

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

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 100

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			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	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	4,765	12,936		17,701	10
11	ICF/DD					11
12	SC		15,512		15,512	12
13	DD 16 OR LESS					13
14	TOTALS	4,765	28,448		33,213	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

D. How many bed-hold days during this year were paid by Public Aid? 25 (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)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES 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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

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

STATE OF ILLINOIS

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Facility Name & ID Number

Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	411,991	22,689		434,680	14,984	449,664	(209,543)	240,121		1
2	Food Purchase		285,784		285,784		285,784	(133,175)	152,609		2
3	Housekeeping	187,233	58,959		246,192		246,192	(114,725)	131,467		3
4	Laundry	86,493	9,457		96,071		96,071	(35,546)	60,525		4
5	Heat and Other Utilities			121	208,010		208,010	(96,933)	111,077		5
6	Maintenance	208,206	170,478	2,793	381,477		381,477	(177,768)	203,709		6
7	Other (specify):*										7
8	TOTAL General Services	893,923	547,367	210,924	1,652,214	14,984	1,667,198	(767,690)	899,508		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,910,800	30,712		1,941,512	28,598	1,970,110	(906,893)	1,063,217		10
10a	Therapy	78,659			78,659		78,659		78,659		10a
11	Activities	88,494		20,200	108,694	63,559	172,253		172,253		11
12	Social Services	602		6,412	7,014		7,014		7,014		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,078,555	30,712	26,612	2,135,879	92,157	2,228,036	(906,893)	1,321,143		16
	C. General Administration										
17	Administrative	40,472		27,002	67,474	117,200	184,674	(78,173)	106,501		17
18	Directors Fees										18
19	Professional Services			67,685	67,685		67,685	(28,651)	39,034		19
20	Dues, Fees, Subscriptions & Promotions			11,326	11,326		11,326	(4,794)	6,532		20
21	Clerical & General Office Expenses	281,530	15,457		296,987	(12,288)	284,699	(120,513)	164,186		21
22	Employee Benefits & Payroll Taxes			568,043	568,043		568,043	(240,453)	327,590		22
23	Inservice Training & Education			3,958	3,958		3,958	(1,675)	2,283		23
24	Travel and Seminar			6,714	6,714		6,714	(2,842)	3,872		24
25	Other Admin. Staff Transportation			4,488	4,488		4,488	(1,900)	2,588		25
26	Insurance-Prop.Liab.Malpractice			103,634	103,634		103,634	(43,868)	59,766		26
27	Other (specify):*			28,592	28,592		28,592	(21,566)	7,026		27
28	TOTAL General Administration	322,002	15,457	821,442	1,158,901	104,912	1,263,813	(544,435)	719,378		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,294,480	593,536	1,058,978	4,946,994	212,053	5,159,047	(2,219,018)	2,940,029		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Our Lady of Angels Retirement Home

#0034975

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			186,410	186,410		186,410	(8,868)	177,542			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			308	308		308		308			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			815,765	815,765		815,765	(345,313)	470,452			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,002,483	1,002,483		1,002,483	(354,181)	648,302			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					18,094	18,094		18,094			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	8,327	6,570		14,897	3,843	18,740		18,740			41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):*	255,232	26,897		282,129	(233,990)	48,139	(48,139)				43
44	TOTAL Special Cost Centers	263,559	33,467	27,375	324,401	(212,053)	112,348	(48,139)	64,209			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,558,039	627,003	2,088,836	6,273,878		6,273,878	(2,621,338)	3,652,540			45

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

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,868)	30		9
10	Interest and Other Investment Income	(806)	27		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	(209,543)	1		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(136)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,467)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,386,518)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,621,338)		\$	30

OHF 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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,621,338)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Our Lady of Angels Retirement Home

ID# 0034975

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Chapel Costs	\$ (27,789)	43	1
2	OLA Fest	(15,873)	43	2
3	Other Fundraising	(4,477)	43	3
4				4
5	Allocation of Religious Order Costs	(133,175)	2	5
6		(114,725)	3	6
7		(35,546)	4	7
8		(96,933)	5	8
9		(177,768)	6	9
10		(906,893)	10	10
11		(78,173)	17	11
12		(28,651)	19	12
13		(4,794)	20	13
14		(120,513)	21	14
15		(240,453)	22	15
16		(1,675)	23	16
17		(2,842)	24	17
18		(1,900)	25	18
19		(43,868)	26	19
20		(5,157)	27	20
21		(345,313)	34	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,386,518)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(209,543)	0	0	0	0	0	0	0	0	0	0	(209,543)	1
2	Food Purchase	(133,175)	0	0	0	0	0	0	0	0	0	0	(133,175)	2
3	Housekeeping	(114,725)	0	0	0	0	0	0	0	0	0	0	(114,725)	3
4	Laundry	(35,546)	0	0	0	0	0	0	0	0	0	0	(35,546)	4
5	Heat and Other Utilities	(96,933)	0	0	0	0	0	0	0	0	0	0	(96,933)	5
6	Maintenance	(177,768)	0	0	0	0	0	0	0	0	0	0	(177,768)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(767,690)	0	0	0	0	0	0	0	0	0	0	(767,690)	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	(906,893)	0	0	0	0	0	0	0	0	0	0	(906,893)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(906,893)	0	0	0	0	0	0	0	0	0	0	(906,893)	16
	C. General Administration													
17	Administrative	(78,173)	0	0	0	0	0	0	0	0	0	0	(78,173)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(28,651)	0	0	0	0	0	0	0	0	0	0	(28,651)	19
20	Fees, Subscriptions & Promotions	(4,794)	0	0	0	0	0	0	0	0	0	0	(4,794)	20
21	Clerical & General Office Expenses	(120,513)	0	0	0	0	0	0	0	0	0	0	(120,513)	21
22	Employee Benefits & Payroll Taxes	(240,453)	0	0	0	0	0	0	0	0	0	0	(240,453)	22
23	Inservice Training & Education	(1,675)	0	0	0	0	0	0	0	0	0	0	(1,675)	23
24	Travel and Seminar	(2,842)	0	0	0	0	0	0	0	0	0	0	(2,842)	24
25	Other Admin. Staff Transportation	(1,900)	0	0	0	0	0	0	0	0	0	0	(1,900)	25
26	Insurance-Prop.Liab.Malpractice	(43,868)	0	0	0	0	0	0	0	0	0	0	(43,868)	26
27	Other (specify):*	(21,566)	0	0	0	0	0	0	0	0	0	0	(21,566)	27
28	TOTAL General Administration	(544,435)	0	0	0	0	0	0	0	0	0	0	(544,435)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,219,018)	0	0	0	0	0	0	0	0	0	0	(2,219,018)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975 Report Period Beginning:

7/1/2002 Ending:

6/30/2003

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(8,868)	0	0	0	0	0	0	0	0	0	0	(8,868) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(345,313)	0	0	0	0	0	0	0	0	0	0	(345,313) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(354,181)	0	0	0	0	0	0	0	0	0	0	(354,181) 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):*	(48,139)	0	0	0	0	0	0	0	0	0	0	(48,139) 43
44	TOTAL Special Cost Centers	(48,139)	0	0	0	0	0	0	0	0	0	0	(48,139) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(2,621,338)	0	0	0	0	0	0	0	0	0	0	(2,621,338) 45

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	100	N/A				

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Rent	\$ 815,765	Sisters Of St. Francis	100.00%	\$ 815,765	\$	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		\$ 815,765			\$ 815,765	\$ *	14

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

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Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1									\$		1	
2											2	
3	Owned by religious order (Total Compensation \$255,232 - listed all over \$20,000)										43-1	3
4												4
5	Sr. Yvonne Weidner	Administrator	CEO	0.00	0	40	100.00	Wage	63,315		17-5	5
6	Sr. Mary Gen Wolfram		Activity Director	0.00	0	40	100.00	Wage	30,843		11-5	6
7	Sr. Elaine Murphy		Admissions Dir.	0.00	0	40	100.00	Wage	30,491		17-5	7
8	Sr. Odelia Kloc		Activities	0.00	0	40	100.00	Wage	27,915		11-5	8
9												9
10	Others Under \$20,000							Wage	102,668			10
11												11
12												12
13								TOTAL	\$ 255,232			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: 7/1/2002 Ending: 3/30/2003

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

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

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

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

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						
		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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	GMAC		X	Vehicle Purchase	\$325.73	01/15/02		6,899	08/05/03	3.9000	308	6						
7												7						
8												8						
9	TOTAL Facility Related				\$325.73		\$	6,899			\$	308	9					
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$				\$		14					
15	TOTALS (line 9+line14)						\$	6,899			\$	308	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: **7/1/2002** Ending: **6/30/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2002 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 2003 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:		1998	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 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 _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975 Report Period Beginning:7/1/2002 Ending:6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326 B. General Construction Type: Exterior Class C Frame Steel & Brick Number of Stories TwoC. Does the Operating Entity? (a) Own the Facility (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? (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Long Term Care</u>	<u>609,840</u>	<u>1962</u>	\$	1
2					2
3	TOTALS	609,840		\$	3

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975

Report Period Beginning:

7/1/2002

Ending:

6/30/2003**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Ceiling Painting	1991		39,535	989	40	989		12,355	9
10		North Parking Lot	1991		40,366	1,009	40	1,009		12,614	10
11		2 Air Conditioning Units	1992		22,403	560	40	560		6,441	11
12		Call System	1992		13,400	335	40	335		3,853	12
13		Television Antenna	1992		778	19	40	19		224	13
14		Elevator Door Motor	1992		820	21	40	21		236	14
15		Garage	1992		9,958	249	40	249		2,863	15
16		Fence Around Compactor	1992		888	22	40	22		255	16
17		Cabinets & Counter Tops	1992		2,700	68	40	68		776	17
18		Sidewalk Improvements	1992		10,038	251	40	251		2,886	18
19		Multi Purpose Room	1993		11,531	288	40	288		3,030	19
20		Nurse Call Light System	1993		28,765	719	40	719		7,551	20
21		Doors	1993		32,652	816	40	816		8,571	21
22		Reseal Road	1993		10,845	271	40	271		2,847	22
23		Cooling Tower	1993		51,950	1,299	40	1,299		13,637	23
24		Miscellaneous	1993		8,542	214	40	214		2,242	24
25		Air Conditioner	1993		5,878	147	40	147		1,543	25
26		Room Numbers	1994		11,307	283	40	283		2,685	26
27		Miscellaneous	1994		33,085	827	40	827		7,858	27
28		Master Clocks	1994		5,655	141	40	141		1,343	28
29		Flourscent Lights	1994		7,619	190	40	190		1,809	29
30		Lotciem Wall And Door	1994		1,549	39	40	39		368	30
31		Library Wall And Door	1994		1,574	40	40	40		374	31
32		Doors	1994		18,079	452	40	452		4,294	32
33		Air Conditioner	1995		4,000	100	40	100		850	33
34		Fire Act Door Closures	1995		6,379	159	40	159		1,356	34
35		Door Closures	1995		2,300	58	40	58		489	35
36		Burners (Boiler)	1995		18,279	457	40	457		3,884	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:

7/1/2002

Ending:

6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Remodel Admissions Office	1995	\$ 2,371	\$ 59	40	\$ 59	\$	\$ 504	37
38	Gas Lines	1995	562	14	40	14		119	38
39	Relocate Duane Controls	1995	1,460	37	40	37		310	39
40	Remodel Lobby	1995	1,455	36	40	36		309	40
41	Doors	1995	35,236	881	40	881		7,488	41
42	Telephone System	1995	17,881	447	40	447		3,800	42
43	Doors	1995	6,207	155	40	155		1,319	43
44	Boiler Room	1995	1,559	39	40	39		331	44
45	Kitchenette Remodeling	1995	1,830	46	40	46		389	45
46	Laundry Room Lighting	1995	975	24	40	24		207	46
47	Elevator Sensing Edges	1995	5,500	138	40	138		1,169	47
48	Sinks	1995	20,932	523	40	523		4,448	48
49	Miscellaneous	1995	79,482	1,987	40	1,987		16,890	49
50	Windows	1996	167,206	4,180	40	4,180		31,351	50
51	Miscellaneous	1996	21,030	526	40	526		3,943	51
52	Chain Link Fence	1997	6,536	163	40	163		1,065	52
53	Boiler Room Asbestos Abatement	1997	98,023	2,451	40	2,451		15,967	53
54	Windows	1997	113,787	2,845	40	2,845		18,535	54
55	Kitchen Ceiling	1997	16,708	418	40	418		2,722	55
56	Roof Replacement D-1	1997	200,052	5,001	40	5,001		32,586	56
57	Remodeling D-1	1997	268,439	6,711	40	6,711		43,726	57
58	Compressor For Air Conditioner	1998	3,445	86	40	86		474	58
59	Kitchen Renovations	1998	9,600	240	40	240		1,320	59
60	Chapel Sound System	1998	5,233	131	40	131		720	60
61	Chapel Pews	1998	5,544	138	40	138		762	61
62	Roof & Skylight Replacement	1998	218,548	5,464	40	5,464		30,050	62
63	Chapel Roof	1999	5,332	133	40	133		600	63
64	Garage Heater	2000	43,625	1,091	40	1,091		3,817	64
65	Garage Doors	2000	4,553	114	40	114		398	65
66	Garage Electrical Wiring	2000	9,685	242	40	242		847	66
67	New Ceiling	2000	43,737	1,093	40	1,093		3,827	67
68	Side Altar	2000	5,400	135	40	135		473	68
69	2 Restrooms	2000	16,450	411	40	411		1,440	69
70	TOTAL (lines 4 thru 69)		\$ 1,839,258	\$ 45,982		\$ 45,982	\$	\$ 339,140	70

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

STATE OF ILLINOIS

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

7/1/2002

Ending:

Page 12B

6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,839,258	\$ 45,982		\$ 45,982	\$	\$ 339,140	1
2	Remodel Public Restrooms (ADA)	2001	28,982	725	40	725		1,762	2
3	Remodel Chaplain's Suite Kitchen	2001	3,730	93	40	93		186	3
4	5 Bathroom Remodel	2001	21,864	1,093	20	1,093		1,911	4
5	6 Bathroom Remodel	2002	24,410	1,220	20	1,220		1,633	5
6	Remodel 2 rooms - C Wing	2002	26,325	1,316	20	1,316		1,426	6
7	Landscape - Garden Walk	2003	11,500		20				7
8	Remodel - C Wing	2003	71,961	1,937	20	1,937		1,937	8
9	Remodel - D Wing	2003	348,181	10,730	20	10,730		10,730	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,376,211	\$ 63,096		\$ 63,096	\$	\$ 358,725	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 844,233	\$ 88,100	\$ 88,100	\$	5 - 15	\$ 503,537	71
72	Current Year Purchases	121,016	8,214	8,214		5 - 15	8,214	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 965,249	\$ 96,314	\$ 96,314	\$		\$ 511,751	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Ford Taurus Wgn 1997	1997	\$ 18,186	\$	\$	\$	5	\$ 18,186	76
77	Patient Care	Freedom Driving Van 1999	1999	35,909	7,182	7,182		5	25,136	77
78	Patient Care	14 Passanger Bus 2002	2002	54,750	10,950	10,950		5	16,425	78
79										79
80	TOTALS			\$ 108,845	\$ 18,132	\$ 18,132	\$		\$ 59,747	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)	\$ 3,450,305	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,542	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 177,542	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)	\$ 930,223	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	John Deer Tractor 1999	\$ 11,000	\$ 2,200	\$ 7,700	86
87	Chevrolet Pickup 1998	26,820	2,682	26,820	87
88	Buick Century 2001	19,932	3,986	8,969	88
89					89
90					90
91	TOTALS	\$ 57,752	\$ 8,868	\$ 43,489	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*		
3	Original Building:	<u>1962</u>	<u>100</u>	<u>7/1/2000</u>	\$ <u>815,765</u>	<u>9</u>		3	
4	Additions							4	
5		<u>Future increases to be negotiated at a later date</u>							5
6								6	
7	TOTAL		100		\$ 815,765			7	

10. Effective dates of current rental agreement:
 Beginning 07/01/2000
 Ending 07/01/2009

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2004</u>	\$ <u>828,000</u>
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

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: _____ *

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

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

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

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

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

STATE OF ILLINOIS

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Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning: 7/1/2002

Ending:

6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2003

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 159,286	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	82,342	3
4	Supply Inventory (priced at <u>Cost</u>)	9,921	4
5	Short-Term Investments	873,249	5
6	Prepaid Insurance	8,780	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Accrued Interest</u>	10,781	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,144,359	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments	1,262,432	12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cost	2,376,211	15
16	Equipment, at Historical Cost	1,131,846	16
17	Accumulated Depreciation (book methods)	(973,713)	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)	\$ 3,796,776	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,941,135	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 50,296	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable	6,899	29
30	Accrued Salaries Payable	213,677	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,385	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	<u>Accrued Profit Sharing</u>	33,000	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 308,257	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	98,287	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)	\$ 98,287	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 406,544	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,534,591	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,941,135	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 695,285	1
2	Restatements (describe):		2
3	Designated Funds Previously Considered Restricted	4,218,965	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,914,250	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(379,659)	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)	\$ (379,659)	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)	\$ 4,534,591	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning: 7/1/2002

Ending:

6/30/2003

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,673,423	1
2	Discounts and Allowances for all Levels	(110,723)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,562,700	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	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	20,769	12
13	Barber and Beauty Care	2,460	13
14	Non-Patient Meals	527	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,800	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	34,683	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 63,239	23
D. Non-Operating Revenue			
24	Contributions	156,288	24
25	Interest and Other Investment Income***	77,411	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 233,699	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	8,484	28
28a	OLA Fest & Other Fund Raising	26,097	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 34,581	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,894,219	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,652,214	31
32	Health Care	2,135,879	32
33	General Administration	1,158,901	33
B. Capital Expense			
34	Ownership	1,002,483	34
C. Ancillary Expense			
35	Special Cost Centers	14,897	35
36	Provider Participation Fee	27,375	36
D. Other Expenses (specify):			
37	Chapel & Fund Raising	26,897	37
38	Religious Personnel Wages	255,232	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,273,878	40
41	Income before Income Taxes (line 30 minus line 40)**	(379,659)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (379,659)	43

* 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: **7/1/2002**

Ending: **6/30/2003**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,502	4,160	\$ 93,623	\$ 22.51	1
2	Assistant Director of Nursing	1,860	2,080	45,710	21.98	2
3	Registered Nurses	19,563	21,433	445,299	20.78	3
4	Licensed Practical Nurses	22,800	25,220	481,940	19.11	4
5	Nurse Aides & Orderlies	79,720	87,640	872,826	9.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,839	6,279	78,659	12.53	8
9	Activity Director	1,912	2,080	30,843	14.83	9
10	Activity Assistants	8,631	8,631	83,231	9.64	10
11	Social Service Workers	1,864	2,112	38,581	18.27	11
12	Dietician	1,820	2,040	19,147	9.39	12
13	Food Service Supervisor	7,214	8,090	115,270	14.25	13
14	Head Cook	8,544	9,424	94,170	9.99	14
15	Cook Helpers/Assistants	15,286	16,086	145,058	9.02	15
16	Dishwashers	6,616	7,056	53,330	7.56	16
17	Maintenance Workers	12,754	14,294	208,206	14.57	17
18	Housekeepers	20,017	21,557	187,233	8.69	18
19	Laundry	9,398	10,278	86,493	8.42	19
20	Administrator	1,570	2,080	63,315	30.44	20
21	Assistant Administrator					21
22	Other Administrative	7,257	8,320	135,353	16.27	22
23	Office Manager	1,666	2,200	50,816	23.10	23
24	Clerical	13,530	15,071	166,839	11.07	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	1,158	1,268	10,590	8.35	31
32	Other Health C: Med. Transport.	2,284	2,284	18,094	7.92	32
33	Other(specify)	2,950	3,100	33,413	10.78	33
34	TOTAL (lines 1 - 33)	257,755	282,783	\$ 3,558,039 *	\$ 12.58	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$	35
36	Medical Director		36
37	Medical Records Consultant		37
38	Nurse Consultant		38
39	Pharmacist Consultant		39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant		45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Craig Tuntland	Develop Dir.		\$ 40,472	Workers' Compensation Insurance	\$ 94,994	IDPH License Fee	\$	
				Unemployment Compensation Insurance	9,333	Advertising: Employee Recruitment		
				FICA Taxes	255,382	Health Care Worker Background Check		
				Employee Health Insurance	142,334	(Indicate # of checks performed)		
				Employee Meals		Subscriptions	3,979	
				Illinois Municipal Retirement Fund (IMRF)*		Memberships	6,378	
						Licenses	969	
				Employee Pension	66,000	Allocated to care of Sisters	(4,794)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 40,472	Allocated to care of Sisters	(240,453)	Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	()	
B. Administrative - Other						Yellow page advertising	()	
Description			Amount			TOTAL (agree to Sch. V,	\$ 6,532	
			\$	TOTAL (agree to Schedule V,	\$ 327,590	line 20, col. 8)		
				line 22, col.8)		G. Schedule of Travel and Seminar**		
						Description	Amount	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services								
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Geo Bagley & Co	Accounting		7,080					
Tracy, Johnson	Legal		4,125				In-State Travel	
BDO Siedman	Consulting		2,000					
Spesia	Legal		1,598					
ADP (Payroll Processing)	Payroll Processing		39,406				Seminar Expense	6,714
Environmental Recycling	Recycling		6,235				Allocated to care of Sisters	(2,842)
Comprehensive Therapeutic	Therapy		2,808					
Healy, Snyder & Bender	Remodeling Control		1,941				Entertainment Expense	()
Others			2,492				(agree to Sch. V,	
							line 24, col. 8)	\$ 3,872
TOTAL (agree to Schedule V, line 19, column 3)			\$ 67,685	TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,569 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? No 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 of Public Aid during this cost report period. \$ 27,375
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

<u>Page 3, Schedule V, Line 27</u>	<u>3, 4 & 6</u>	Column <u>7</u>	<u>8</u>
Advertising	2,227	(2,227)	0
Public Relations	13,240	(13,240)	0
Investment Expenses	806	(806)	0
Donations	136	(136)	0
Miscellaneous	<u>12,183</u>	<u>(5,157)</u>	<u>7,026</u>
Total Other	<u>28,592</u>	<u>(21,566)</u>	<u>7,026</u>

<u>Page 4, Schedule V, Line 43</u>	<u>1</u>	<u>2</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Wages To Religious (Reclass all except Chapel)	255,232	0	255,232	(233,990)	21,252	(21,252)
Chapel Costs	0	6,547	6,547		6,547	(6,547)
OLA Fest	0	15,873	15,873		15,873	(15,873)
Other Fund Raising	<u>0</u>	<u>4,477</u>	<u>4,477</u>	<u>0</u>	<u>4,477</u>	<u>(4,477)</u>
	<u>255,232</u>	<u>26,897</u>	<u>282,129</u>	<u>(233,990)</u>	<u>48,149</u>	<u>(48,149)</u>

Page 20, Schedule XX, Line 7

Prior cost reports started with only deductible costs and did not include any adjustments or reclassifications

Page 20, Schedule XX, Line 7

Costs were allocated based upon direct labor costs for nursing or housekeeping for the sisters area.