FOR BHF USE

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0034975

Facility Name: OUR LADY OF ANGELS RETIREMENT HOME

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

County: WILL

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

HFS ID Number:

Date of Initial License for Current Owners: 8/1/1962

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 7/1/17 to 6/30/18 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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5	50	Sheltered Care (SC)	50	18,250	5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,005	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,517	2,078	3,844	11,439	8
9	SNF/PED					9
10	ICF	4,916	10,193	0	15,109	10
11	ICF/DD					11
12	SC	0	14,215	0	14,215	12
13	DD 16 OR LESS					13
14	TOTALS	10,433	26,486	3,844	40,763	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.52%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 8/10/1962

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 3,844

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT H # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	473,854	46,476	10,230	530,560		530,560	(44,837)	485,723			1
2	Food Purchase		338,975		338,975		338,975	(47,694)	291,281			2
3	Housekeeping	182,539	48,427		230,966		230,966	(4,513)	226,453			3
4	Laundry	78,657	12,608	1,039	92,304		92,304	(1,945)	90,359			4
5	Heat and Other Utilities			223,577	223,577		223,577	(27,947)	195,630			5
6	Maintenance	220,123		235,116	455,239		455,239	(89,796)	365,443			6
7	Other (specify):*											7
8	**TOTAL General Services**	955,173	446,486	469,962	1,871,621		1,871,621	(216,732)	1,654,889			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,264,059	171,703	25,266	3,461,028		3,461,028		3,461,028			10
10a	Therapy											10a
11	Activities	123,157	18,875		142,032		142,032	(35,768)	106,264			11
12	Social Services	132,894		1,938	134,832		134,832	(3,286)	131,546			12
13	CNA Training											13
14	Program Transportation	25,240		6,132	31,372		31,372	(2,496)	28,876			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,545,350	190,578	57,336	3,793,264		3,793,264	(41,550)	3,751,714			16
	C. General Administration											
17	Administrative	84,153			84,153		84,153	(2,081)	82,072			17
18	Directors Fees											18
19	Professional Services			176,168	176,168		176,168	(4,356)	171,812			19
20	Dues, Fees, Subscriptions & Promotions			56,446	56,446		56,446	(20,460)	35,986			20
21	Clerical & General Office Expenses	360,661	25,312	286,374	672,347		672,347	(268,384)	403,963			21
22	Employee Benefits & Payroll Taxes			1,029,892	1,029,892		1,029,892	(25,394)	1,004,498			22
23	Inservice Training & Education			5,314	5,314		5,314		5,314			23
24	Travel and Seminar			4,500	4,500		4,500	(999)	3,501			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,179	101,179		101,179	(9,006)	92,173			26
27	Other (specify):*											27
28	**TOTAL General Administration**	444,814	25,312	1,659,873	2,129,999		2,129,999	(330,680)	1,799,319			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,945,337	662,376	2,187,171	7,794,884		7,794,884	(588,962)	7,205,922			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	13,422	141,849	100.00%	9.46%	473,854	44,837
Food	Meals Served	13,422	141,849	100.00%	9.46%	338,975	32,074
Housekeeping	Census Factored	4,474	45,237	25.00%	2.47%	182,539	4,513
Laundry	Census Factored	4,474	45,237	25.00%	2.47%	78,657	1,945
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	223,577	27,947
Maintenance	Square Feet	1	8	100.00%	12.50%	455,239	56,905
Activities	Census	4,474	45,237	25.00%	2.47%	123,157	3,045
Social Services	Census	4,474	45,237	25.00%	2.47%	132,894	3,286
Program Transportation	Census	4,474	45,237	100.00%	9.89%	25,240	2,496
Administrative	Census	4,474	45,237	25.00%	2.47%	84,153	2,081
Professional Fees	Census	4,474	45,237	25.00%	2.47%	176,168	4,356
Dues, Fees, Subscriptions and Promotions	Census	4,474	45,237	25.00%	2.47%	56,446	1,396
Clerical and Office Expenses	Census	4,474	45,237	25.00%	2.47%	360,661	8,917
Travel and Seminar	Census	4,474	45,237	25.00%	2.47%	4,500	111
Insurance - Property	Square Feet	1	8	100.00%	12.50%	64,866	8,108
Insurance - Liability	Census	4,474	45,237	25.00%	2.47%	36,313	898
Depreciation	Square Feet	1	8	100.00%	12.50%	240,906	30,113
Equipment Rental	Census	4,474	45,237	25.00%	2.47%	19,937	493
Employee Benefits	Census	4,474	45,237	25.00%	2.47%	1,027,047	25,394
						4,105,129	258,916

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

Firm Name	Invoice Date	Expense Type	Allowable Amount
Tracy, Johnson & Wilson	7/5/2017	General Matters	65
Polsinelli PC	7/21/17	Contract review	213
Polsinelli PC	6/16/17	Review Admissions issue - medicare 100 days lapsing	110
Polsinelli PC	8/17/17	Revise contrct, include respite and short term stay	1,293
Polsinelli PC	8/17/17	Review contract, summarize & finalize	638
Polsinelli PC	9/14/17	Correspondence re: resident room rates	523
Tracy, Johnson & Wilson	10/5/17	General Matters	564
Polsinelli PC	10/10/17	Rvise Admissions Contract, Conf re: authorization forı	1,600
Tracy, Johnson & Wilson	11/2/17	General Matters	342
Polsinelli PC	11/16/17	Review new guidance from OCR, recommend HIPPA forms in admissions packet	415
Tracy, Johnson & Wilson	12/4/17	General Matters	148
Tracy, Johnson & Wilson	1/4/18	General Matters	1,249
Polsinelli PC	1/26/18	Review "offsetting expense of record review" Review Therapy Contract	1,100
Polsinelli PC	1/26/18	Review & revise Admission Agreement	1,020
Tracy, Johnson & Wilson	3/5/18	General Matters	19
Tracy, Johnson & Wilson	3/1/18	General Matters	375
Tracy, Johnson & Wilson	4/4/18	General Matters	176
Polsinelli PC	4/19/18	Tele conference - discuss client inquiry re: surveyor interpretation of abuse Regulations	220
Polsinelli PC	4/19/18	Correspondence to - securing payment from resident's who are denied Medicare benefits and how to use guarnators	176
Polsinelli PC	5/18/18	Prepare contract materials into separate work doc's for use in electronic record systems	352
Tracy, Johnson & Wilson	6/4/18	General Matters	435
		Total	**11,029**

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME #0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			240,906	240,906		240,906	(30,113)	210,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,149	4,149		4,149	(8,792)	(4,643)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,873	847,873		847,873	(847,873)				34
35	Rent-Equipment & Vehicles			19,937	19,937		19,937	(493)	19,444			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,112,865	1,112,865		1,112,865	(887,271)	225,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		180,968	510,039	691,007		691,007		691,007			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,270	4,270		4,270		4,270			41
42	Provider Participation Fee			186,280	186,280		186,280		186,280			42
43	Other (specify):* Devel/Chapel	51,961		85,788	137,749		137,749	(85,788)	51,961			43
44	**TOTAL Special Cost Centers**	51,961	180,968	786,377	1,019,306		1,019,306	(85,788)	933,518			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,997,298	843,344	4,086,413	9,927,055		9,927,055	(1,562,021)	8,365,034			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	51,961
Chapel Expenses	47,220
Fund Raising - Public Relations	38,568
Total	**137,749**

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	(15,620)	02		4
5	Telephone, TV & Radio in Resident Rooms	(53,377)	21		5
6	Rented Facility Space	(36,786)	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	(8,792)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,803)	21		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	(5,477)	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	(194,810)	21		24
25	Fund Raising, Advertising and Promotional	(18,257)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(807)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (338,729)		$	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))**	$ (338,729)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OUR LADY OF ANGELS RETIREMENT HOME

ID# 0034975

Report Period Beginning: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Income	$ (32,723)	11	1
2	Charity Expense	(1,000)	21	2
3	Chapel Expenses (Non-adjusted for Income)	(47,220)	43	3
4	Development Expenses	(38,568)	43	4
5	Capitalized Asset - Under $2500 threshold	3,895	06	5
6	Independent Living (Allocated Costs)			6
7	Dietary	(44,837)	01	7
8	Food	(32,074)	02	8
9	Housekeeping	(4,513)	03	9
10	Laundry	(1,945)	04	10
11	Heat & Other Utilities	(27,947)	05	11
12	Maintenance	(56,905)	06	12
13	Activities	(3,045)	11	13
14	Social Services	(3,286)	12	14
15	Program Transportation	(2,496)	14	15
16	Administrative	(2,081)	17	16
17	Professional Fees	(4,356)	19	17
18	Dues, Fees, Subscriptions & Promotions	(1,396)	20	18
19	Clerical & Office Expenses	(8,917)	21	19
20	Travel & Seminar	(111)	24	20
21	Insurance - Property	(8,108)	26	21
22	Insurance - Liability	(898)	26	22
23	Depreciation	(30,113)	30	23
24	Equipment Rental	(493)	35	24
25	Employee Benefits	(25,394)	22	25
26	Non-care Related Travel	(888)	24	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**	(375,419)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	(44,837)	0	0	0	0	0	0	0	0	0	0	(44,837)	1
2	Food Purchase	(47,694)	0	0	0	0	0	0	0	0	0	0	(47,694)	2
3	Housekeeping	(4,513)	0	0	0	0	0	0	0	0	0	0	(4,513)	3
4	Laundry	(1,945)	0	0	0	0	0	0	0	0	0	0	(1,945)	4
5	Heat and Other Utilities	(27,947)	0	0	0	0	0	0	0	0	0	0	(27,947)	5
6	Maintenance	(89,796)	0	0	0	0	0	0	0	0	0	0	(89,796)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(216,732)	0	0	0	0	0	0	0	0	0	0	(216,732)	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	(35,768)	0	0	0	0	0	0	0	0	0	0	(35,768)	11
12	Social Services	(3,286)	0	0	0	0	0	0	0	0	0	0	(3,286)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,496)	0	0	0	0	0	0	0	0	0	0	(2,496)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(41,550)	0	0	0	0	0	0	0	0	0	0	(41,550)	16
	C. General Administration													
17	Administrative	(2,081)	0	0	0	0	0	0	0	0	0	0	(2,081)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,356)	0	0	0	0	0	0	0	0	0	0	(4,356)	19
20	Fees, Subscriptions & Promotions	(20,460)	0	0	0	0	0	0	0	0	0	0	(20,460)	20
21	Clerical & General Office Expenses	(268,384)	0	0	0	0	0	0	0	0	0	0	(268,384)	21
22	Employee Benefits & Payroll Taxes	(25,394)	0	0	0	0	0	0	0	0	0	0	(25,394)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(999)	0	0	0	0	0	0	0	0	0	0	(999)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,006)	0	0	0	0	0	0	0	0	0	0	(9,006)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(330,680)	0	0	0	0	0	0	0	0	0	0	(330,680)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(588,962)	0	0	0	0	0	0	0	0	0	0	(588,962)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	(30,113)	0	0	0	0	0	0	0	0	0	0	(30,113)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,792)	0	0	0	0	0	0	0	0	0	0	(8,792)	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	(493)	0	0	0	0	0	0	0	0	0	0	(493)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,398)	(847,873)	0	0	0	0	0	0	0	0	0	(887,271)	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):*	(85,788)	0	0	0	0	0	0	0	0	0	0	(85,788)	43
44	**TOTAL Special Cost Centers**	(85,788)	0	0	0	0	0	0	0	0	0	0	(85,788)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(714,148)	(847,873)	0	0	0	0	0	0	0	0	0	(1,562,021)	45

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 847,873	Sisters of St. Francis of Mary Immaculate	100.00%	$	$ (847,873)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 847,873			$	$ * (847,873)	14

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

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	David Leggero	BOD						3
4	Mary Jo Mackniskas	BOD						4
5	Gerry Brady	BOD						5
6	Jackie Edmonson	BOD						6
7	Sr. Rosemary Fonck, OSF	BOD						7
8	Sr. Mary Jane Griffin, OSF	BOD						8
9	Eileen Gutierrez	BOD						9
10	Eric Holloway	BOD						10
11	Greg Newsome	BOD						11
12	Sr. Barbara Kwiatkowski, OSF	BOD						12
13	Dorothy Spiczak	BOD						13
14	Philip Wierzbinski	BOD						14
15	Sr. Dolores Zemont, OSF	BOD						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 RETIREMENT I # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.	Social Services	See Below	0	14	100.00	Salary	$ 11,640	11-01	1
2	Sr. Odelia Kloc, OSF	Enrichment Coord.	Activities	See Below	0	32	100.00	Salary	27,761	11-01	2
3	Sr. Geri Podobnik	MDS Coordinator	Nursing	See Below	0	16	100.00	Salary	15,925	10-01	3
4											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	$ 55,326		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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 RETIREMENT H # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 BAN K		X	CASH FLOWS	$7,341.78	1/3/14	393,585	43,480	12/26/18	4.5000	4,078	6
7	CHRISTIAN BROTHERS		X	INS POLICY INT CHARGES							71	7
8												8
9	TOTAL Facility Related				$7,341.78		$ 393,585	$ 43,480			$ 4,149	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 393,585	$ 43,480			$ 4,149	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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OUR LADY OF ANGELS RETIREMENT 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 1,572,423	1
2					2
3	TOTALS	609,840		$ 1,572,423	3

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	87,194						9
10	VARIOUS			1995	78,867						10
11	VARIOUS			1996	188,527						11
12	VARIOUS			1997	188,236						12
13	VARIOUS			1998	703,545						13
14	VARIOUS			1999	242,370						14
15	VARIOUS			2000	5,332						15
16	VARIOUS			2001	156,163						16
17	VARIOUS			2002	72,599						17
18	VARIOUS			2003	431,643						18
19	VARIOUS			2004	46,300						19
20	VARIOUS			2005	103,405						20
21	VARIOUS			2006	6,705						21
22	VARIOUS			2007	3,208,187						22
23	VARIOUS			2008	177,923						23
24	VARIOUS			2009	35,873						24
25	VARIOUS			2010	91,651						25
26	VARIOUS			2011	236,817						26
27	VARIOUS			2012	8,247						27
28	VARIOUS			2013	35,753						28
29	VARIOUS			2014	170,121						29
30											30
31											31
32											32
33											33
34											34
35											35
36						130,278		130,278		2,203,085	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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	Cooling Tower	2015	$ 44,823	$ 2,988	15	$ 2,988	$	$ 11,108	37
38	Boiler - Tube	2015	9,355	624	15	624		2,391	38
39	Boiler - Main	2015	3,965	793	5	793		2,908	39
40	Room Improvements - Sheltered Care - Carpet & Painting	2015	9,471	1,894	5	1,894		6,472	40
41	Boiler	2015	4,161	832	5	832		2,843	41
42	Water Tank	2015	3,968	794	5	794		2,646	42
43	Sprinkler Repairs	2015	2,791	558	5	558		1,860	43
44	A&B Hallways - Fire Door Upgrade Project (IDPH Survey)	2015	260,982	10,439	25	10,439		33,928	44
45	Asbestos removal, Replace Fire Doors & Ceilings	2015							45
46	Elevator Pit Ladders	2015	7,780	778	10	778		2,529	46
47	A&B Hallways - Sprinkler, Alarm, Electrical Work	2015	25,546	1,022	25	1,022		3,235	47
48	Fireproofing - Beams (A&B Halls)	2015	10,900	1,090	10	1,090		3,270	48
49	Angels Café Remodel - carpet, paint, asbestos removal	2016	44,215	2,211	20	2,211		4,592	49
50	Boiler - replacement	2016	4,947	247	20	247		515	50
51	Carpet - Offices - E Wing	2016	33,937	6,787	10	6,787		11,615	51
52	D-1 Copper Piping & Cover	2016	7,815	284	28	284		639	52
53	Air conditioning repairs (main)	2016	3,628	363	10	363		756	53
54	A1/B1 Nurses Station - move & call light upgrade	2016	5,920	592	10	592		1,252	54
55	Camera/Wiring Closet Improvements	2017	10,804	878	10	878		1,534	55
56	Roof Replacement - B&D Wings	2017	134,860	6,743	28	6,743		11,238	56
57	Office Upgrades - Carpet & Paint - Upstairs Circle	2017	24,127	2,413	10	2,413		3,016	57
58	Electrical Work - A/C Outlet Relocation - C Wings & Fire Alarms	2017	35,211	1,275	28	1,275		1,546	58
59	A/C Compressor - Chapel/Lobby/D-Wing	2017	8,936	596	15	596		645	59
60	Phone System Wiring	2017	3,804	136	28	136		147	60
61	Activity Room - Move - Asbestos Removal, Carpet, Paint & Electr	2017	33,978	2,265	15	2,265		2,265	61
62	Outdoor Improvement - Pavers & Sod	2017	8,045	536	15	536		536	62
63	Window Screen Replacement	2017	2,565	257	10	257		257	63
64	Activity Room - remodel - acoustic ceilings, cabinets, A/C, window	2018	50,355	3,490	15	3,490		3,490	64
65	Electrical Work - Boiler Relief Valve & Switch & Kitchen	2018	15,112	344	28	344		344	65
66	Roof Replacement - B&D Wings & Circle	2018	214,800	2,754	39	2,754		2,754	66
67	Carpet - Offices - 2nd floor	2018	7,092	362	5	362		362	67
68	Replacement of main water pipe - D1	2018	18,932	189	25	189		189	68
69	Fire Door Improvements - Skilled Unit	2018	6,434	71	15	71		71	69
70	TOTAL (lines 4 thru 69)		$ 8,907,139	$ 184,884		$ 184,884	$	$ 2,324,039	70

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

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 242,964	$ 38,387	$ 38,387	$		$ 127,899	71
72	Current Year Purchases	133,008	6,237	6,237			6,237	72
73	Fully Depreciated Assets	514,050					514,050	73
74								74
75	TOTALS	$ 890,022	$ 44,624	$ 44,624	$		$ 648,186	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	Fully Depreciated Vehicles		$ 95,085	$	$	$	5	$ 95,085	76
77	Facility	Repairs	2012	3,038	45	45	(0)	5	3,038	77
78	Facility	Tires & Suspension	2015	2,965	593	593	0	5	2,125	78
79	Facility	Ford Bus	2015	53,798	10,760	10,760	0	5	35,865	79
80	TOTALS			$ 154,886	$ 11,398	$ 11,398	$ 0		$ 136,113	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)	$ 11,524,470	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,906	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 240,906	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,108,338	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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 19,937 Description: COPIERS
(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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 159,210	$		$ 159,210	1
2	Licensed Speech and Language Development Therapist		hrs			77,400			77,400	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			187,509			187,509	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				180,968		180,968	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs				1,725		1,725	11
12	Other (specify): SEE SUPPLEMENTAL									12
13	Other (specify): SEE SUPPLEMENTAL						84,195		84,195	13
14	TOTAL			$		$ 424,119	$ 266,888		$ 691,007	14

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

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 16 Supplemental
07/01/17 - 06/30/18

Page 16 Line 12 Column 6: Other Ancillary Supplies

Medical Supplies	1,725
Total	1,725

Page 16 Line 13 Column 6: Other Ancillary Expense

Laboratory	18,849
Radiology	23,380
Other Hospital Services	41,966
Total	84,195

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/18 (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	$ 982,579	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,346)	2,037,450		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	230,185		6
7	Other Prepaid Expenses	16,938		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,267,152	$	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	4,441,081		15
16	Equipment, at Historical Cost	1,044,907		16
17	Accumulated Depreciation (book methods)	(3,108,338)		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)**	$ 2,377,650	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,644,802	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 615,870	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	43,480		29
30	Accrued Salaries Payable	392,924		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	163,215		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,215,489	$	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)**	$ 1,215,489	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,418,892	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,634,381	$	48

***(See instructions.)**

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,627,568	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(198,255)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,429,313	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(10,421)	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)**	$ (10,421)	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)**	$ 4,418,892	24 *

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

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 9,674,964	1
2	Discounts and Allowances for all Levels	(268,499)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,406,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,971	12
13	Barber and Beauty Care	3,211	13
14	Non-Patient Meals	15,620	14
15	Telephone, Television and Radio	5,894	15
16	Rental of Facility Space	36,786	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	107	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 67,589	23
	D. Non-Operating Revenue		
24	Contributions	345,256	24
25	Interest and Other Investment Income***	8,792	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 354,048	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	51,006	27
28	Chapel Income	32,723	28
28a	Discounts Earned	4,803	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 88,532	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,916,634	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,871,621	31
32	Health Care	3,793,264	32
33	General Administration	2,129,999	33
	B. Capital Expense		
34	Ownership	1,112,865	34
	C. Ancillary Expense		
35	Special Cost Centers	833,026	35
36	Provider Participation Fee	186,280	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,927,055	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,421)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,421)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,532,719	44
45	Private Pay - Net Inpatient Revenue	5,183,838	45
46	Medicare - Net Inpatient Revenue	2,197,606	46
47	Other-(specify) Independent Living	492,302	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,406,465	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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	1,916	2,080	$ 83,777	$ 40.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,201	29,036	832,100	28.66	3
4	Licensed Practical Nurses	22,137	23,876	614,497	25.74	4
5	CNAs & Orderlies	89,985	95,784	1,389,308	14.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,093	6,741	70,467	10.45	8
9	Activity Director	3,151	3,489	63,098	18.08	9
10	Activity Assistants	5,734	5,991	60,059	10.02	10
11	Social Service Workers	6,360	6,762	132,894	19.65	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,096	53,157	25.36	13
14	Head Cook	14,108	14,891	197,620	13.27	14
15	Cook Helpers/Assistants	16,716	17,617	182,445	10.36	15
16	Dishwashers	4,037	4,331	40,632	9.38	16
17	Maintenance Workers	10,908	11,493	220,123	19.15	17
18	Housekeepers	18,058	19,372	182,539	9.42	18
19	Laundry	6,121	6,637	78,657	11.85	19
20	Administrator	1,892	2,080	84,153	40.46	20
21	Assistant Administrator					21
22	Other Administrative	18,452	19,307	360,661	18.68	22
23	Office Manager					23
24	Clerical					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	1,873	2,058	32,140	15.62	31
32	Other Health C: Cental Supply Cler	17,792	18,864	241,770	12.82	32
33	Other(specify) Driver & Chapel	3,539	4,028	77,201	19.17	33
34	TOTAL (lines 1 - 33)	278,129	296,533	$ 4,997,298 *	$ 16.85	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 10,230	01-03	35
36	Medical Director	MONTHLY	24,000	09-03	36
37	Medical Records Consultant	QUARTERLY	1,300	10-03	37
38	Nurse Consultant	INTERMITTEN	19,910	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	1,406	12-03	45
46	Other(specify) MDS CONSULTANT	INTERMITTEN	4,056	10-03	46
47	MANAGEMENT CONSULTANT	INTERMITTEN	8,333	19-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 69,235		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	63	$ 3,147	10-1	50
51	Licensed Practical Nurses	75	3,015	10-1	51
52	Certified Nurse Assistants/Aides	13,002	346,389	10-1	52
53	TOTAL (lines 50 - 52)	13,140	$ 352,551		53

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
George Block	Administrator		$ 84,153
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,153

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
QUALITY THERAPY & CONSULT	CONSULTANT	$ 2,438
CAROLYN MACGRUDER	CONSULTANT	100
SISTERS OF ST. FRANCIS/SR. LOI	CONSULTANT	2,513
LEE MORIARTY	CONSULTANT	3,282
DTW	COMPUTER	43,608
EXECUTIVE DATA SYSTEMS	COMPUTER	694
BARRACUDA NETWORK	COMPUTER	1,578
INTEGRITY DATA	DATA PROCESSING	2,500
CERNER/CARETRACKER	DATA PROCESSING	9,396
NTT DATA/CANTATA	DATA PROCESSING	32,099
SUREQUEST	DATA PROCESSING	468
SEE SUPPLEMENTAL		77,493
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 176,168

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 224,133
Unemployment Compensation Insurance	(31,914)
FICA Taxes	348,640
Employee Health Insurance	366,081
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
EMPLOYEE LIFE INSURANCE	6,707
EMPLOYEE PHYSICALS	20,165
EMPLOYEE PENSION PLAN	78,897
EMPLOYEE RELATIONS	17,183
LESS: ADJUSTMENTS	(25,394)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,004,498

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	17,034
Health Care Worker Background Check	5,866
(Indicate # of checks performed)	
Patient Background Checks	
DUES - ASSOCIATIONS	10,475
LICENSES	2,017
ADVERTISING & PROMOTION	19,064
LESS; ADJUSTMENTS	(1,396)
Less: Public Relations Expense	(85)
Non-allowable advertising	(18,172)
Yellow page advertising	(807)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,986

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 RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CASAMBA	DATA PROCESSING	$ 992
ISOLVED HCM	DATA PROCESSING	1,289
TELUSYS	DATA PROCESSING	595
COMCAST	INTERNET	5,172
SMARTLINX	PAYROLL PROCESSING	20,838
POINT CLICK CARE	DATA PROCESSING	9,906
ABILITY	DATA PROCESSING	8,372
GOOGLE APPS	DATA PROCESSING	9,375
PERSONNEL PLANNERS	UNEMPLOYMENT	1,125
WERMER ROGER DURAN & RUZ	ACCOUNTING	6,900
TEMPLIN HEALTH CARE	ACCOUNTING	1,900
SEE PG 3 SUPP B	LEGAL FEES	11,029
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 77,493

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.

Our Lady of Angels Retirement Home
Line 23 - Inservice Training & Education

Firm Name	Invoice Date	Expense Type	Allowable Amount
CE Solutions	1/15/18	On-line Continuing Education Program	2,405
Kurtz Ambulance	9/26/17	CPR Training/Renewal	187
Kurtz Ambulance	4/16/18	CPR Training/Renewal	187
Pathway Health	9/18/17	Educational Materials	581
Med-Pass	11/15/17	Reference Materials	292
Pathway Health	11/28/17	Educational Materials	1,163
Linda Roberts & Associates	2/28/18	Food Handlers Class	149
Certified Food & Nutrition	6/15/18	Food Handlers Class	350
		Total	**5,314**

Facility Name & ID Number OUR LADY OF ANGELS RETIREMENT HOME # 0034975 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 ILLINOIS - $9,849**

(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? **7 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,882** 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. $ **186,280**
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. $ **15,620**

(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. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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