	2006	5,545	370	15	370		3,514	23
24	Pool house camp	2006	13,574	1,357	10	1,357		12,892	24
25	Replace tiles, laundry	2007	4,900	490	10	490		4,655	25
26	Masonry repairs	2007	101,462	6,764	15	6,764		57,494	26
27	Bott rofing	2007	17,577	1,172	15	1,172		9,962	27
28	Painting, wall covering	2007	4,184	418	10	418		3,553	28
29	Air system gym	2007	19,381	1,292	15	1,292		10,985	29
30	Walk-in refrig., & painting	2007	12,200		5			12,200	30
31	Bott roof tiles	2007	28,526	1,902	15	1,902		16,167	31
32	Walk-in tubs installed	2007	67,631	3,382	20	3,382		28,739	32
33	Omdppr * Outdoor filters and repairs	2007	83,721	8,372	10	8,372		66,450	33
34	TOTAL (lines 1 thru 33)		$ 6,759,214	$ 186,900		$ 186,900	$	$ 5,880,045	34

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,759,214	$ 186,900		$ 186,900	$	$ 5,880,045	1
2	Gate wallpack & fixtures	2008	7,322	732	10	732		4,630	2
3	Reinsulate pipes	2008	7,351	735	10	735		4,650	3
4	Install whirlpool, tubs	2008	32,157	1,608	20	1,608		12,060	4
5	New Boiler system Hadronic piping	2008	134,986	6,749	20	6,749		50,618	5
6	Kitchen air handler	2008	29,500	1,967	15	1,967		14,752	6
7	New flooring, carpeting	2008	75,553	5,036	15	5,036		37,770	7
8	Roof repair	2009	9,789	978	10	978		6,145	8
9	Water pipe - pipin	2009	7,248	725	10	725		4,713	9
10	Wall covering dorms	2009	11,125	1,112	10	1,112		7,228	10
11	Tile block wall	2009	37,896	2,526	15	2,526		16,419	11
12	New flooring & carpeting Apts	2009	121,350	8,090	15	8,090		51,016	12
13	Sprinklers, valves	2010	9,311	931	10	931		5,120	13
14	Concrete masonry	2010	10,400	1,040	10	1,040		5,720	14
15	Water heater	2010	5,565	1,113	5	1,113		6,121	15
16	Roof repair. Ptg. Evves	2010	9,137	1,827	5	1,827		10,048	16
17	Seal coating parking lot	2010	3,445	689	5	689		3,790	17
18	U.S. fire protect.Complete sprinkler Sys. Activ.	2011	221,255	14,750	15	14,750		66,375	18
19	New water service for sprinklers, pumps	2011	25,655	1,283	20	1,283		5,738	19
20	New soffits re pipes, ceili ng tiles, dry wall. Sprlr	2011	42,593	2,130	20	2,130		9,583	20
21	New fire panels and devices re sprinkler system	2011	55,000	3,667	15	3,667		16,501	21
22	Electrical Shunt trip and fan shutdown	2011	4,400	293	15	293		1,319	22
23	Painting for alll instrusions re Sprinkler system	2011	26,000	5,200	5	5,200		23,400	23
24	Snow melt system	2011	7,953	1,590	5	1,590		7,090	24
25	Nurses ststion	2011	6,925	692	10	692		3,114	25
26	Fire alarm and electric	2011	7,825	782	10	782		3,519	26
27	Steel Top/ steam valve	2011	7,620	762	10	762		3,429	27
28	A/C Kitchen	2011	13,750	1,375	10	1,375		6,188	28
29	Wiring re tubs & lights	2012	4,274	427	10	427		1,495	29
30	A/C recreation camp	2012	16,310	1,631	10	1,631		5,709	30
31	work & railings	2012	28,500	1,900	15	1,900		7,600	31
32	Install showers, faucets	2012	19,500	1,300	15	1,300		4,550	32
33	Install roof shelter	2012	11,950	1,195	10	1,195		3,975	33
34	TOTAL (lines 1 thru 33)		$ 7,770,859	$ 261,735		$ 261,735	$	$ 6,290,430	34

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,770,859	$ 261,735		$ 261,735	$	$ 6,290,430	1
2	Install water heaters	2012	8,651	865	10	865		3,028	2
3	Install new flooring, residential bedrooms	2012	13,666	1,367	10	1,367		5,240	3
4	Painting Nurses stations retrofit fire dampers	2012	3,555	710	5	710		2,485	4
5	Retrofit fire dampers	2012	9,080	908	10	908		3,632	5
6	Power tempering valves	2012	9,366	936	10	936		3,744	6
7	Install gym sprinkler system	2012	140,377	9,358	15	9,358		32,753	7
8	Bulkheads, ACT ceiling re sprinkler system	2012	35,249	1,762	20	1,762		6,167	8
9	Fire alarm update re gym	2012	47,429	3,162	15	3,162		11,067	9
10	Heater vestibule	2012	5,550	555	10	555		1,943	10
11	Painting ceiling soffits	2013	4,865	973	5	973		2,432	11
12	Painting stair wells	2013	4,730	946	5	946		2,365	12
13	Hall server	2013	6,671	667	10	667		1,668	13
14	Reconfigure conduits	2013	9,519	635	15	635		1,587	14
15	Drywall re doors	2013	5,837	1,167	5	1,167		2,918	15
16	Millwork re sills	2013	2,905	194	15	194		485	16
17	Masonry walls	2013	7,837	522	15	522		1,305	17
18	Install kitchen hoods	2013	18,122	1,208	15	1,208		3,020	18
19	Install foffits re sprinkler valves	2013	12,154	1,215	10	1,215		3,038	19
20	Install automatice door openers	2014	38,152	2,543	15	2,543		3,815	20
21	Nurses Stations in apartments	2014	17,415	1,163	15	1,163		1,744	21
22	Natural gas generator	2014	12,250	817	15	817		1,225	22
23	Stairwells masonry and railings	2014	66,916	3,346	20	3,346		5,019	23
24	Basement Sprinkler system	2014	8,828	441	20	441		662	24
25	Concrete re gym and Courtyard	2014	9,690	646	15	646		969	25
26	Install acrovyn doors in Apartments	2014	6,534	436	15	436		654	26
27	Install cooling system for server	2014	11,411	761	15	761		1,141	27
28	Wiring and cabling for Apts & Nurses station	2014	80,318	5,355	15	5,355		6,034	28
29	Electronic charting system	2014	38,808	7,762	5	7,762		11,643	29
30	Wiring and cabling for smart boards	2014	68,575	4,572	15	4,572		6,858	30
31	Smart boards	2014	56,344	11,269	5	11,269		16,903	31
32	Wiring and cabling for Center	2014	37,580	2,505	15	2,505		3,758	32
33	Concrete replacement for camp pool	2014	18,880	1,258	15	1,258		1,887	33
34	TOTAL (lines 1 thru 33)		$ 8,588,123	$ 331,759		$ 331,759	$	$ 6,441,619	34

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,588,123	$ 331,759		$ 331,759	$	$ 6,441,619	1
2	Courtyard shelter for pts. 1-4	2014	54,576	2,746	20	2,746		4,110	2
3	Hughes door openers	2015	41,413	1,380	15	1,380		1,380	3
4	Argo fire alarm	2015	4,578	458	5	458		458	4
5	Air Gym combus	2015	2,690	269	5	269		269	5
6	Cabinets Apt 1-2	2015	2,930	147	10	147		147	6
7	Remodel bathroom	2015	26,498	883	15	883		883	7
8	Sealant parking lot	2015	5,700	570	5	570		570	8
9	Window, Nepco	2015	18,896	1,964	10	1,964		1,964	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,745,404	$ 340,176		$ 340,176	$	$ 6,451,400	34

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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	$ 1,133,483	$ 50,559	$ 50,559	$		$ 969,385	71
72	Current Year Purchases	31,316	7,146	7,146			7,146	72
73	Fully Depreciated Assets	138,169						73
74								74
75	TOTALS	$ 1,302,968	$ 57,705	$ 57,705	$		$ 976,531	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	Patient Care	White Transit 2012	2013	$ 40,282	$ 10,071	$ 10,071	$		$ 25,176	76
77										77
78										78
79										79
80	TOTALS			$ 40,282	$ 10,071	$ 10,071	$		$ 25,176	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)	$ 10,164,129	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 407,952	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 407,952	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)	$ 7,453,107	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 7/1/14 Ending: 6/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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

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

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 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? [X] YES [ ] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		6,294		6,294
4	Clinical Wages (b)		12,606		12,606
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 18,900	$	$ 18,900
10	SUM OF line 9, col. 1 and 2 (e)	$ 18,900			

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	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	28

(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 Rose Angela Hall # 0033761 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Rose Angela Hall # 0033761 **Report Period Beginning:** 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	$	$ 1,327,684	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		481,461	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		54,925	6
7	Other Prepaid Expenses		14,353	7
8	Accounts Receivable (owners or related parties)	(4,521,621)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (4,521,621)	$ 1,878,423	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,039,147	3,075,254	15
16	Equipment, at Historical Cost	1,351,250		16
17	Accumulated Depreciation (book methods)	(3,429,510)		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)**	$ 1,960,887	$ 3,075,254	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,560,734)	$ 4,953,677	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 27,703	$ 200,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,386	136,556	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,690	17,803	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 107,779	$ 355,192	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 107,779	$ 355,192	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,668,513)	$ 4,598,485	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,560,734)	$ 4,953,677	48

***(See instructions.)**

Facility Name & ID Number Rose Angela Hall **#** 0033761 **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**	$ (1,617,746)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,617,746)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,050,767)	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)**	$ (1,050,767)	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)**	$ (2,668,513)	24	*

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

Facility Name & ID Number Rose Angela Hall # 0033761 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	$ 3,716,301	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,716,301	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	18,900	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,900	23
	D. Non-Operating Revenue		
24	Contributions	8,600	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,600	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,743,801	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	966,866	31
32	Health Care	2,287,144	32
33	General Administration	879,027	33
	B. Capital Expense		
34	Ownership	436,003	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	225,528	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,794,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,050,767)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,050,767)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,074,954	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA Benefits	639,274	47
48	Other-(specify) WorkShop earned income	2,073	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,716,301	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 Rose Angela Hall # 0033761 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	2,030	2,137	$ 64,003	$ 29.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,990	9,461	154,889	16.37	3
4	Licensed Practical Nurses	9,508	10,008	295,379	29.51	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,990	2,096	34,698	16.55	9
10	Activity Assistants					10
11	Social Service Workers	640	665	33,068	49.73	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,080	60,966	29.31	13
14	Head Cook	670	693	13,536	19.53	14
15	Cook Helpers/Assistants	11,375	11,846	130,508	11.02	15
16	Dishwashers					16
17	Maintenance Workers	4,210	4,432	113,140	25.53	17
18	Housekeepers	4,580	4,800	50,352	10.49	18
19	Laundry	2,000	2,045	21,830	10.67	19
20	Administrator	2,040	2,080	51,958	24.98	20
21	Assistant Administrator	2,040	2,080	45,760	22.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,150	19,090	273,647	14.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	200	200	30,600	153.00	27
28	Qualified MR Prof. (QMRP)	9,780	10,210	187,774	18.39	28
29	Resident Services Coordinator	8,580	9,028	252,771	28.00	29
30	Habilitation Aides (DD Homes)	100,980	104,103	1,058,544	10.17	30
31	Medical Records	2,445	2,571	26,700	10.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,248	199,625	$ 2,900,123 *	$ 14.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	n/a	$ 5,515	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	n/a	22,369	line 10 C3	37
38	Nurse Consultant	n/a	7,296	Line 10 C3	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	n/a	6,218	Line 10 C 3	44
45	Social Service Consultant				45
46	Other(specify) dentist	n/a	4,283	Line 10 C3	46
47	Psychiatrist	35	8,700	Line 10 C3	47
48	FoodService Professional Mgmt Fee	n/a	24,176	Line 1 C3	48
49	TOTAL (lines 35 - 48)	35	$ 78,557		49

C. CONTRACT NURSES

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Zdanowski	Administrator		$ 51,958
Sr. Janet Kosman	Asst. Administrator		45,760
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,718

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
Bansley, Brescia & Cpo.,P.C.	Auditor	$ 34,209
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 34,209

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,885
Unemployment Compensation Insurance	5,402
FICA Taxes	196,173
Employee Health Insurance	40,693
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	72,744
TOTAL (agree to Schedule V, line 22, col.8)	$ 349,897

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 50)	1,625
Patient Background Checks	
Dues,fees	1,826
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,651

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
AMDATA convention	1,300
Psych Meds	539
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,839

**See instructions.

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 5,440 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. NO

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 225,528
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

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

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

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Bansley, Brescia & Co., P.C.

(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. NO
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME & ID number ROSE ANGELA HALL # 0333731
Report period July 1, 2014 - June 30, 2015

NAME	OFFICE
Sr. Charleen Badiola (1)	Vice President
Sr. Rita Butler	President
Sr. Darlene Johnson	Director
Sr. Janet Kosman	Secretary / Treasurer
Sr. Mercy Secida	Director

(1) Sr. Charleen Badiola approves invoices for payment and oversees Maintenance of Buildings

The Facility pays rent to the religious order,
The Daughters of St. Mary of Providence
for the use of the buildings and grounds

SCHEDULE VIII - Allocations of Indirect Costs SEE ATTACHED WORKSHEETS