

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 N/A

	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	37	Skilled (SNF)	37	13,505	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5	50	Sheltered Care (SC)	50	18,250	5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,005	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			2,846	2,846	8
9	SNF/PED					9
10	ICF	13,406	13,885		27,291	10
11	ICF/DD					11
12	SC		14,833		14,833	12
13	DD 16 OR LESS					13
14	TOTALS	13,406	28,718	2,846	44,970	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.93%

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)
N/A

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 37 and days of care provided 2,846

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

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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	436,961	19,047	9,442	465,450		465,450	(44,187)	421,263		1
2	Food Purchase		298,774		298,774		298,774	(28,364)	270,410		2
3	Housekeeping	188,299	27,987		216,286		216,286	(39,615)	176,671		3
4	Laundry	55,631	10,939		66,570		66,570		66,570		4
5	Heat and Other Utilities			307,649	307,649		307,649	(43,950)	263,699		5
6	Maintenance	224,567		170,325	394,892		394,892	(78,447)	316,445		6
7	Other (specify):*										7
8	TOTAL General Services	905,458	356,747	487,416	1,749,621		1,749,621	(234,563)	1,515,058		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,223,079	82,617	3,829	2,309,525		2,309,525	(1,695)	2,307,830		10
10a	Therapy	98,844			98,844		98,844		98,844		10a
11	Activities	193,690	8,859	4,154	206,703		206,703	(21,259)	185,444		11
12	Social Services	151,812		2,861	154,673		154,673	(14,684)	139,989		12
13	CNA Training										13
14	Program Transportation			11,525	11,525		11,525	(1,094)	10,431		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,667,425	91,476	40,369	2,799,270		2,799,270	(38,732)	2,760,538		16
	C. General Administration										
17	Administrative	155,323			155,323		155,323	(14,745)	140,578		17
18	Directors Fees										18
19	Professional Services			61,889	61,889		61,889	(5,875)	56,014		19
20	Dues, Fees, Subscriptions & Promotions			31,251	31,251		31,251	(16,209)	15,042		20
21	Clerical & General Office Expenses	363,855	27,161	84,419	475,435		475,435	(102,863)	372,572		21
22	Employee Benefits & Payroll Taxes			1,013,944	1,013,944		1,013,944	(44,587)	969,357		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,368	14,368		14,368	(1,364)	13,004		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			119,782	119,782		119,782	(14,000)	105,782		26
27	Other (specify):*										27
28	TOTAL General Administration	519,178	27,161	1,325,653	1,871,992		1,871,992	(199,644)	1,672,348		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,092,061	475,384	1,853,438	6,420,883		6,420,883	(472,939)	5,947,944		29

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

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

Facility Name & ID Number

Our Lady of Angels Retirement Home

#0034975

Report Period Beginning:

07/01/08

Ending:

06/30/09

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			172,628	172,628		172,628	(24,661)	147,967			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			765,848	765,848		765,848	(764,520)	1,328			34
35	Rent-Equipment & Vehicles			8,547	8,547		8,547	(811)	7,736			35
36	Other (specify):*											36
37	TOTAL Ownership			947,023	947,023		947,023	(789,993)	157,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,967	251,699	343,666		343,666		343,666			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,408	4,408		4,408	(4,408)				41
42	Provider Participation Fee			47,633	47,633		47,633		47,633			42
43	Other (specify):* Develop./Chapel	59,282		33,958	93,240		93,240	(93,240)				43
44	TOTAL Special Cost Centers	59,282	91,967	337,698	488,947		488,947	(97,648)	391,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,151,343	567,351	3,138,159	7,856,853		7,856,853	(1,360,580)	6,496,273			45

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

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	(46,766)	21		5
6	Rented Facility Space	(17,806)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(704)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,645)	21		24
25	Fund Raising, Advertising and Promotional	(5,889)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,500)	20		28
29	Other-Attach Schedule	(510,750)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (596,060)		\$	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)	(764,520)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (764,520)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,360,580)		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

Our Lady of Angels Retirement Home

ID# 0034975

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Interest and Late Payment Penalties	\$ (5,122)	21	1
2	Public Relations	(3,538)	20	2
3	Bank Charges	(1,100)	21	3
4	Investment Expense	(619)	21	4
5	Board Gift	(21)	21	5
6	Development Salary	(59,282)	43	6
7	Development Expenses	(26,964)	43	7
8	Chapel	(6,994)	43	8
9	Recycling Income	(510)	21	9
10	Insurance Reimbursement - Auto Repairs	(2,251)	06	10
11	Coffee and Gift Shop Income (Ext. of Expense)	(4,408)	41	11
12				12
13	OLA Village Income - Expense Reimbursement			13
14	Housekeeping	(10,169)	03	14
15	Maintenance	(5,650)	06	15
16	Nursing	(1,695)	10	16
17	Activities	(1,808)	11	17
18				18
19	Independent Living Units - 14 (Allocated Cost)			19
20	Dietary	(44,187)	01	20
21	Food	(28,364)	02	21
22	Housekeeping	(29,445)	03	22
23	Heat and Other Utilities	(43,950)	05	23
24	Maintenance	(52,741)	06	24
25	Activities	(19,452)	11	25
26	Social Services	(14,684)	12	26
27	Program Transportation	(1,094)	14	27
28	Administrative	(14,745)	17	28
29	Professional Fees	(5,875)	19	29
30	Dues, Fees, Subscriptions & Promotions	(1,578)	20	30
31	Clerical and Office Expenses	(39,080)	21	31
32	Travel and Seminar	(1,364)	24	32
33	Insurance	(14,000)	26	33
34	Depreciation	(24,661)	30	34
35	Equipment Rental	(811)	35	35
36	Employee Benefits	(44,587)	22	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	(510,750)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	(44,187)	0	0	0	0	0	0	0	0	0	0	(44,187)	1
2	Food Purchase	(28,364)	0	0	0	0	0	0	0	0	0	0	(28,364)	2
3	Housekeeping	(39,615)	0	0	0	0	0	0	0	0	0	0	(39,615)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(43,950)	0	0	0	0	0	0	0	0	0	0	(43,950)	5
6	Maintenance	(78,447)	0	0	0	0	0	0	0	0	0	0	(78,447)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(234,563)	0	(234,563)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,695)	0	0	0	0	0	0	0	0	0	0	(1,695)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(21,259)	0	0	0	0	0	0	0	0	0	0	(21,259)	11
12	Social Services	(14,684)	0	0	0	0	0	0	0	0	0	0	(14,684)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,094)	0	0	0	0	0	0	0	0	0	0	(1,094)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(38,732)	0	(38,732)	16									
	C. General Administration													
17	Administrative	(14,745)	0	0	0	0	0	0	0	0	0	0	(14,745)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,875)	0	0	0	0	0	0	0	0	0	0	(5,875)	19
20	Fees, Subscriptions & Promotions	(16,209)	0	0	0	0	0	0	0	0	0	0	(16,209)	20
21	Clerical & General Office Expenses	(102,863)	0	0	0	0	0	0	0	0	0	0	(102,863)	21
22	Employee Benefits & Payroll Taxes	(44,587)	0	0	0	0	0	0	0	0	0	0	(44,587)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,364)	0	0	0	0	0	0	0	0	0	0	(1,364)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(14,000)	0	0	0	0	0	0	0	0	0	0	(14,000)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(199,644)	0	(199,644)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(472,939)	0	(472,939)	29									

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/08 Ending:06/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(24,661)	0	0	0	0	0	0	0	0	0	0	(24,661)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(764,520)	0	0	0	0	0	0	0	0	0	(764,520)	34
35	Rent-Equipment & Vehicles	(811)	0	0	0	0	0	0	0	0	0	0	(811)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,473)	(764,520)	0	(789,993)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(4,408)	0	0	0	0	0	0	0	0	0	0	(4,408)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(93,240)	0	0	0	0	0	0	0	0	0	0	(93,240)	43
44	TOTAL Special Cost Centers	(97,648)	0	0	0	0	0	0	0	0	0	0	(97,648)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(596,060)	(764,520)	0	0	0	0	0	0	0	0	0	(1,360,580)	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	\$ 764,520	Sisters of St. Francis of Mary Immaculate	100.00%	\$	\$	(764,520) 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		\$ 764,520			\$	\$ *	(764,520) 14

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

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/08 Ending: 06/30/09

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

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/08

Ending:

06/30/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
	B. Non-Facility Related*																	
10	Sisters of St. Francis				Cash Asset Transfer							10						
11	of Mary Immaculate		X		of OLA Village Assets				17,798			11						
12	Illinois Department of											12						
13	Health and Family			X	Medicaid Integrity Audit				39,383			13						
14	TOTAL Non-Facility Related						\$	\$	57,181		\$	14						
15	TOTALS (line 9+line14)						\$	\$	57,181		\$	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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.)

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

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975 Report Period Beginning:

07/01/08 Ending:

06/30/09

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 Units (Built on adjacent property outside of Our Lady of Angels Retirement Home) - Property transferred to different legal entity on 11/20/09.

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

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

Report Period Beginning:

07/01/08

Ending:

06/30/09**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	137		1962	1962	\$ 1,572,423	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		8,000						9
10	Various		1983		89,578						10
11	Various		1984		78,857						11
12	Various		1985		22,845						12
13	Various		1987		10,742						13
14	Various		1988		2,330						14
15	Various		1990		26,014						15
16	Various		1991		136,675						16
17	Various		1992		62,593						17
18	Various		1993		149,990						18
19	Various		1994		34,476						19
20	Various		1995		89,923						20
21	Various		1996		204,209						21
22	Various		1997		365,084						22
23	Various		1998		34,996						23
24	Various		1999		5,332						24
25	Various		2000		123,450						25
26	Various		2001		54,577						26
27	Various		2002		398,917						27
28	Various		2003		83,462						28
29	Various		2004		133,665						29
30	Various		2005		80,832						30
31	Fire Alarm Equipment		2006		9,723						31
32	Sewer and Water Line		2006		8,447						32
33	Boiler Tank Repair		2006		4,710						33
34	Smoke Detectors and Doors		2006		8,775						34
35	Fire Doors		2006		6,705						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

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

Report Period Beginning:

07/01/08

Ending:

06/30/09**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	Walk in Cooler Repairs and Doors	2006	\$ 16,743	\$		\$	\$	\$	37
38	Boiler Repairs	2006	23,566						38
39	Activity Room / Auditorium Remodeling	2007	86,934						39
40	Walkin Cooler Repairs / Updates	2007	5,200						40
41	Building Renovations	2007	3,107,313						41
42	Driveway Canopy	2007	8,740						42
43	Elevator Repairs	2008	2,310						43
44	Elevator Repairs	2008	4,290						44
45	IDPH Survey Modifications	2008	6,765						45
46	IDPH Survey Modifications	2008	2,032						46
47	Sidewalk	2008	3,000						47
48	Asbestos Removal	2008	5,000						48
49	Hot Water Heater Repair	2008	5,990						49
50	Boiler Repairs	2008	15,229						50
51	Handicap Ramp	2008	6,300						51
52	Exterior Lighting	2008	13,265						52
53	Exterior Lighting	2008	9,435						53
54	Construction Renovations	2009	2,450						54
55	Electrical Work	2009	4,423						55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			78,535		78,535		876,192	69
70	TOTAL (lines 4 thru 69)		\$ 7,136,315	\$ 78,535		\$ 78,535	\$	\$ 876,192	70

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

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	\$ 956,047	\$ 62,024	\$ 62,024		10	\$ 730,706	71
72	Current Year Purchases	20,357	3,137	3,137		10	3,137	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 976,404	\$ 65,161	\$ 65,161			\$ 733,843	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	21,359	4,271	4,271		5	14,594	78
79										79
80	TOTALS			\$ 112,018	\$ 4,271	\$ 4,271			\$ 105,253	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)	\$ 8,224,737	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,967	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)	\$ 1,715,288	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	1997 - Chevy Truck	\$ 26,820	\$	\$ 26,820	86
87	2000 - Deere Tractor	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.

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	Storage				1,328			5
6								6
7	TOTAL				\$ 1,328			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: \$ 7,736 Description: Postage Machine - \$1,331 / Copiers - \$7,216 / Non Allowable - (\$811)

(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 07/01/99

Ending 06/30/09

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

Fiscal Year Ending Annual Rent

12. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	39-03	hrs	\$		\$ 99,902	\$		\$ 99,902	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			18,111			18,111	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			119,232			119,232	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				89,799		89,799	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Medical Supplies</u>	39-02					2,168		2,168	12
13	Other (specify): <u>Lab / X-ray / Other</u>	39-03				14,453			14,453	13
14	TOTAL			\$		\$ 251,699	\$ 91,967		\$ 343,666	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/09**

(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	\$ 496,486	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>68,327</u>)	1,143,742		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	12,421		5
6	Prepaid Insurance	173,318		6
7	Other Prepaid Expenses	18,781		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,844,748	\$	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	2,923,032		15
16	Equipment, at Historical Cost	1,126,239		16
17	Accumulated Depreciation (book methods)	(1,753,108)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,296,163	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,140,911	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 813,108	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,941		28
29	Short-Term Notes Payable	57,181		29
30	Accrued Salaries Payable	220,442		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	<u>Accrued PTO & Payroll Taxes</u>	289,166		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,383,838	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,383,838	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,757,073	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,140,911	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,223,974	1
2	Restatements (describe):		2
3	OLA Village - Post Year End Adjustments (Non Facility)	17,652	3
4	Rounding Adjustment	(7)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,241,619	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	515,454	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)	\$ 515,454	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)	\$ 2,757,073	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975Report Period Beginning: 07/01/08Ending: 06/30/09

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	\$ 7,141,279	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,141,279	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,317	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 83,317	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,682	12
13	Barber and Beauty Care	1,973	13
14	Non-Patient Meals	5,581	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	17,806	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	176,131	21
22	Laundry	2,173	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 211,346	23
D. Non-Operating Revenue			
24	Contributions	566,843	24
25	Interest and Other Investment Income***	2,794	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 569,637	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	366,728	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 366,728	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,372,307	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,749,621	31
32	Health Care	2,799,270	32
33	General Administration	1,871,992	33
B. Capital Expense			
34	Ownership	947,023	34
C. Ancillary Expense			
35	Special Cost Centers	441,314	35
36	Provider Participation Fee	47,633	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,856,853	40
41	Income before Income Taxes (line 30 minus line 40)**	515,454	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 515,454	43

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

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

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

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

Facility Name & ID Number Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	1,864	2,080	\$ 68,745	\$ 33.05	1
2	Assistant Director of Nursing	2,696	2,976	89,050	29.92	2
3	Registered Nurses	17,892	19,175	518,317	27.03	3
4	Licensed Practical Nurses	27,760	30,743	685,182	22.29	4
5	CNAs & Orderlies	73,661	79,890	838,832	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,672	7,430	98,844	13.30	8
9	Activity Director	3,506	4,107	72,521	17.66	9
10	Activity Assistants	8,714	9,894	121,169	12.25	10
11	Social Service Workers	8,309	9,282	151,812	16.36	11
12	Dietician					12
13	Food Service Supervisor	1,816	2,080	54,270	26.09	13
14	Head Cook	11,667	12,477	147,654	11.83	14
15	Cook Helpers/Assistants	20,339	21,531	198,091	9.20	15
16	Dishwashers	4,619	4,731	36,945	7.81	16
17	Maintenance Workers	10,940	12,408	224,567	18.10	17
18	Housekeepers	17,365	19,772	188,299	9.52	18
19	Laundry	5,230	5,745	55,631	9.68	19
20	Administrator	1,968	2,080	82,636	39.73	20
21	Assistant Administrator					21
22	Other Administrative	1,360	1,640	72,687	44.32	22
23	Office Manager					23
24	Clerical	18,559	20,807	363,855	17.49	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	1,846	1,979	22,954	11.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Development</u>	2,412	2,506	59,282	23.66	33
34	TOTAL (lines 1 - 33)	249,195	273,333	\$ 4,151,343 *	\$ 15.19	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	\$ 9,442	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Quarterly	690	10-03	37
38	Nurse Consultant	As Needed	3,139	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	4,154	11-03	44
45	Social Service Consultant	Monthly	2,861	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,286		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

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975Report Period Beginning: 07/01/08Ending: 06/30/09**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?
If YES, give association name and amount. LSN=\$5,039, ICLTC=\$1,382, AAHSA=\$874
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,559 Line 10-02
- (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. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES _____ 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. \$ 47,633
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. \$ _____ 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? 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: _____
- (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.