

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0033761

Facility Name: Rose-Angela Hall

Address: 4200 North Austin Avenue Chicago 60634
 Number City Zip Code

County: _____

Telephone Number: 773-545-8300 **Fax #** 443-545-2984

HFS ID Number: _____

Date of Initial License for Current Owners: 08/19/88

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Beverly Sorensen **Telephone Number:** 773-545-8300X1311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 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) _____	<u>09/22/06</u>
	(Type or Print Name) <u>Sr. Rita Butler</u>	(Date)
Paid Preparer	(Title) <u>Director</u>	
	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Rose-Angela Hall

0033761 Report Period Beginning: 07/01/05 Ending: 06//30/06

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	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		Intermediate (ICF)			3
4	80	Intermediate/DD	80	29,200	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	26,459			26,459
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	26,459			26,459

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.61%

D. How many bed-hold days during this year were paid by the Department?

2,738 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 09/13/88

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

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

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	147,780	8,604	23,505	179,889		179,889	179,889			1
2	Food Purchase		92,702		92,702		92,702	92,702			2
3	Housekeeping	44,727	10,196		54,923		54,923	54,923			3
4	Laundry	15,436	2,223		17,659		17,659	17,659			4
5	Heat and Other Utilities			130,443	130,443		130,443	130,443			5
6	Maintenance	88,195	68,272	90,495	246,962		246,962	246,962			6
7	Other (specify):*										7
8	TOTAL General Services	296,138	181,997	244,443	722,578		722,578	722,578			8
	B. Health Care and Programs										
9	Medical Director	29,168			29,168		29,168	29,168			9
10	Nursing and Medical Records	1,511,433	41,492	23,752	1,576,677		1,576,677	1,576,677			10
10a	Therapy	22,515		23,348	45,863		45,863	45,863			10a
11	Activities	39,563			39,563		39,563	39,563			11
12	Social Services	19,472			19,472		19,472	19,472			12
13	CNA Training	9,702	79		9,781		9,781	9,781			13
14	Program Transportation		17,347		17,347		17,347	17,347			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,631,853	58,918	47,100	1,737,871		1,737,871	1,737,871			16
	C. General Administration										
17	Administrative	102,883			102,883		102,883	102,883			17
18	Directors Fees										18
19	Professional Services			36,299	36,299		36,299	36,299			19
20	Dues, Fees, Subscriptions & Promotions			6,230	6,230		6,230	6,230			20
21	Clerical & General Office Expenses	162,132	54,922	12,354	229,408		229,408	229,408			21
22	Employee Benefits & Payroll Taxes			314,447	314,447		314,447	314,447			22
23	Inservice Training & Education			375	375		375	375			23
24	Travel and Seminar			399	399		399	399			24
25	Other Admin. Staff Transportation			1,928	1,928		1,928	1,928			25
26	Insurance-Prop.Liab.Malpractice			53,599	53,599		53,599	53,599			26
27	Other (specify):*										27
28	TOTAL General Administration	265,015	54,922	425,631	745,568		745,568	745,568			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,193,006	295,837	717,174	3,206,017		3,206,017	3,206,017			29

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

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

Facility Name & ID Number Rose-Angela Hall

#0033761

Report Period Beginning:

07/01/05

Ending:

06//30/06

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			281,899	281,899	281,899	281,899					30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			281,899	281,899	281,899	281,899					37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,952	215,952	215,952	215,952					42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			215,952	215,952	215,952	215,952					44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,193,006	295,837	1,215,025	3,703,868	3,703,868	3,703,868					45

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending: 06/30/06

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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))	\$		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

BHF USE ONLY					
48		49		50	
				51	
					52

Rose-Angela Hall

ID# 0033761
 Report Period Beginning: 07/01/05
 Ending: 06/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number Rose-Angela Hall

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Report Period Beginning:

07/01/05

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06/30/06

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
<u>Daughters of St. Mary of Providence</u>	<u>100</u>			<u>St Mary of Providence</u>	<u>Chicago, IL</u>	<u>Operating Corp.</u>

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		
<u>1</u>	<u>V</u>	<u>Rent Facility/</u>	\$			\$		<u>1</u>
<u>2</u>	<u>V</u>	<u>Bldg, Grounds</u>	<u>66,000</u>	<u>Daughters of St. Mary of Providence</u>	<u>100.00%</u>	<u>66,000</u>		<u>2</u>
<u>3</u>	<u>V</u>							<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>							<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>							<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	Total		\$ 66,000			\$ 66,000	\$ *	<u>14</u>

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

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/05 Ending: 06/30/06

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											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending: 06/30/06

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

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

Name of Related Organization Daughters of St. Mary of Providence
 Street Address 4200 N. Austin Avenue
 City / State / Zip Code Chicago, IL 60634
 Phone Number (773-545-8300
 Fax Number (773-545-2984

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

Facility Name & ID Number Rose-Angela Hall

0033761 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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											
										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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 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 2006 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:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rose-Angela Hall COUNTY _____

FACILITY IDPH LICENSE NUMBER 0033761

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Rose-Angela Hall

0033761 Report Period Beginning:

07/01/05 Ending:

06//30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,510 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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>Residential</u>	<u>66,437</u>	<u>1925</u>	<u>\$ 50,975</u>	<u>1</u>
2	<u>Improvements</u>		<u>Various</u>	<u>24,500</u>	<u>2</u>
3	TOTALS	<u>66,437</u>		<u>\$ 75,475</u>	<u>3</u>

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/05

Ending:

06//30/06

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1979	1980	\$ 2,031,195	\$ 17,314	30	\$ 17,314		\$ 1,867,928	4
5			1938	1938	73,366		60			73,366	5
6			1956	1956	259,122		25			259,122	6
7			1928	1928	104,867		45			104,867	7
8			1953	1953	71,484		45			71,484	8
	Improvement Type**										
9		Remodling Painting Drywall		1980	85,251		20			85,251	9
10		Repairs		1980	24,301	243	20	243		24,048	10
11		Roof/tuckpointing		1988	8,466	423	20	423		7,578	11
12		Repairs, Painting Decorating		1955	41,231		10			41,231	12
13		Decorating		1990	3,836	47	10	47		3,836	13
14		Asphalt Paving Lot		1990	16,650		15			16,650	14
15		Garage Disposal		1990	24,862	995	25	995		16,912	15
16		Remodling		1991	45,685	2,284	20	2,284		33,571	16
17		New boiler-Kitchen Bldg		1998	12,320	821	15	821		7,389	17
18		New boiler-Adm. Bldg		1998	5,320	355	15	355		3,195	18
19		Install Handicap ramp/remidel front entrance		2001	140,185	7,010	20	7,010		38,555	19
20		Remove & install new fence around perimeter&electronic gate		2001	106,000	5,300	20	5,300		29,150	20
21		Addl re electronic gates & fence		2002	19,421	971	20	971		4,855	21
22		New rooftop HVAC units to replace existing		2002	248,000	16,533	15	16,533		73,398	22
23		Addl re ramp & fence ICF		2003	103,055	5,153	15	5,153		18,035	23
24		Sidewaoks Underground SnowMelt		2004	41,354	2,067	20	2,067		5,168	24
25		Parking lot stone & asphalt		2004	35,732	2,382	15	2,382		5,955	25
26		Carpentry, Shelving, Gate		1988	44,779		15			44,779	26
27		Outdoor rec. area		1989	12,400		15			12,400	27
28		G. Hall windows AC		1991	24,239	1,212	20	1,212		18,511	28
29		Roofing		1991	10,852		20			10,852	29
30		Remodling Nurses station, Adm Bldg.		1991	156,249	7,916	20	7,916		125,389	30
31		Walk in Cooler remodling		1991	44,095	2,205	20	2,205		32,426	31
32		Remodling kitchen		1991	31,445	1,572	10	1,572		24,366	32
33		Roofing		1992	12,170		15			12,170	33
34		Plimbing,Heating,Painting Tile art		1993	30,813	2,054	15	2,054		27,729	34
35		Painting decorative tile		1992	14,977		10			14,977	35
36		Alarm system		1994	10,837	533	15	533		9,506	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/05

Ending:

06//30/06

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	Emergency lights, snow melt cables, roofing	1995	\$ 65,535	\$	10	\$	\$	\$ 65,535	37
38	Handicap Bath, Whirlpool	1996	19,365	1,291	15	1,291		13,394	38
39	Painting, Patching, Decorating	1996	37,184		5			37,184	39
40	New Boiler #1-4	1996	32,273	1,614	20	1,614		16,813	40
41	Install Bath	1996	4,208	281	15	281		2,950	41
42	Repair Glass, roofing	1996	2,996		15			2,996	42
43	Tuckpointing, roof repair	1997	6,428	642	10	642		6,099	43
44	Electrical re A/C	1997	2,460	164	15	164		1,640	44
45	Window replacement a/c installation	1997	23,947	1,198	20	1,198		11,381	45
46	Painting, wall covering	1997	1,462		5			1,462	46
47	Architectural re windows, remodeling	1998	930	92	10	92		782	47
48	Elevator door	1998	1,200	80	15	80		680	48
49	New roof Adm Bldg.	1998	13,968	698	20	698		5,933	49
50	Painting decorating Adm. Bldg.	1998	950		5			950	50
51	Guanella hall boiler	1998	14,758	738	20	738		6,273	51
52	New doors, stops, exits	1998	15,989	1,066	15	1,066		9,061	52
53	Painting , decorating	1998	25,548		5			25,548	53
54	Handrails	1998	6,132	408	15	408		3,468	54
55	New boiler, ht coils D#1	1998	53,531	2,676	20	2,676		22,802	55
56	Painting,decorating Dorms	1999	18,294		5			18,294	56
57	Handicap handrails installed	1999	14,174	945	15	945		7,087	57
58	Install walkin kitchen freezer	1999	17,409	1,161	15	1,161		8,708	58
59	Reconfigure office, and handicap ramp & washroom	1999	54,060	2,703	20	2,703		20,273	59
60	Replace broken sewer & sidewalk	1999	17,168	859	20	859		6,442	60
61	New wallcovering and decorating G. Hall	1999	23,831	2,383	10	2,383		17,872	61
62	Installation of fire pump	1999	8,300	415	20	415		3,113	62
63	Pip in new heads re fire system	1999	2,060	137	15	137		1,028	63
64	Chapel roof repair & piping	1999	2,939	294	10	294		2,187	64
65	Carpeting Chapel	2000	1,511	302	5	302		1,555	65
66	Painting, wall covering re hallways	2000	1,742	174	10	174		1,131	66
67	New heaters hallways	2000	656	44	15	44		308	67
68	Remodel Kitchen ramp	2000	35,464	1,773	20	1,773		12,395	68
69	Pavement repairs & Replace	2000	10,527	526	20	526		3,417	69
70	TOTAL (lines 4 thru 69)		\$ 4,431,558	\$ 100,054		\$ 100,054	\$	\$ 3,463,410	70

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

Facility Name & ID Number Rose-Angela Hall

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		\$ 4,431,558	\$ 100,054		\$ 100,054	\$	\$ 3,463,410	1
2	Install water supply valves	2000	21,820	1,091	20	1,091		7,091	2
3	Windows replaced in dorms	2000	85,550	4,278	20	4,278		27,807	3
4	Roof repair dorms	2000	13,520	1,352	10	1,352		8,788	4
5	Replace kitchen windows	2000	10,553	528	20	528		3,696	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		2,686	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		20,809	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		4,232	8
9	New water line piping	2000	11,006	550	20	550		3,575	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		2,970	10
11	Ashpalt paving lot	2001	5,141	1,028	5	1,028		5,412	11
12	Fire alarm system	2001	6,938	694	10	694		3,817	12
13	G. Hall decorating hallways	2001	5,540	1,108	5	1,108		6,094	13
14	Remove asbestos tile/replace	2001	5,192	519	10	519		2,856	14
15	Firewall door framing	2001	22,631	1,508	15	1,508		8,294	15
16	New hot water tanks repiping	2001	24,801	1,654	15	1,654		9,130	16
17	Shower door, replace drain	2001	11,732	782	15	782		4,302	17
18	Outdoor pavilion, gazebos	2001	41,095	2,740	15	2,740		15,069	18
19	Balcony roof repair	2002	5,803	1,160	5	1,160		4,947	19
20	Fire alarm system	2002	4,496	450	10	450		2,025	20
21	Plumbing work	2002	42,173	4,217	10	4,217		18,976	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		6,903	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		4,707	23
24	Tuckpointing	2002	11,585	1,158	10	1,158		5,211	24
25	Doors re Chapel	2003	1,642	164	10	164		574	25
26	Plumbing-water tanks sm basin	2003	16,551	1,655	10	1,655		5,793	26
27	Roof curbs	2003	12,430	829	10	829		2,901	27
28	Elec. Wiring & smoke detectors	2003	5,327	532	15	532		1,867	28
29	Insulate pipes, door	2003	4,378	438	10	438		1,533	29
30	Windows, tuckpointing, Nepco	2003	25,922	2,592	10	2,592		9,072	30
31	Gas Generator	2004	189,933	12,662	10	12,662		31,655	31
32	Roof tiles, decprating	2004	21,956	4,391	5	4,391		10,979	32
33	New laundry area	2004	17,227	1,148	15	1,148		2,870	33
34	TOTAL (lines 1 thru 33)		\$ 5,187,959	\$ 156,613		\$ 156,613	\$	\$ 3,710,051	34

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

Facility Name & ID Number Rose-Angela Hall

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 12B, Carried Forward		\$ 5,187,959	\$ 156,613		\$ 156,613	\$	\$ 3,710,051	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		4,475	2
3	Base parking lot, underground snow melt	2004	52,967	5,296	10	5,296		13,045	3
4	New fire alarm system	2004	68,500	4,567	15	4,567		11,417	4
5	A?C kitachen	2004	9,890	989	10	989		2,473	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		12,630	6
7	Handicap ramp re gym	2004	34,730	1,736	20	1,736		5,208	7
8	Gym windows	2004	8,245	550	15	550		1,650	8
9	Gym roofing	2004	17,997	3,600	5	3,600		10,800	9
10	Plumbing, washroom remodel	2004	6,468	647	10	647		1,941	10
11	Esxterior masonry, joints	2004	32,686	2,180	15	2,180		5,424	11
12	Gas Generator, balance	2005	26,180	1,745	15	1,745		2,618	12
13	Complete roof replacement	2005	380,077	19,004	20	19,004		28,506	13
14	Installation attic exhaust	2005	99,968	4,998	20	4,998		7,497	14
15	Complete new fire alarm system	2005	130,900	6,545	20	6,545		9,817	15
16	Sewer & gas lines	2005	47,795	2,390	20	2,390		4,385	16
17	Paving lot	2005	31,920	2,128	15	2,128		3,192	17
18	Wallcover, tiles, painting	2005	69,115	6,911	10	6,911		10,367	18
19	Electrical repairs, security	2005	30,411	3,041	10	3,041		4,561	19
20	Laundry/Kitchen repairs	2005	30,103	2,007	15	2,007		2,656	20
21	Hot water, gas line	2006	5,380	143	10	143		143	21
22	Painting, Caulking	2006	16,065	675	10	675		675	22
23	Generator adjust	2006	5,545	184	15	184		184	23
24	Pool house, camp	2006	13,574	679	10	679		679	24
25	Replace tile- Laundry	2006	4,900	245	10	245		245	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,421,690	\$ 232,824		\$ 232,824	\$	\$ 3,854,639	34

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 6,421,690	\$ 232,824		\$ 232,824	\$	\$ 3,854,639	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,421,690	\$ 232,824		\$ 232,824	\$	\$ 3,854,639	34

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

Facility Name & ID Number Rose-Angela Hall # 0033761 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	\$ 661,082	\$ 40,060	\$ 40,060	\$		\$ 542,430	71
72	Current Year Purchases	53,560	3,683	3,683		15	3,683	72
73	Fully Depreciated Assets	138,169					138,169	73
74								74
75	TOTALS	\$ 852,811	\$ 43,743	\$ 43,743	\$		\$ 684,282	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	Windstar 2004	2004	\$ 21,328	\$ 5,332	\$ 5,332	\$	4	\$ 13,330	76
77										77
78										78
79										79
80	TOTALS			\$ 21,328	\$ 5,332	\$ 5,332	\$		\$ 13,330	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)	\$	7,371,304	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	281,899	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	281,899	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)	\$	4,552,251	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending: 06/30/06

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		79		79
3	Classroom Wages (a)		3,234		3,234
4	Clinical Wages (b)		6,468		6,468
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,781	\$	\$ 9,781
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,781		

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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$	\$									1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescrpts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Rose-Angela Hall# 0033761Report Period Beginning: 07/01/05

Ending:

06/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,207,862	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	525,560	734,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		32,421	6
7	Other Prepaid Expenses		10,049	7
8	Accounts Receivable (owners or related parties)	(1,555,947)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,030,387)	\$ 1,985,285	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	2,307,495	5,173,956	15
16	Equipment, at Historical Cost	874,139	1,441,902	16
17	Accumulated Depreciation (book methods)	(1,432,149)	(3,425,516)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,749,485	\$ 3,190,342	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 719,098	\$ 5,175,627	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,058	\$ 87,576	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,351	192,814	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,566	5,881	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 130,975	\$ 286,271	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)	\$ 130,975	\$ 286,271	46
47	TOTAL EQUITY(page 18, line 24)	\$ 588,123	\$ 4,889,356	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 719,098	\$ 5,175,627	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 620,873	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 620,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,750)	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)	\$ (32,750)	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)	\$ 588,123	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	\$ 3,653,316	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,653,316	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	9,702	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,702	23
D. Non-Operating Revenue			
24	Contributions	8,100	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,100	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,671,118	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	722,578	31
32	Health Care	1,737,871	32
33	General Administration	745,568	33
B. Capital Expense			
34	Ownership	281,899	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	215,952	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,703,868	40
41	Income before Income Taxes (line 30 minus line 40)**	(32,750)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (32,750)	43

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

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

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

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending:

06/30/06

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	1,720	1,820	\$ 43,678	\$ 24.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,230	6,627	159,670	24.09	3
4	Licensed Practical Nurses	6,230	6,628	158,539	23.92	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,307	2,454	39,485	16.09	9
10	Activity Assistants	13	13	78	6.00	10
11	Social Service Workers	418	418	19,472	46.58	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,000	42,409	21.20	13
14	Head Cook	292	292	4,762	16.31	14
15	Cook Helpers/Assistants	9,827	10,454	100,609	9.62	15
16	Dishwashers					16
17	Maintenance Workers	4,200	4,470	88,195	19.73	17
18	Housekeepers	4,670	4,970	44,727	9.00	18
19	Laundry	1,900	2,018	15,436	7.65	19
20	Administrator	2,450	2,600	71,370	27.45	20
21	Assistant Administrator	1,388	1,477	31,513	21.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,455	11,122	162,132	14.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	170	170	29,168	171.58	27
28	Qualified MR Prof. (QMRP)	12,277	13,061	231,064	17.69	28
29	Resident Services Coordinator	9,633	10,140	171,596	16.92	29
30	Habilitation Aides (DD Homes)	77,900	82,868	746,164	9.00	30
31	Medical Records	1,978	2,104	32,939	15.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,938	165,706	\$ 2,193,006 *	\$ 13.23	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	130	\$ 4,620	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	37	1,504	Lin 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	362	19,883	Lin 10aC3	40
41	Occupational Therapy Consultant	63	3,465	Lin 10aC3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dentist</u>	n/a	4,350	Lin 10 C3	46
47	<u>Psychologist-Psychiatrist</u>	83	8,605	Lin 10 C3	47
48	<u>FoodService Professional Mgmt Fee</u>	n/a	18,885	Lin 1 C3	48
49	TOTAL (lines 35 - 48)	675	\$ 61,312		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	239	9,293	Lin 10 C3	51
52	Certified Nurse Assistants/Aides			52	
53	TOTAL (lines 50 - 52)	239	\$ 9,293		53

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	
St/ Janet Kosman	Administrator		\$ 71,370	Workers' Compensation Insurance	\$ 33,889	IDPH License Fee	\$ 200	
Darlene Zadnowski	Asst Administrator		31,513	Unemployment Compensation Insurance	10,814	Advertising: Employee Recruitment	5,790	
				FICA Taxes	134,553	Health Care Worker Background Check		
				Employee Health Insurance	80,373	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	25 240	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	54,818			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 102,883					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							IAP activity prof.	195
							INR Alzhemers	179
							ARC	25
							Entertainment Expense	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL				
(Attach a copy of any management service agreement)							(agree to Sch. V,	
C. Professional Services							line 24, col. 8)	\$ 399
Vendor/Payee	Type		Amount					
Deloitte & Touche LLP	Auditor		\$ 36,299					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 36,299					

* 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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,912 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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. \$ 215,952
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 15%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Deloitte & Touche LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES 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? n/a
- (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? _____
Attach invoices and a summary of services for all architect and appraisal fees.

List of Board Members during period July 1, 2005 - June 30, 2006 -

NAME	OFFICE
Sr. Patricia McCafferty	President
Sr. Rita Butler (1)	Vice-President
Sr. Antoinette Palmisano	Treasurer
Sr. Janet Kosman	Secretary
Sr. Mary Patricia Whyte	Director

(1) Sr. Rita Butler approves invoices for payment and oversees maintenance of buildings.

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

SCHEDULE VIII Allocation of Indirect Costs SEE ATTACHED WORKSHEETS