FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Diane Simon **Telephone Number:** (815) 725-6631
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 7/1/15 to 6/30/16 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: 7/1/15 Ending: 6/30/16

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	13,542	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5	50	Sheltered Care (SC)	50	18,300	5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,142	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	4,617	2,909	4,501	12,027	8
9	SNF/PED					9
10	ICF	5,197	10,430	0	15,627	10
11	ICF/DD					11
12	SC		14,789		14,789	12
13	DD 16 OR LESS					13
14	TOTALS	9,814	28,128	4,501	42,443	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.65%

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 _____

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: 6/30/2016 Fiscal Year: 6/30/2016

* 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: 7/1/15 Ending: 6/30/16

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	407,105	29,509	7,680	444,294		444,294	(41,672)	402,622			1
2	Food Purchase		318,360		318,360		318,360	(48,640)	269,720			2
3	Housekeeping	209,008	53,988		262,996		262,996	(6,037)	256,959			3
4	Laundry	83,817	7,072	1,313	92,202		92,202	(2,421)	89,781			4
5	Heat and Other Utilities			202,391	202,391		202,391	(25,299)	177,092			5
6	Maintenance	236,094		218,823	454,917		454,917	(69,860)	385,058			6
7	Other (specify):*											7
8	**TOTAL General Services**	936,024	408,929	430,207	1,775,160		1,775,160	(193,929)	1,581,232			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,746,062	184,726	15,001	2,945,789		2,945,789		2,945,789			10
10a	Therapy											10a
11	Activities	118,653	15,559		134,212		134,212	(38,012)	96,200			11
12	Social Services	91,635		1,414	93,049		93,049	(2,647)	90,402			12
13	CNA Training											13
14	Program Transportation	22,234		5,726	27,960		27,960	(2,569)	25,391			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,978,584	200,285	46,141	3,225,010		3,225,010	(43,228)	3,181,782			16
	C. General Administration											
17	Administrative	86,234			86,234		86,234	(2,491)	83,743			17
18	Directors Fees											18
19	Professional Services			151,630	151,630		151,630	(4,486)	147,144			19
20	Dues, Fees, Subscriptions & Promotions			36,551	36,551		36,551	(13,530)	23,021			20
21	Clerical & General Office Expenses	335,014	26,511	148,231	509,756		509,756	(130,879)	378,877			21
22	Employee Benefits & Payroll Taxes			970,850	970,850		970,850	(28,043)	942,807			22
23	Inservice Training & Education			8,741	8,741		8,741		8,741			23
24	Travel and Seminar			3,422	3,422		3,422	(189)	3,233			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,359	123,359		123,359	(9,681)	113,678			26
27	Other (specify):*											27
28	**TOTAL General Administration**	421,248	26,511	1,442,784	1,890,543		1,890,543	(189,299)	1,701,244			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,335,856	635,725	1,919,132	6,890,713		6,890,713	(426,456)	6,464,258			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	14,520	141,849	100.00%	10.24%	407,105	41,672
Food	Meals Served	14,520	141,849	100.00%	10.24%	318,360	32,588
Housekeeping	Census Factored	4,860	42,063	25.00%	2.89%	209,008	6,037
Laundry	Census Factored	4,860	42,063	25.00%	2.89%	83,817	2,421
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	202,391	25,299
Maintenance	Square Feet	1	8	100.00%	12.50%	218,823	27,353
Activities	Census	4,860	42,063	25.00%	2.89%	118,653	3,427
Social Services	Census	4,860	42,063	25.00%	2.89%	91,635	2,647
Program Transportation	Census	4,860	42,063	100.00%	11.55%	22,234	2,569
Administrative	Census	4,860	42,063	25.00%	2.89%	86,234	2,491
Professional Fees	Census	4,860	42,063	25.00%	2.89%	155,297	4,486
Dues, Fees, Subscriptions and Promotions	Census	4,860	42,063	25.00%	2.89%	32,884	950
Clerical and Office Expenses	Census	4,860	42,063	25.00%	2.89%	325,621	9,406
Travel and Seminar	Census	4,860	42,063	25.00%	2.89%	6,542	189
Insurance - Property	Square Feet	1	8	100.00%	12.50%	63,645	7,956
Insurance - Liability	Census	4,860	42,063	25.00%	2.89%	59,714	1,725
Depreciation	Square Feet	1	8	100.00%	12.50%	212,012	26,502
Equipment Rental	Census	4,860	42,063	25.00%	2.89%	22,048	637
Employee Benefits	Census	4,860	42,063	25.00%	2.89%	970,850	28,043
						3,606,873	226,397

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

Firm Name	Invoice Date	Expense Type	Allowable Amount
Tracy, Johnson & Wilson	7/7/2015	General Matters	148
Polsinelli PC	7/16/2015	Bad Debt issues	385
Polsinelli PC	7/16/2016	IDPH Survey Results	448
Polsinelli PC	8/24/2015	IDPH Survey Results	735
Polsinelli PC	8/24/2016	General Matters	347
Tracy, Johnson & Wilson	9/9/2015	Employee issue	623
Polsinelli PC	9/11/2015	General Matters	140
Polsinelli PC	10/8/2015	Review Survey Results & IDPH Appeal	2,280
Tracy, Johnson & Wilson	10/6/2015	Employee issue	1,110
Polsinelli PC	11/30/2015	Review Survey Results & IDPH Appeal	1,358
Tracy, Johnson & Wilson	12/3/2015	Contract Review	426
Polsinelli PC	12/30/2015	General Matters	420
Tracy, Johnson & Wilson	1/6/2016	Severance Agreement Review	130
Polsinelli PC	1/20/2016	Medicare as secondary payor	1,341
Polsinelli PC	2/23/2016	Review Survey Results & IDPH Appeal	443
Tracy, Johnson & Wilson	3/8/2016	Document review & Contract review	546
Polsinelli PC	3/21/2016	IDPH Settlement & Contract Review	3,210
Tracy, Johnson & Wilson	4/5/2016	Terminated Contract review, Review IDPH letter	546
Polsinelli PC	4/27/2016	Transition of staff & Execute Consent Agreement	1,480
Tracy, Johnson & Wilson	5/9/2016	Asbestos removal contract review	324
Polsinelli PC	5/24/2016	General Matters	350
Tracy, Johnson & Wilson	6/3/2016	Review facility agreement, Subpoena review	389
Polsinelli PC	6/23/2016	Documentation related to Medicare Bed Transfers	360
		Total	**17,535**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME #0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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			212,012	212,012		212,012	(32,273)	179,739			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,053	34,053		34,053	(28,946)	5,107			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,874	847,874		847,874	(847,873)	1			34
35	Rent-Equipment & Vehicles			22,048	22,048		22,048	(637)	21,411			35
36	Other (specify):*											36
37	TOTAL Ownership			1,115,987	1,115,987		1,115,987	(909,729)	206,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,926	806,916	827,842		827,842		827,842			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			6,638	6,638		6,638		6,638			41
42	Provider Participation Fee			188,808	188,808		188,808		188,808			42
43	Other (specify):* Devel/Chapel	47,572		51,542	99,114		99,114	(100,859)	(1,745)			43
44	TOTAL Special Cost Centers	47,572	20,926	1,053,904	1,122,402		1,122,402	(100,859)	1,021,543			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,383,428	656,651	4,089,023	9,129,102		9,129,102	(1,437,044)	7,692,058			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
Pastoral Care - Salary	47,572
Chapel Expenses	48,774
Fund Raising - Public Relations	2,768
Total	**99,114**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	(16,052)	02		4
5	Telephone, TV & Radio in Resident Rooms	(54,599)	21		5
6	Rented Facility Space	(39,802)	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	(8,779)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,310)	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	(60,025)	21		24
25	Fund Raising, Advertising and Promotional	(11,771)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(809)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (198,147)		$	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))**	$ (198,147)		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: 7/1/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Income	$ (34,585)	11	1
2	Bank Charges	(1,745)	43	2
3	Theft Loss	(290)	21	3
4	Memorial Expense	(249)	21	4
5	Chapel Expenses (Non-adjusted for Income)	(96,346)	43	5
6	Development Expenses	(2,768)	43	6
7	Capitalized Asset - Under $2500 Threshold	(2,705)	06	7
8	Capitalized Asset - Depreciation Adjustment	(5,771)	30	8
9	Independent Living (Allocated Costs)			9
10	Dietary	(41,672)	01	10
11	Food	(32,588)	02	11
12	Housekeeping	(6,037)	03	12
13	Laundry	(2,421)	04	13
14	Heat & Other Utilities	(25,299)	05	14
15	Maintenance	(27,353)	06	15
16	Activities	(3,427)	11	16
17	Social Services	(2,647)	12	17
18	Program Transportation	(2,569)	14	18
19	Administrative	(2,491)	17	19
20	Professional Fees	(4,486)	19	20
21	Dues, Fees, Subscriptions & Promotions	(950)	20	21
22	Clerical & Office Expenses	(9,406)	21	22
23	Travel & Seminar	(189)	24	23
24	Insurance - Property	(7,956)	26	24
25	Insurance - Liability	(1,725)	26	25
26	Depreciation	(26,502)	30	26
27	Equipment Rental	(637)	35	27
28	Employee Benefits	(28,043)	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**	(370,857)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	(41,672)	0	0	0	0	0	0	0	0	0	0	(41,672)	1
2	Food Purchase	(48,640)	0	0	0	0	0	0	0	0	0	0	(48,640)	2
3	Housekeeping	(6,037)	0	0	0	0	0	0	0	0	0	0	(6,037)	3
4	Laundry	(2,421)	0	0	0	0	0	0	0	0	0	0	(2,421)	4
5	Heat and Other Utilities	(25,299)	0	0	0	0	0	0	0	0	0	0	(25,299)	5
6	Maintenance	(69,860)	0	0	0	0	0	0	0	0	0	0	(69,860)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(193,929)	0	0	0	0	0	0	0	0	0	0	(193,929)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(38,012)	0	0	0	0	0	0	0	0	0	0	(38,012)	11
12	Social Services	(2,647)	0	0	0	0	0	0	0	0	0	0	(2,647)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,569)	0	0	0	0	0	0	0	0	0	0	(2,569)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(43,228)	0	0	0	0	0	0	0	0	0	0	(43,228)	16
	C. General Administration													
17	Administrative	(2,491)	0	0	0	0	0	0	0	0	0	0	(2,491)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,486)	0	0	0	0	0	0	0	0	0	0	(4,486)	19
20	Fees, Subscriptions & Promotions	(13,530)	0	0	0	0	0	0	0	0	0	0	(13,530)	20
21	Clerical & General Office Expenses	(130,879)	0	0	0	0	0	0	0	0	0	0	(130,879)	21
22	Employee Benefits & Payroll Taxes	(28,043)	0	0	0	0	0	0	0	0	0	0	(28,043)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(189)	0	0	0	0	0	0	0	0	0	0	(189)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,681)	0	0	0	0	0	0	0	0	0	0	(9,681)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(189,299)	0	0	0	0	0	0	0	0	0	0	(189,299)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(426,456)	0	0	0	0	0	0	0	0	0	0	(426,456)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,273)	0	0	0	0	0	0	0	0	0	0	(32,273)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,779)	(20,167)	0	0	0	0	0	0	0	0	0	(28,946)	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	(637)	0	0	0	0	0	0	0	0	0	0	(637)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(41,689)	(868,040)	0	0	0	0	0	0	0	0	0	(909,729)	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):*	(100,859)	0	0	0	0	0	0	0	0	0	0	(100,859)	43
44	**TOTAL Special Cost Centers**	(100,859)	0	0	0	0	0	0	0	0	0	0	(100,859)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(569,004)	(868,040)	0	0	0	0	0	0	0	0	0	(1,437,044)	45

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	32	Interest Expense	20,167	Sisters of St. Francis of Mary Immaculate	100.00%		(20,167)	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			$ 868,040			$	$ * (868,040)	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: 7/1/15 Ending: 6/30/16

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	Kathryn Giegerich	BOD						2
3	Sr. Mary Jane Griffin, OSF	BOD						3
4	Gerry Brady	BOD						4
5	Don Cordano	BOD						5
6	Fr. William Dewan	BOD						6
7	Jackie Edmonson	BOD						7
8	Tom Grotovsky	BOD						8
9	David Leggero	BOD						9
10	Sr. Clarita Schumacher, OSF	BOD						10
11	Dorothy Spiczak	BOD						11
12	Sr. Dolores Zemont, OSF	BOD						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: 7/1/15 Ending: 6/30/16

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	14	100.00	Salary	$ 20,266	11-01	1
2	Sr. Odelia Kloc, OSF	Enrichment Coord.	Administrative	See Below	0	32	100.00	Salary	29,663	11-01	2
3	Sr. Mary Ann Jerkofsky, OSF	Admissions Asst.	Administrative	See Below	0	20	100.00	Salary	11,878	21-01	3
4	Sr. Geri Podobnik, OSF	MDS Coord.	Nursing	See Below	0	16	100.00	Salary	22,939	10-01	4
5											5
6											6
7											7
8	The Sisters are members of										8
9	the Sisters of St. Francis that										9
10	sponsors OLA as a non-profit										10
11	organization.										11
12											12
13								TOTAL	$ 84,746		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: 7/1/15 Ending: 6/30/16

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: 7/1/15 Ending: 6/30/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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	207,785	12/26/18	4.5000	11,421	6
7	CHRISTIAN BROTHERS		X	INS POLICY INT CHARGES							2,465	7
8	SISTERS OF ST. FRANCIS	X		CASH FLOWS	$10,000.00	6/1/12	200,000		4/1/16	4.0000	20,167	8
9	TOTAL Facility Related				$17,341.78		$ 593,585	$ 207,785			$ 34,053	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 593,585	$ 207,785			$ 34,053	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: 7/1/15 Ending: 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 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 2015 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 2015.

	(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/1/15 Ending: 6/30/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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			1994	98,040		15-40				9
10	VARIOUS			1995	78,867		15-40				10
11	VARIOUS			1996	206,408		15-40				11
12	VARIOUS			1997	188,236		15-40				12
13	VARIOUS			1998	703,545		15-40				13
14	VARIOUS			1999	242,370		15-40				14
15	VARIOUS			2000	5,332		15-40				15
16	VARIOUS			2001	156,163		15-40				16
17	VARIOUS			2002	72,599		15-40				17
18	VARIOUS			2003	431,643		15-40				18
19	VARIOUS			2004	46,300		15-40				19
20	VARIOUS			2005	103,405		15-40				20
21	VARIOUS			2006	38,792		15-40				21
22	VARIOUS			2007	3,208,187		15-40				22
23	VARIOUS			2008	177,923		15-40				23
24	VARIOUS			2009	35,873		15-40				24
25	VARIOUS			2010	91,651		15-40				25
26	VARIOUS			2011	257,670		15-40				26
27	VARIOUS			2012	8,247		15-40				27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36						128,060		128,060		1,902,054	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	Fire Panel	2013	$ 21,753	$ 1,451	15	$ 1,451	$	$ 5,559	37
38	Air Conditioning Work	2013	7,269	727	10	727		2,726	38
39	Boiler Work	2013	3,368	674	5	674		2,190	39
40	Fire Detectors	2013	3,363	673	5	673		2,075	40
41	Parking Lot Reseal	2013	5,665	1,133	5	1,133		3,115	41
42	Tuckpoint - Entrance	2013	3,312	221	15	221		571	42
43	A/C - B2 Dining Room	2013	11,227	1,123	10	1,123		2,994	43
44	Elevator Upgrades	2014	143,244	7,162	20	7,162		16,712	44
45	Laundry - Heating Line	2014	3,265	327	10	327		789	45
46	Exterior Lighting	2014	3,408	170	20	170		383	46
47	Cooling Tower	2015	44,823	2,988	15	2,988		5,132	47
48	Boiler - Tube	2015	9,355	624	15	624		1,144	48
49	Boiler - Main	2015	3,965	793	5	793		1,322	49
50	Room Improvements - Sheltered Care - Carpet & Painting	2015	9,471	1,894	5	1,894		2,683	50
51	Boiler	2015	4,161	832	5	832		1,179	51
52	Water Tank	2015	3,968	794	5	794		1,059	52
53	Sprinkler Repairs	2015	2,791	558	5	558		744	53
54	A & B Hallways - Fire Door Upgrade Project (IDPH Survey)	2015	260,982	10,439	25	10,439		13,049	54
55	Asbestos Removal, Replace Fire Doors & Ceilings								55
56	Elevator Pit Ladders	2015	7,780	778	10	778		973	56
57	A & B Hallways - Sprinkler, Alarms, Lighting & Electrical Work	2015	25,546	1,022	25	1,022		1,192	57
58	Fireproofing - Beams	2015	10,900	1,090	10	1,090		1,090	58
59	Angels Café Remodel - carpet, paint, asbestos removal	2016	16,894	70	20	70		70	59
60	Boiler - replacement	2016	4,947	21	20	21		21	60
61	Carpet - Offices	2016	33,937	1,435	10	1,435		1,435	61
62	D-1 Copper Piping and Cover	2016	7,815	71	28	71		71	62
63	Air Conditioning Repairs	2016	3,628	30	10	30		30	63
64	Move A1/B1 Nurses Station - Call Light Upgrade	2016	5,920	68	10	68		68	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,386,431	$ 165,228		$ 165,228	$	$ 1,970,430	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: 7/1/15 Ending: 6/30/16

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	$ 212,969	$ 25,905	$ 25,905	$		$ 243,127	71
72	Current Year Purchases	87,701	7,519	7,519			7,519	72
73	Fully Depreciated Assets	466,559					466,559	73
74								74
75	TOTALS	$ 767,229	$ 33,424	$ 33,424	$		$ 717,205	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	$	$	$		$ 21,359	76
77	Facility	Repairs	2012	3,038	607	607			2,385	77
78	Facility	Tires & Suspension	2015	2,965	593	593			939	78
79	Facility	Ford Bus	2015	53,798	12,160	12,160			15,746	79
80	TOTALS			$ 81,160	$ 13,360	$ 13,360	$		$ 40,429	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)	$ 9,234,820	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,012	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,012	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)	$ 2,728,064	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: 7/1/15 Ending: 6/30/16

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 ☒ 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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 22,048 Description: COPIERS $22,048
(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: 7/1/15 Ending: 6/30/16

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: 7/1/15 Ending: 6/30/16

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	$		$ 248,208	$		$ 248,208	1
2	Licensed Speech and Language Development Therapist		hrs			55,371			55,371	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			250,994			250,994	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				163,339		163,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): SEE SUPPLEMENTAL						7,331		7,331	12
13	Other (specify): SEE SUPPLEMENTAL						102,599		102,599	13
14	TOTAL			$		$ 554,573	$ 273,269		$ 827,842	14

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

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 16 Supplemental
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Page 16 Line 12 Column 6: Other Ancillary Supplies

Medical Supplies	7,331
Total	7,331

Page 16 Line 13 Column 6: Other Ancillary Expense

Laboratory	25,310
Radiology	28,853
Other Hospital Services	48,437
Total	102,600

STATE OF ILLINOIS

Facility Name & ID Number OUR LADY OF ANGELS RET HOME **#** 0034975 **Report Period Beginning:** 7/1/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(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	$ 1,257,281	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 31,521)	1,566,513		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	229,616		6
7	Other Prepaid Expenses	16,757		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,070,167	$	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	3,838,705		15
16	Equipment, at Historical Cost	929,115		16
17	Accumulated Depreciation (book methods)	(2,728,064)		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)**	$ 2,039,756	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,109,923	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 684,613	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	395,302		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,079,915	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	207,785		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)**	$ 207,785	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,287,700	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,858,311	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,146,011	$	48

***(See instructions.)**

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,132,406	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,132,406	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	725,905	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)**	$ 725,905	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)**	$ 3,858,311	24 *

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	$ 9,637,625	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,637,625	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,352	12
13	Barber and Beauty Care	5,525	13
14	Non-Patient Meals	16,052	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	39,802	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	1,206	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 69,937	23
	D. Non-Operating Revenue		
24	Contributions	136,484	24
25	Interest and Other Investment Income***	8,779	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 145,263	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Discounts Earned	1,091	28
28a	Miscellaneous Revenue	1,091	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,182	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,855,007	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,775,160	31
32	Health Care	3,225,010	32
33	General Administration	1,890,543	33
	B. Capital Expense		
34	Ownership	1,115,987	34
	C. Ancillary Expense		
35	Special Cost Centers	933,594	35
36	Provider Participation Fee	188,808	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,129,102	40
41	**Income before Income Taxes (line 30 minus line 40)****	725,905	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 725,905	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,252,204	44
45	Private Pay - Net Inpatient Revenue	5,446,717	45
46	Medicare - Net Inpatient Revenue	2,437,657	46
47	Other-(specify) INDEPENDENT LIVING	501,047	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,637,625	49

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

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

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

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

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	1,896	2,080	$ 90,495	$ 43.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,878	25,608	714,728	27.91	3
4	Licensed Practical Nurses	24,218	27,072	625,309	23.10	4
5	CNAs & Orderlies	91,160	98,425	1,160,678	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,292	5,839	71,791	12.30	8
9	Activity Director	3,396	3,794	67,419	17.77	9
10	Activity Assistants	4,862	5,099	51,234	10.05	10
11	Social Service Workers	4,259	4,551	91,635	20.14	11
12	Dietician					12
13	Food Service Supervisor	1,860	2,233	48,651	21.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,314	27,282	309,650	11.35	15
16	Dishwashers	5,231	5,309	48,804	9.19	16
17	Maintenance Workers	11,798	13,023	236,094	18.13	17
18	Housekeepers	19,890	21,505	209,008	9.72	18
19	Laundry	6,096	6,977	83,817	12.01	19
20	Administrator	1,956	2,080	86,234	41.46	20
21	Assistant Administrator					21
22	Other Administrative	1,876	2,080	70,083	33.69	22
23	Office Manager					23
24	Clerical	14,737	15,887	264,931	16.68	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	1,925	2,084	30,639	14.70	31
32	Other Health C: Central Supply Cl	2,024	2,160	52,422	24.27	32
33	Other(specify) DRIVER & CHAP	3,778	4,043	69,806	17.27	33
34	TOTAL (lines 1 - 33)	255,446	277,131	$ 4,383,428 *	$ 15.82	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	$ 7,680	01-03	35
36	Medical Director	MONTHLY	24,000	09-03	36
37	Medical Records Consultant	QUARTERLY	861	10-03	37
38	Nurse Consultant	INTERMITTEN	14,140	10-03	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				44
45	Social Service Consultant	QUARTERLY	1,414	12-03	45
46	Other(specify)				46
47	MANAGEMENT CONSULTANT	INTERMITTEN	9,929	19-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 58,024		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: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGE BLOCK	ADMINISTRATOR		$ 86,234
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,234

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
ABILITY NETWORK	DATA PROCESSING	$ 9,576
BARRACUDA NETWORKS	DATA PROCESSING	1,937
MY FAX	DATA PROCESSING	420
GOOGLE APPS	DATA PROCESSING	2,707
COMCAST	DATA PROCESSING	5,101
CYNTHIA POWERS	CONSULTANT	720
DTW	COMPUTER CONS	47,733
EXPERIAN HEALTH	CONSULTANT	275
IMPG RISK MANAGEMENT SERV	CONSULTANT	1,500
MARY ANN KRUPA	ACCOUNTING	3,939
NTT DATA	DATA PROCESSING	28,982
SEE SUPPLEMENTAL SCHEDULE		48,740
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 151,630

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,132
Unemployment Compensation Insurance	31,599
FICA Taxes	320,126
Employee Health Insurance	300,327
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
EMPLOYEE LIFE INSURANCE	2,790
EMPLOYEE PHYSICALS	16,996
EMPLOYEE PENSION PLAN	77,256
EMPLOYEE RELATIONS	17,624
LESS: ADJUSTMENTS	(28,043)
TOTAL (agree to Schedule V, line 22, col.8)	$ 942,807

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,041
Health Care Worker Background Check	4,917
(Indicate # of checks performed)	
Patient Background Checks	
DUES - ASSOCIATIONS	12,007
LICENSES	18
ADVERTISING & PROMOTION	11,623
PUBLIC RELATIONS	955
Less: Public Relations Expense	(955)
Non-allowable advertising	(11,776)
Yellow page advertising	(809)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,011

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGE BLOCK	ADMINISTRATOR		$ 86,234
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,234

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
PERSONNEL PLANNERS	UNEMP CONS	$ 1,563
LEGAL EXP - SEE PG 3 SUP B	LEGAL	17,535
CARETRACKER	DATA PROCESSING	10,156
QUALITY THERAPY & CONS	CONSULTANT	3,770
SUREQUEST	DATA PROCESSING	1,764
TELUSYS	DATA PROCESSING	862
TEMPLIN HEALTHCARE	ACCOUNTING	2,090
WERMER, ROGERS, DORAN & RU	ACCOUNTING	10,500
PRACTICAL SYSTEM SOLUTIONS	DATA PROCESSING	500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 48,740

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		$

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OUR LADY OF ANGELS RET HOME # 0034975 Report Period Beginning: 7/1/15 Ending: 6/30/16

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. **LEADING AGE $3,043 & LSN $6,236**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,318** 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? 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. $ **188,808**
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. $ **16,052**

(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? **N/A**
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? **NO**
Firm Name: **NO**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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