

Facility Name & ID Number Rose-Angela Hall

0033761 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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	80	Intermediate/DD	80	28,964	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	28,964	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	27,376			27,376	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,376			27,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.52%

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

1,588 (Do not include bed-hold days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 09/13/88

J. Was the facility purchased or leased after January 1, 1978?
 YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 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	209,079	5,650	25,846	240,575	240,575	240,575	240,575			1
2	Food Purchase		100,839		100,839	100,839	100,839	100,839			2
3	Housekeeping	44,665	13,754		58,419	58,419	58,419	58,419			3
4	Laundry	15,984	8,408		24,392	24,392	24,392	24,392			4
5	Heat and Other Utilities			139,478	139,478	139,478	139,478	139,478			5
6	Maintenance	99,131	67,186	98,209	264,526	264,526	264,526	264,526			6
7	Other (specify):*										7
8	TOTAL General Services	368,859	195,837	263,533	828,229	828,229	828,229	828,229			8
	B. Health Care and Programs										
9	Medical Director	30,600			30,600	30,600	30,600	30,600			9
10	Nursing and Medical Records	1,675,767	33,120	21,081	1,729,968	1,729,968	1,729,968	1,729,968			10
10a	Therapy	25,427		33,260	58,687	58,687	58,687	58,687			10a
11	Activities										11
12	Social Services	25,748			25,748	25,748	25,748	25,748			12
13	CNA Training	7,762	760		8,522	8,522	8,522	8,522			13
14	Program Transportation			11,451	11,451	11,451	11,451	11,451			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,765,304	33,880	65,792	1,864,976	1,864,976	1,864,976	1,864,976			16
	C. General Administration										
17	Administrative	94,291			94,291	94,291	94,291	94,291			17
18	Directors Fees										18
19	Professional Services			33,750	33,750	33,750	33,750	33,750			19
20	Dues, Fees, Subscriptions & Promotions			2,764	2,764	2,764	2,764	2,764			20
21	Clerical & General Office Expenses	161,509	62,646	18,191	242,346	242,346	242,346	242,346			21
22	Employee Benefits & Payroll Taxes			329,022	329,022	329,022	329,022	329,022			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,909	1,909	1,909	1,909	1,909			24
25	Other Admin. Staff Transportation			1,942	1,942	1,942	1,942	1,942			25
26	Insurance-Prop.Liab.Malpractice			52,836	52,836	52,836	52,836	52,836			26
27	Other (specify):*										27
28	TOTAL General Administration	255,800	62,646	440,414	758,860	758,860	758,860	758,860			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,389,963	292,363	769,739	3,452,065	3,452,065	3,452,065	3,452,065			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.

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			325,156	325,156		325,156		325,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			325,156	325,156		325,156		325,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,152	206,152		206,152		206,152			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			206,152	206,152		206,152		206,152			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,389,963	292,363	1,301,047	3,983,373		3,983,373		3,983,373			45

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

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

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
Daughters of St. Mary of Providence	100			St. Mary of Providence	Chicago, IL.	Operating Corp.

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	Rent Facility/	\$ 66,000	Daughters of St. Mary of Providence	100.00%	\$ 66,000	\$	1
2	V	Bldg., Grounds						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		\$ 66,000			\$ 66,000	\$ *	14

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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related									14										
15	TOTALS (line 9+line14)									15										

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rose-Angela Hall COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033761

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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.

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Residential</u>	<u>66,437</u>	<u>1925</u>	<u>\$ 50,975</u>	<u>1</u>
2	<u>Improvements</u>		<u>Various</u>	<u>24,500</u>	<u>2</u>
3	TOTALS	66,437		\$ 75,475	3

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1979	1980	\$ 2,031,195	\$ 17,314	30	\$ 17,314		\$ 1,919,870	4
5			1938	1938	73,366		60			73,366	5
6			1956	1956	259,122		25			259,122	6
7			1928	1928	104,867		45			104,867	7
8			1953	1953	71,484		45			71,484	8
	Improvement Type**										
9		Remodling, Painting, Drywall		1980	85,251		20			85,251	9
10		Repairs		1980	24,301		20			24,301	10
11		Roof/tuckpointing		1988	8,466		20			8,466	11
12		Repairs, Painting, Decorating		1955	41,231		10			41,231	12
13		Decorating		1990	3,836		10			3,836	13
14		Asphalt Paving Lot		1990	16,650		15			16,650	14
15		Garage disposal		1900	24,862	995	25	995		19,897	15
16		Remdoling, Painting Drywall		1991	45,685	2,284	20	2,284		40,423	16
17		New boiler-Kitchen Bldg.		1998	12,320	821	15	821		9,852	17
18		New boiler-Admin. Bldg.		1998	5,320	355	15	355		4,260	18
19		Install Handicap ramp/remodel Front entrance		2001	140,185	7,010	20	7,010		59,585	19
20		Remove & Install new fence around perimeter & electronic gate		2001	106,000	5,300	20	5,300		45,050	20
21		Addl re electronic gate & fence		2002	19,421	971	20	971		7,768	21
22		New rooftop HVAC units to replace existing		2002	248,000	16,533	15	16,533		122,997	22
23		Addl re ramp & fence ICF		2003	103,055	5,153	15	5,153		33,494	23
24		Sidewalkds underground snowmelt		2004	41,354	2,067	20	2,067		11,369	24
25		Parking lot stone & asphalt		2004	35,732	2,382	15	2,382		13,101	25
26		Carpentry, shelving, gate		1988	44,779		15			44,779	26
27		Outdoor rec. area		1989	12,400		15			12,400	27
28		G. Hall windows AC		1991	24,239	1,212	20	1,212		22,147	28
29		Roofing		1991	10,852		20			10,852	29
30		Remdoling Nurses station, Adm. Bldg.		1991	156,249	7,916	20	7,916		149,137	30
31		Walk In Cooler remodling		1991	44,095	2,205	20	2,205		39,041	31
32		Remodle Kitchen		1991	31,445	1,572	10	1,572		29,082	32
33		Roofing		1992	12,170		15			12,170	33
34		Plumbing, heating, painting, tile art		1993	30,813		15			30,813	34
35		Paintng, decorative tile		1992	14,977		10			14,977	35
36		Alarm System		1994	10,837	265	15	265		10,837	36

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

See Page 12A, Line 70 for total

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Emergency lights, snow melt cables, roofing	1995	\$ 65,535	\$	10	\$	\$	\$ 65,535	37
38	Handicap Bath, Whirlpool	1996	19,365	1,291	15	1,291		17,267	38
39	Painting,Patching, Decorating	1996	37,184		5			37,184	39
40	New Boiler #1-4	1996	32,273	1,614	20	1,614		21,655	40
41	Install Bath	1996	4,208	281	15	281		3,793	41
42	Repair glass, roofing	1996	2,996		15			2,996	42
43	Tuckpointing, roof repair	1997	6,428		10			6,428	43
44	Electrical re A/C	1997	2,460	164	15	164		2,132	44
45	Wqindow replacement A/C installation	1997	23,947	1,198	20	1,198		14,975	45
46	Painting, wal covering	1997	1,462		5			1,462	46
47	Architectural re windows, remodeling	1998	930		10			930	47
48	Elevator door	1998	1,200	80	15	80		920	48
49	New roof Adm. Bldg	1998	13,968	698	20	698		8,027	49
50	Painting, decorating Adm. Bldg	1998	950		5			950	50
51	Guanella Hall boiler	1998	14,758	738	20	738		8,487	51
52	New door stops, exits	1998	15,989	1,066	15	1,066		12,259	52
53	Painting, decorating Adm. Bldg	1998	25,548		5			25,548	53
54	Handrails	1998	6,132	408	15	408		4,692	54
55	New boiler, ht.coils D#1	1998	53,531	2,676	20	2,676		30,830	55
56	Painting, decorating dorms	1999	18,294		5			18,294	56
57	Handicap handrails installed	1999	14,174	945	15	945		9,922	57
58	Install Walk In kitchen freezer	1999	17,409	1,161	15	1,161		12,191	58
59	Reconfigure office & handicap ramp & washroom	1999	54,060	2,703	20	2,703		28,382	59
60	Replace broken sewer & sidewalk	1999	17,168	859	20	859		9,019	60
61	New wall covering and decorating G. Hall	1999	23,831	1,193	10	1,193		23,831	61
62	Installation of fire pump	1999	8,300	415	20	415		4,358	62
63	Pip in new heads re fire system	1999	2,060	137	15	137		1,439	63
64	Chapel roof repair & piping	1999	2,939	294	10	294		3,069	64
65	Carpeting Chapel	2000	1,511		5			1,511	65
66	Painting, wall covering re hallways	2000	1,742	174	10	174		1,653	66
67	New heater hall ways	2000	656	44	15	44		440	67
68	Remodle Kitchen ramp	2000	35,464	1,773	20	1,773		17,714	68
69	Pavement repairs and replace	2000	10,527	526	20	526		4,995	69
70	TOTAL (lines 4 thru 69)		\$ 4,431,558	\$ 94,793		\$ 94,793	\$	\$ 3,755,363	70

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/08

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	
1	Totals from Page 12A, Carried Forward		\$ 4,431,558	\$ 94,793		\$ 94,793	\$	\$ 3,755,363	1
2	Install water supply valves	2000	21,820	1,091	20	1,091		10,364	2
3	Windows replaced in dorms	2000	85,550	4,278	20	4,278		40,641	3
4	Roof repair dorms	2000	13,520	1,352	10	1,352		12,844	4
5	Replace kitchen windows	2000	10,553	528	20	528		5,280	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		4,018	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		30,406	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		6,185	8
9	New water line piping	2000	11,006	550	20	550		5,225	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		4,341	10
11	Asphalt paving lot	2001	5,141		5			5,141	11
12	Fir alarm system	2001	6,938	694	10	694		5,899	12
13	G. Hall decorating hallways	2001	5,540		5			5,540	13
14	Remove asbestos tile/replace	2001	5,192	519	10	519		4,413	14
15	Firewall door framing	2001	22,631	1,508	15	1,508		12,818	15
16	New hot water tanks repiping	2001	24,801	1,654	15	1,654		14,092	16
17	shower door, replace drain	2001	11,732	782	15	782		6,648	17
18	Outdoor pavilion, gazebos	2001	41,095	2,740	15	2,740		23,289	18
19	Balcony roof repair	2001	5,803	(856)	5	(856)		5,803	19
20	Fire alarm system	2001	4,496	450	10	450		3,375	20
21	Plumbing work	2002	42,173	4,217	10	4,217		31,627	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		11,505	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		7,845	23
24	Tuckpointing	2002	11,585	1,158	10	1,158		8,685	24
25	Doors re Chapel	2003	1,642	164	10	164		1,066	25
26	Plumbing-water tanks, sm. Basin	2003	16,551	1,655	10	1,655		10,758	26
27	Roof curbs	2003	12,430	829	10	829		5,388	27
28	Elec. Wiring & smoke detectors	2003	5,327	532	15	532		3,463	28
29	Insulate pipes, door	2003	4,378	438	10	438		2,847	29
30	Windows, tuckpointing, Nepco	2003	25,922	2,592	10	2,592		16,848	30
31	Gas generator	2004	189,933	12,662	10	12,662		69,641	31
32	Roof tiles, decorating	2004	21,956	4,391	5	4,391		24,152	32
33	New laundry area	2004	17,227	1,148	15	1,148		6,314	33
34	TOTAL (lines 1 thru 33)		\$ 5,187,959	\$ 147,200		\$ 147,200	\$	\$ 4,161,824	34

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning:

07/01/08

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	
1	Totals from Page 12B, Carried Forward		\$ 5,187,959	\$ 147,200		\$ 147,200	\$	\$ 4,161,824	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		9,698	2
3	Base parking lot, underground snowmelt	2004	52,967	5,296	10	5,296		28,933	3
4	New fire alarm system	2004	68,500	4,567	15	4,567		25,118	4
5	A/C Kitchen	2004	9,890	989	10	989		5,440	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		25,260	6
7	Handicap ramp re gym	2004	34,730	1,736	20	1,736		10,416	7
8	Gym windows	2004	8,245	550	15	550		3,300	8
9	Gym roof	2004	17,997	3,600	5	3,600		21,600	9
10	Plumbing, washroom remodel	2004	6,468	647	10	647		3,882	10
11	Exterior masonry, joints	2004	32,686	2,180	15	2,180		11,964	11
12	Gas generator balance	2005	26,180	1,745	15	1,745		7,853	12
13	Complete roof replacement	2005	380,077	19,004	20	19,004		85,518	13
14	Installation Attic exhaust	2005	99,968	4,998	20	4,998		22,491	14
15	Complete new fire system	2005	130,900	6,545	20	6,545		29,452	15
16	Sewer & Gas lines	2005	47,795	2,390	20	2,390		11,555	16
17	Paving lot	2005	31,920	2,128	15	2,128		9,576	17
18	Wallcover, tiles, painting	2005	69,115	6,911	10	6,911		31,100	18
19	Electrical repairs , security	2005	30,411	3,041	10	3,041		13,684	19
20	Laundry, Kitchen repairs	2005	30,103	2,007	15	2,007		8,677	20
21	Hotwater gas line	2006	5,380	538	10	538		1,757	21
22	Painting, Caulking	2006	16,065	3,213	5	3,213		10,314	22
23	Generator adjust	2006	5,545	370	15	370		1,294	23
24	Pool house, camp	2006	13,574	1,357	10	1,357		4,750	24
25	Replace tiles Laundry	2006	4,900	490	10	490		1,715	25
26	Masonry repairs	2007	101,462	6,764	15	6,764		16,910	26
27	Bott roofing	2007	17,577	1,172	15	1,172		2,930	27
28	Painting Wall covering	2007	4,184	418	10	418		1,045	28
29	Air svstem gym	2007	19,381	1,292	15	1,292		3,233	29
30	Walk-in refrig. & painting	2007	12,200	2,440	5	2,440		6,100	30
31	Bott roof tiles	2007	28,526	1,902	15	1,902		4,755	31
32	Walk-in tubs installed	2007	67,631	3,382	20	3,382		8,447	32
33	Indoor & outdoor filters & repairs	2007	83,721	8,372	10	8,372		20,930	33
34	TOTAL (lines 1 thru 33)		\$ 6,756,372	\$ 253,195		\$ 253,195	\$	\$ 4,611,521	34

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

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 12C, Carried Forward		\$ 6,756,372	\$ 253,195		\$ 253,195	\$	\$ 4,611,521	1
2	Gate Wallpack & fixtures	2008	7,322	388	10	388		582	2
3	Reinsulate pipes	2008	7,351	390	10	390		585	3
4	Install whirlpool, tubs	2008	32,157	1,608	20	1,608		2,412	4
5	New Boiler Sys. Hdronic Piping	2008	134,986	6,749	20	6,749		10,124	5
6	Kitchen Air Handler	2008	29,500	1,967	15	1,967		2,950	6
7	New flooring & carpeting	2008	75,553	5,036	15	5,036		7,554	7
8	Roof	2009	9,789	277	10	277		277	8
9	Water pipe- pipin	2009	7,248	363	10	363		363	9
10	Wall Covering Dorms.	2009	11,125	556	10	556		556	10
11	Tile Block wall	2009	37,896	1,263	15	1,263		1,263	11
12	New flooring and carpeting	2009	121,350	2,476	15	2,476		2,476	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,230,649	\$ 274,268		\$ 274,268	\$	\$ 4,640,663	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 833,417	\$ 48,717	\$ 48,717	\$		\$ 687,166	71
72	Current Year Purchases	28,062	2,171	2,171			2,171	72
73	Fully Depreciated Assets	138,169						73
74								74
75	TOTALS	\$ 999,648	\$ 50,888	\$ 50,888	\$		\$ 689,337	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Windstar 2004	2004	\$ 21,328	\$	\$	\$	4	\$ 21,328	76
77										77
78										78
79										79
80	TOTALS			\$ 21,328	\$	\$	\$		\$ 21,328	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)	\$ 8,327,100	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 325,156	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 325,156	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)	\$ 5,351,328	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rose-Angela Hall

0033761

Report Period Beginning: 07/01/08

Ending: 06/30/09

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

**

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

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

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

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

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

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	_____ /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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		760		760
3	Classroom Wages (a)		2,587		2,587
4	Clinical Wages (b)		5,175		5,175
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,522	\$	\$ 8,522
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,522		

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

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

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

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

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

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

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,369,768	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	801,965	1,142,752	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		21,390	6
7	Other Prepaid Expenses		14,469	7
8	Accounts Receivable (owners or related parties)	(2,599,526)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,797,561)	\$ 2,548,379	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	2,964,433	6,484,048	15
16	Equipment, at Historical Cost	1,020,976	1,627,318	16
17	Accumulated Depreciation (book methods)	(1,920,965)	(4,676,133)	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)	\$ 2,064,444	\$ 3,435,233	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 266,883	\$ 5,983,612	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,810	\$ 170,952	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,521	234,206	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,855	10,871	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 192,186	\$ 416,029	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)	\$ 192,186	\$ 416,029	46
47	TOTAL EQUITY(page 18, line 24)	\$ 74,697	\$ 5,567,583	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 266,883	\$ 5,983,612	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 272,042	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 272,042	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,345)	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)	\$ (197,345)	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)	\$ 74,697	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,770,166	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,770,166	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	7,762	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,762	23
	D. Non-Operating Revenue		
24	Contributions	8,100	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,100	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,786,028	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	828,229	31
32	Health Care	1,864,976	32
33	General Administration	758,860	33
	B. Capital Expense		
34	Ownership	325,156	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	206,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,983,373	40
41	Income before Income Taxes (line 30 minus line 40)**	(197,345)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (197,345)	43

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

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

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

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

Facility Name & ID Number Rose-Angela Hall

0033761

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	1,900	2,202	\$ 70,556	\$ 32.04	1
2	Assistant Director of Nursing	1,283	1,350	33,800	25.04	2
3	Registered Nurses	7,500	7,931	200,147	25.24	3
4	Licensed Practical Nurses	6,558	6,869	149,413	21.75	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,056	2,175	36,580	16.82	9
10	Activity Assistants					10
11	Social Service Workers	521	521	25,748	49.42	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,080	48,813	23.47	13
14	Head Cook	1,080	1,141	18,146	15.90	14
15	Cook Helpers/Assistants	11,656	12,325	142,120	11.53	15
16	Dishwashers					16
17	Maintenance Workers	4,885	5,166	99,131	19.19	17
18	Housekeepers	4,498	4,756	44,665	9.39	18
19	Laundry	2,020	2,040	15,984	7.84	19
20	Administrator	2,096	2,216	54,248	24.48	20
21	Assistant Administrator	1,762	1,864	40,043	21.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,532	12,194	161,509	13.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	200	200	30,600	153.00	27
28	Qualified MR Prof. (QMRP)	9,268	9,800	174,994	17.86	28
29	Resident Services Coordinator	10,150	10,732	206,499	19.24	29
30	Habilitation Aides (DD Homes)	81,360	86,031	803,075	9.33	30
31	Medical Records	2,008	2,123	33,892	15.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,373	173,716	\$ 2,389,963 *	\$ 13.76	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	\$ 4,782	Lin 1 C3	35	
36	Medical Director			36	
37	Medical Records Consultant	2,496	Lin 10 C3	37	
38	Nurse Consultant	5,655	Lin 10 C3	38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant	29,854	Lin 10a C3	40	
41	Occupational Therapy Consultant	3,406	Lin 10aC3	41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify) <u>Dentist</u>	n/a	4,680	Lin 10 C3	46
47	<u>Phychiatrist</u>	36	8,250	Lin 10 C3	47
48	<u>FoodServiceProfessional Mgmt Fee</u>	n/a	21,064	Lin 1 C3	48
49	TOTAL (lines 35 - 48)	36	\$ 80,187		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 Rose-Angela Hall

0033761

Report Period Beginning: 07/01/08

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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	
Darlene Zdanowski	Administrator		\$ 54,248	Workers' Compensation Insurance	\$ 28,219	IDPH License Fee	\$ 200	
Sr. Rita Butler	Asst. Administrator		40,043	Unemployment Compensation Insurance	8,248	Advertising: Employee Recruitment	1,800	
				FICA Taxes	148,256	Health Care Worker Background Check (Indicate # of checks performed <u>19</u>)	304	
				Employee Health Insurance	82,943	Patient Background Checks		
				Employee Meals		Dues	460	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension				
					61,356			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,291					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 329,022	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,764	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
BIK & CO., LLP	Auditor		\$ 33,750				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Crisis Prevention	1,239
							INR Alzheimer	420
							Arc Special needs	250
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 33,750	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,909

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rose-Angela Hall# 0033761

Report Period Beginning:

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Ending:

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. NO
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,620 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. \$ 206,152
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 15%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BIK & CO, LLP
- (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.

FACILITY NAME & id number - Rose Angela Hall #0033761
Report Period: July 1, 2008 - June 30, 2009

SCHEDULE VII -A-

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

(1) The Facility pays rent to the religious order, The Daughters of St. Mary of Providence for the use of the building and grounds.

SCHEDULE VIII - Allocation of Indirect Costs - SEE ATTACHED WORKSHEETS