

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 08/17/08

	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)	37	11,766	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	137	48,266	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	Total	
8	SNF		382		382	8
9	SNF/PED					9
10	ICF	10,764	12,586		23,350	10
11	ICF/DD					11
12	SC		15,786		15,786	12
13	DD 16 OR LESS					13
14	TOTALS	10,764	28,754		39,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.88%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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 08/10/62

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: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number Our Lady Of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	513,433	15,118	9,929	538,480		538,480	(57,747)	480,733		1
2	Food Purchase		311,443		311,443		311,443	(33,400)	278,043		2
3	Housekeeping	169,705	28,121	183	198,009		198,009	(24,751)	173,258		3
4	Laundry	75,527	13,482		89,009		89,009	(9,791)	79,218		4
5	Heat and Other Utilities			288,319	288,319		288,319	(36,040)	252,279		5
6	Maintenance	224,735		178,656	403,391		403,391	(50,424)	352,967		6
7	Other (specify):*										7
8	TOTAL General Services	983,400	368,164	477,087	1,828,651		1,828,651	(212,153)	1,616,498		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,120,083	64,977	6,491	2,191,551		2,191,551		2,191,551		10
10a	Therapy										10a
11	Activities	178,315	3,526	481	182,322		182,322	(19,552)	162,770		11
12	Social Services	143,744		1,518	145,262		145,262	(15,578)	129,684		12
13	CNA Training										13
14	Program Transportation			6,402	6,402		6,402	(687)	5,715		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,442,142	68,503	32,892	2,543,537		2,543,537	(35,817)	2,507,720		16
	C. General Administration										
17	Administrative	167,274			167,274		167,274	(17,939)	149,335		17
18	Directors Fees										18
19	Professional Services			176,251	176,251		176,251	(18,901)	157,350		19
20	Dues, Fees, Subscriptions & Promotions			35,500	35,500		35,500	(9,068)	26,432		20
21	Clerical & General Office Expenses	334,484	29,517	108,311	472,312		472,312	(133,010)	339,302		21
22	Employee Benefits & Payroll Taxes			1,005,680	1,005,680		1,005,680	(49,491)	956,189		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,339	7,339		7,339	(787)	6,552		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			122,261	122,261		122,261	(15,283)	106,978		26
27	Other (specify):*										27
28	TOTAL General Administration	501,758	29,517	1,455,342	1,986,617		1,986,617	(244,479)	1,742,138		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,927,300	466,184	1,965,321	6,358,805		6,358,805	(492,449)	5,866,356		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:

07/01/07

Ending:

06/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			164,504	164,504		164,504	(21,386)	143,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,274	42,274		42,274	(42,274)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			788,910	788,910		788,910	(788,910)				34
35	Rent-Equipment & Vehicles			9,870	9,870		9,870	(1,086)	8,784			35
36	Other (specify):*											36
37	TOTAL Ownership			1,005,558	1,005,558		1,005,558	(853,656)	151,902			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			3,751	3,751		3,751	(3,751)				41
42	Provider Participation Fee			45,024	45,024		45,024		45,024			42
43	Other (specify):*	157,498		748,098	905,596		905,596	(905,596)				43
44	TOTAL Special Cost Centers	157,498		796,873	954,371		954,371	(909,347)	45,024			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,084,798	466,184	3,767,752	8,318,734		8,318,734	(2,255,452)	6,063,282			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(37,269)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(0)	30		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		02		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	(845)	21		18
19	Entertainment				19
20	Contributions	(2,815)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,000)	21		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	(3,501)	20		28
29	Other-Attach Schedule	(1,382,112)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,466,542)		\$	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)	(788,910)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (788,910)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,255,452)		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						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	

SEE ACCOUNTANTS' COMPILATION REPORT

Our Lady Of Angels Retirement HomeID# 0034975Report Period Beginning: 07/01/07Ending: 06/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (1,998)	21	1
2	Public Relations	(2,392)	20	2
3	Investment Expenses	(2,455)	21	3
4	Board Charges	(842)	21	4
5	Non-Allowable Interest	(42,274)	32	5
6				6
7	Independent Living Units - 14 (Allocated Costs)			7
8	Dietary	(57,747)	01	8
9	Food	(33,400)	02	9
10	Housekeeping	(24,751)	03	10
11	Heat and Other Utilities	(36,040)	05	11
12	Maintenance	(50,424)	06	12
13	Activities	(19,552)	11	13
14	Social Services	(15,578)	12	14
15	Program Transportation	(687)	14	15
16	Administrative	(17,939)	17	16
17	Professional Fees	(18,901)	19	17
18	Dues, Fees, Subscriptions and Promotions	(3,175)	20	18
19	Clerical and Office Expenses	(41,404)	21	19
20	Employee Benefits & Payroll Taxes	(49,491)	22	20
21	Travel and Seminar	(787)	24	21
22	Insurance	(15,283)	26	22
23	Laundry	(9,791)	04	23
24	Depreciation	(21,386)	30	24
25	Equipment Rental	(1,086)	35	25
26				26
27	Independent Living Cottages - 28 (Direct Costs)			27
28	Salary	(53,757)	43	28
29	Employee Benefits & Payroll Taxes	(8,055)	43	29
30	Housekeeping	(253)	43	30
31	Marketing	(621,086)	43	31
32	Telephone	(1,489)	43	32
33	Gas / Electric	(350)	43	33
34	Water	(21)	43	34
35	Security	(1,160)	43	35
36	Office Expenses	(3,684)	43	36
37	Investment Expenses	(283)	43	37
38	Rent	(60,000)	43	38
39	Depreciation	(22,468)	43	39
40	Property Insurance	(411)	43	40
41				41
42	Development Salary	(103,741)	43	42
43	Development Expenses	(25,514)	43	43
44	Memorial Expenses	(764)	43	44
45	Chapel Expenses	(2,560)	43	45
46	Coffee and Gift Shop Expense to Extent of Income	(3,751)	41	46
47	Miscellaneous Income	(5,382)	21	47
48				48
49	Total	(1,382,112)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/07

Ending:

06/30/08

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(57,747)											(57,747)	1
2	Food Purchase	(33,400)											(33,400)	2
3	Housekeeping	(24,751)											(24,751)	3
4	Laundry	(9,791)											(9,791)	4
5	Heat and Other Utilities	(36,040)											(36,040)	5
6	Maintenance	(50,424)											(50,424)	6
7	Other (specify):*													7
8	TOTAL General Services	(212,153)											(212,153)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(19,552)											(19,552)	11
12	Social Services	(15,578)											(15,578)	12
13	CNA Training													13
14	Program Transportation	(687)											(687)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(35,817)											(35,817)	16
	C. General Administration													
17	Administrative	(17,939)											(17,939)	17
18	Directors Fees													18
19	Professional Services	(18,901)											(18,901)	19
20	Fees, Subscriptions & Promotions	(9,068)											(9,068)	20
21	Clerical & General Office Expenses	(133,010)											(133,010)	21
22	Employee Benefits & Payroll Taxes	(49,491)											(49,491)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(787)											(787)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(15,283)											(15,283)	26
27	Other (specify):*													27
28	TOTAL General Administration	(244,479)											(244,479)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(492,449)											(492,449)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975

Report Period Beginning:

07/01/07

Ending:

06/30/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,386)											(21,386)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(42,274)											(42,274)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(788,910)										(788,910)	34
35	Rent-Equipment & Vehicles	(1,086)											(1,086)	35
36	Other (specify):*													36
37	TOTAL Ownership	(64,746)	(788,910)										(853,656)	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	(3,751)											(3,751)	41
42	Provider Participation Fee													42
43	Other (specify):*	(905,596)											(905,596)	43
44	TOTAL Special Cost Centers	(909,347)											(909,347)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,466,542)	(788,910)										(2,255,452)	45

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 of Mary Immaculate	100%	N/A		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	34 Rent	\$ 788,910	Sisters of St. Francis of Mary Immaculate	100.00%	\$	\$	(788,910) 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		\$ 788,910			\$	\$ *	(788,910) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady Of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	Sisters of St. Francis								\$	1
2	of Mary Immaculate	(See Attached)								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975

Report Period Beginning:

07/01/07

Ending: 06/30/08

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	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Our Lady Of Angels Retirement Home

0034975

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	First Midwest Bank		X	Site Development	N/A	06/28/07	\$ 5,800,000	\$ 5,076,284	06/30/09	Variable	\$	1								
2	First Midwest Bank		X	Building Construction	N/A	06/28/07	4,975,000	4,697,707	03/31/09	Variable		42,274	2							
3													3							
4													4							
5	See Supplemental Schedule												5							
Working Capital																				
6	Sisters of St. Francis												6							
7	of Mary Immaculate	X		Working Capital				19,657	06/30/08				7							
8	See Supplemental Schedule												8							
9	TOTAL Facility Related						\$ 10,775,000	\$ 9,793,648			\$	42,274	9							
B. Non-Facility Related*																				
10													10							
11	Page 5 Adjustment		X									(42,274)	11							
12													12							
13	See Supplemental Schedule												13							
14	TOTAL Non-Facility Related						\$	\$			\$	(42,274)	14							
15	TOTALS (line 9+line14)						\$ 10,775,000	\$ 9,793,648			\$	(0)	15							

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

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 2007 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 2008 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:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

Our Lady of Angels Retirement Home is not subject to real estate taxes.

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.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975 Report Period Beginning:

07/01/07 Ending:

06/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326 B. General Construction Type: Exterior Brick Frame Steel and Brick Number of Stories Two

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).

Independent Living - 14 Units (Represents 1/8 of Facility)

Independent Living - 28 Cottages (Built outside of Our Lady of Angels Retirement Home on adjacent land).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>609,840</u>	<u>1962</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	609,840		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	137		1962	1962	\$ 1,572,423	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	8,000		20				9
10	Various			1983	89,578		20				10
11	Various			1984	78,857		20				11
12	Various			1985	22,845		20				12
13	Various			1987	10,742		20				13
14	Various			1988	2,330		20				14
15	Various			1990	26,014		20				15
16	Various			1991	136,675		20				16
17	Various			1992	62,593		20				17
18	Various			1993	149,990		20				18
19	Various			1994	34,476		20				19
20	Various			1995	89,923		20				20
21	Various			1996	204,209		20				21
22	Various			1997	365,084		20				22
23	Various			1998	34,996		20				23
24	Various			1999	5,332		20				24
25	Various			2000	123,450		20				25
26	Various			2001	54,577		20				26
27	Various			2002	398,917		20				27
28	Various			2003	83,462		20				28
29	Various			2004	133,665		20				29
30											30
31											31
32											32
33											33
34											34
35											35
36											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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)							67
68	Related Party Allocations (Pages 12-REP & 12A-REP)							68
69	Financial Statement Depreciation				84,971	84,971	772,996	69
70	TOTAL (lines 4 thru 69)	\$ 3,688,138	\$ 84,971		\$ 84,971	\$	\$ 772,996	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

07/01/07

Ending:

06/30/08**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		\$ 3,688,138	\$ 84,971		\$ 84,971	\$	\$ 772,996	1
2	Auxillary Generator	2005	30,508		20				2
3	Piping	2005	2,740		20				3
4	Piping	2005	20,900		20				4
5	Smoke Detectors	2005	1,115		20				5
6	Elevator Repair	2005	5,350		20				6
7	Painting	2005	17,319		20				7
8	Parking Lot Sealed	2005	2,900		20				8
9	Fire Alarm Equipment	2006	9,723		20				9
10	Sewer & Water Line	2006	8,447		20				10
11	Boiler Tank Repair	2006	4,710		20				11
12	Smoke Detectors And Doors	2006	8,775		20				12
13	Fire Doors	2006	6,705		20				13
14	Walk In Cooler Repairs / Updates	2006	16,743		20				14
15	Boiler Repairs	2006	23,566		20				15
16	Activity Room / Auditorium Remodeling	2007	86,934		20				16
17	Walk In Cooler Repairs / Updates	2007	5,200		20				17
18	Building Renovations	2007	3,107,313		20				18
19	Driveway Canopy	2007	8,740		20				19
20	Elevator Repairs	2008	2,310		20				20
21	Elevator Repairs	2008	4,290		20				21
22	Idph Survey Modifications	2008	6,765		20				22
23	Idph Survey Modifications	2008	2,032		20				23
24	Sidewalk	2008	3,000		20				24
25	Asbestos Removal	2008	5,000		20				25
26	Hot Water Heater Repair	2008	5,990		20				26
27	Boiler Repaor	2008	15,229		20				27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,100,442	\$ 84,971		\$ 84,971	\$	\$ 772,996	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	\$ 895,702	\$ 53,170	\$ 53,170	\$ 0	10	\$ 667,234	71
72	Current Year Purchases	60,144	1,261	1,261	(0)	10	1,449	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 955,846	\$ 54,431	\$ 54,431	\$ (0)		\$ 668,683	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	Facility	Freedom Van	1999	\$ 35,909	\$	\$	\$	5	\$ 35,909	76
77	Facility	Glaval Universal Bus	2002	54,750				5	54,750	77
78	Facility	Ford Five Hundred	2006	21,357	3,716	3,716	0	5	10,322	78
79										79
80	TOTALS			\$ 112,016	\$ 3,716	\$ 3,716	\$ 0		\$ 100,981	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)	\$ 8,168,304	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,118	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,118	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,542,660	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	Chevy Truck - 1997	\$ 26,820	\$	\$ 26,820	86
87	Deere Tractor - 2000	11,000		11,000	87
88					88
89					89
90					90
91	TOTALS	\$ 37,820	\$	\$ 37,820	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sisters of St. Francis of Mary Immaculate

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 8,784 Description: See Attached Schedule

(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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

Supplemental Schedule of Equipment Rental
06/30/08

<u>Description</u>	<u>Amount</u>
16A Neopost - Postage Machine	1,669
16B McGrath Office Equipment - Copier	8,201
16C Non-Allowable Equipment Rental (Independent Living Allocation)	-1,086
16D	
16E	
16F	
16G	
16H	
16I	
16J	
16K	
16L	
16M	
16N	
16O	
16P	
16Q	
16R	
16S	
16T	
Total	<u>8,784</u>

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 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975

Report Period Beginning: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(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	\$ 509,957	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	386,900		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,092,967		5
6	Prepaid Insurance	165,029		6
7	Other Prepaid Expenses	5,912		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,160,765	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,088,401		14
15	Leasehold Improvements, at Historical Cost	2,887,159		15
16	Equipment, at Historical Cost	1,105,682		16
17	Accumulated Depreciation (book methods)	(1,602,947)		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): See Attached Schedule	1,517,579		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,995,874	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,156,639	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 676,710	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	9,793,648		29
30	Accrued Salaries Payable	452,301		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	207,500		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,130,159	\$	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	See Attached Schedule	1,802,506		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,802,506	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,932,665	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,223,974	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,156,639	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Our Lady Of Angels Retirement Home# 0034975Report Period Beginning: 07/01/07Ending: 06/30/08**Supplemental Schedule of Other Assets and Liabilities**As of 06/30/08

Other Current Assets:	<u>Amount</u>	<u>Amount</u>	Other Current Liabilities	<u>Amount</u>	<u>Amount</u>
09A			36A Security Deposits	207,500	
09B			36B		
09C			36C		
09D			36D		
09E			36E		
09F			36F		
09G			36G		
				<u>207,500</u>	
				<u>207,500</u>	
Other Non-Current Assets:	<u>Amount</u>	<u>Amount</u>	Other Non-Current Liabilities	<u>Amount</u>	<u>Amount</u>
23A Construction In Progress	1,517,579		43A Entrance Fees	1,802,506	
23B			43B		
23C			43C		
23D			43D		
23E			43E		
23F			43F		
23G			43G		
				<u>1,802,506</u>	
	<u>1,517,579</u>			<u>1,802,506</u>	

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,114,358	1
2	Restatements (describe):		2
3	Rounding Difference	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,114,356	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,890,382)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,890,382)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,223,974	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 4,885,145	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,885,145	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,334	12
13	Barber and Beauty Care	1,228	13
14	Non-Patient Meals	4,497	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	11,674	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	96,914	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 119,647	23
	D. Non-Operating Revenue		
24	Contributions	473,484	24
25	Interest and Other Investment Income***	39,512	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 512,996	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	910,564	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 910,564	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,428,352	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,828,651	31
32	Health Care	2,543,537	32
33	General Administration	1,986,617	33
	B. Capital Expense		
34	Ownership	1,005,558	34
	C. Ancillary Expense		
35	Special Cost Centers	909,347	35
36	Provider Participation Fee	45,024	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,318,734	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,890,382)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,890,382)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Supplemental Schedule of Revenues**06/30/08**

<u>Description</u>	<u>Amount</u>
28A Independent Living (Adjustment - Pg. 5)	823,178
28B Ola Village (Expenses Classified To Line 43)	12,933
28C Laundry And Vending Commissions	1,774
28D Activity Income (Adjustment - Pg. 5)	336
28E Miscellaneous Revenue	4,291
28F Miscellaneous Revenue	1,091
28G Ola Fest Income (Expenses Classified To Line 43)	62,694
28H Golf Outing Income (Expenses Classified To Line 43)	3,600
28I Christmas Bazaar (Expenses Classified To Line 43)	667
28J	
28K	
28L	
28M	
28N	
28O	
28P	
28Q	
28R	
28S	
28T	
Total	<u>910,564</u>

Facility Name & ID Number Our Lady Of Angels Retirement Home

0034975

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	2,000	2,080	\$ 62,174	\$ 29.89	1
2	Assistant Director of Nursing	4,000	4,160	121,668	29.25	2
3	Registered Nurses	17,185	17,875	446,886	25.00	3
4	Licensed Practical Nurses	32,559	34,235	717,944	20.97	4
5	CNAs & Orderlies	75,439	80,225	747,728	9.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,261	3,404	65,471	19.23	9
10	Activity Assistants	8,699	9,080	112,844	12.43	10
11	Social Service Workers	8,292	8,930	143,744	16.10	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	54,829	26.36	13
14	Head Cook	8,365	8,427	112,503	13.35	14
15	Cook Helpers/Assistants	41,110	42,038	346,101	8.23	15
16	Dishwashers					16
17	Maintenance Workers	12,818	13,458	224,735	16.70	17
18	Housekeepers	18,287	19,229	169,705	8.83	18
19	Laundry	7,513	7,795	75,527	9.69	19
20	Administrator	4,000	4,160	167,274	40.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,914	25,001	334,484	13.38	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	1,234	1,284	23,683	18.44	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	6,701	6,939	157,498	22.70	33
34	TOTAL (lines 1 - 33)	277,377	290,400	\$ 4,084,798 *	\$ 14.07	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	Monthly	\$ 9,929	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Quarterly	360	10-03	37
38	Nurse Consultant		5,063	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	481	11-03	44
45	Social Service Consultant	Monthly	1,518	12-03	45
46	Other(specify)				46
47	<u>Rehab Consultant</u>		1,068	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,419		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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
33A Development	4,301	4,454	\$ 103,741	\$ 23.29
33B OLA Village	2,400	2,485	53,757	21.63
33C				
33D				
33E				
33F				
33G				
33H				
33I				
33J				
33K				
33L				
33M				
33N				
33O				
33P				
33Q				
33R				
33S				
33T				
	<u>6,701</u>	<u>6,939</u>	\$ <u>157,498</u>	\$ <u>22.70</u>

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	
<u>Sr. Maria Pesavento</u>	<u>Exec. Director</u>	<u>0</u>	\$ <u>89,226</u>	<u>Workers' Compensation Insurance</u>	\$ <u>268,446</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
<u>Michelle Hart-Carlson</u>	<u>Administrator</u>	<u>0</u>	<u>78,048</u>	<u>Unemployment Compensation Insurance</u>	<u>17,635</u>	<u>Advertising: Employee Recruitment</u>	<u>6,656</u>	
				<u>FICA Taxes</u>	<u>296,123</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>335,813</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>3,240</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses and Fees</u>	<u>2,346</u>	
				<u>Employee Physicals</u>	<u>2,115</u>	<u>Advertising and Public Relations</u>	<u>5,893</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>167,274</u>	<u>Pension Contributions and Plan Fees</u>	<u>80,631</u>	<u>Dues and Subscriptions</u>	<u>15,374</u>	
(List each licensed administrator separately.)				<u>Other Employee Benefits</u>	<u>4,916</u>	<u>Non-Allowable Dues, Fees, Subscriptions</u>	<u>(3,175)</u>	
				<u>Non-Allowable Employee Benefits</u>	<u>(49,491)</u>			
						<u>Less: Public Relations Expense</u>	<u>(2,392)</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>(3,501)</u>	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>956,189</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>26,432</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
							<u>Out-of-State Travel</u>	\$ _____
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	<u>7,339</u>
							<u>Non-Allowable Seminar</u>	<u>(787)</u>
							<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>176,251</u>	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>6,552</u>
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. INHAA-\$100/LSN-\$9,908/ICLTC-\$5,546
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 137
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 - 7 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,068 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. \$ 45,024
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 - d. Have vehicle usage logs been maintained?
 - 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. \$ _____
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees