



Facility Name & ID Number Rose Angela Hall

# 0033761 Report Period Beginning: 7/01/13 Ending: 6/30/14

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		Intermediate/DD	80	29,200	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	80	29,200	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	27,123			27,123	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,123			27,123	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.89%

D. How many bed-hold days during this year were paid by the Department? 1,804 (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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/14 Fiscal Year: 6/30/14

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

Facility Name &amp; ID Number

Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

**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
	<b>A. General Services</b>										
1	Dietary	171,530	10,192	29,033	210,755		210,755	210,755			1
2	Food Purchase		129,125		129,125		129,125	129,125			2
3	Housekeeping	46,426	22,303		68,729		68,729	68,729			3
4	Laundry	17,181	23,126		40,307		40,307	40,307			4
5	Heat and Other Utilities			148,862	148,862		148,862	148,862			5
6	Maintenance	108,185	31,571	163,399	303,155		303,155	303,155			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	343,322	216,317	341,294	900,933		900,933	900,933			8
	<b>B. Health Care and Programs</b>										
9	Medical Director	30,600			30,600		30,600	30,600			9
10	Nursing and Medical Records	1,840,659	33,162	25,164	1,898,985		1,898,985	1,898,985			10
10a	Therapy	29,795			29,795		29,795	29,795			10a
11	Activities	36,688			36,688		36,688	36,688			11
12	Social Services	31,868			31,868		31,868	31,868			12
13	CNA Training	52,919			52,919		52,919	52,919			13
14	Program Transportation			7,919	7,919		7,919	7,919			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,022,529	33,162	33,083	2,088,774		2,088,774	2,088,774			16
	<b>C. General Administration</b>										
17	Administrative	109,418			109,418		109,418	109,418			17
18	Directors Fees										18
19	Professional Services			25,097	25,097		25,097	25,097			19
20	Dues, Fees, Subscriptions & Promotions			2,442	2,442		2,442	2,442			20
21	Clerical & General Office Expenses	200,398	50,222	16,804	267,424		267,424	267,424			21
22	Employee Benefits & Payroll Taxes			350,923	350,923		350,923	350,923			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,998	1,998		1,998	1,998			24
25	Other Admin. Staff Transportation			1,397	1,397		1,397	1,397			25
26	Insurance-Prop.Liab.Malpractice			49,037	49,037		49,037	49,037			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	309,816	50,222	447,698	807,736		807,736	807,736			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,675,667	299,701	822,075	3,797,443		3,797,443	3,797,443			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 &amp; ID Number

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#0033761

Report Period Beginning:

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Ending:

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## 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	
	<b>D. Ownership</b>											
30	Depreciation			392,434	392,434		392,434		392,434			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	<b>TOTAL Ownership</b>			392,434	392,434		392,434		392,434			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			216,480	216,480		216,480		216,480			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			216,480	216,480		216,480		216,480			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,675,667	299,701	1,430,989	4,406,357		4,406,357		4,406,357			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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**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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number Rose Angela Hall

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Ending:

Summary B

6/30/14

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45</b>

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# 0033761

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Rent Facility/	\$ 66,000		100.00%	\$ 66,000	\$	1
2	V	Buildings, 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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Rose Angela Hall

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

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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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

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

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2013 report.		\$			1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2														
3. Under or (over) accrual (line 2 minus line 1).		\$			3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td>16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010 _____	9																	
	2011 _____	10																	
	2012 _____	11																	
	2013 _____	12																	

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2013 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 2013 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 2013.

	(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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Rose Angela Hall

# 0033761 Report Period Beginning:

7/01/13 Ending:

6/30/14

**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 Days 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>	1
2	<u>Improvements</u>		<u>Various</u>	<u>24,500</u>	2
3	<b>TOTALS</b>	<b>66,437</b>		<b>\$ 75,475</b>	3

Facility Name &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		1979	1980	\$ 2,031,195	\$ 16,592	30	\$ 16,592		\$ 2,003,552	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
	<b>Improvement Type**</b>									
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	Garbage Disposal		1990	24,862	995	25	995		24,872	15
16	Remodling, Painting Drywall		1991	45,685		20			45,685	16
17	New Boiler-Kitchen Bldg.		1998	12,320		15			12,320	17
18	New Boiler- Admin. Bldg.		1998	5,320		15			5,320	18
19	Install Handicap Ramp, Remodle front entrance		2001	140,185	7,010	20	7,010		94,635	19
20	Remove & Install new fence around perimeter & elect.Gate		2001	106,000	5,300	20	5,300		71,550	20
21	Addl re electronic Gate & Fence		2002	19,421	971	20	971		12,623	21
22	New rppftop HVAC units to replace existing		2002	248,000	16,533	15	16,533		205,662	22
23	Addl re ramp & fence		2003	103,055	5,153	15	5,153		59,259	23
24	Side walk underground melt		2004	41,354	2,067	20	2,067		21,704	24
25	Parking lot stone and asphalt		2004	35,732	2,382	15	2,382		25,011	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		20			24,239	28
29	Roofing		1991	10,852		20			10,852	29
30	Remodling Nurses station, Adm Bldg.		1991	156,249		20			156,249	30
31	Walk-In-Cooler remodling		1991	44,095		20			44,095	31
32	Remodel kitchen		1991	31,445		10			31,445	32
33	Roofing		1992	12,170		15			12,170	33
34	Plumbing, heating, painting, tile art		1993	30,813		15			30,813	34
35	Painting, decorative tile		1993	14,977		10			14,977	35
36	Alarm system		1994	10,837		15			10,837	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 &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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		15			19,365	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		29,725	40
41	Install bath	1996	4,208		15			4,208	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 AC	1997	2,460		15			2,460	44
45	Window replacement A/C installation	1997	23,947	1,198	20	1,198		20,965	45
46	Painting, wallcovering	1997	1,462		5			1,462	46
47	Archictural re windows, remodeling	1998	930		10			930	47
48	Elevator door	1998	1,200		15			1,200	48
49	New roof Adm. Bldg	1998	13,968	698	20	698		11,517	49
50	Painting,decorating Adm. Bldg	1998	950		5			950	50
51	Guanelia Hall Boiler	1998	14,758	738	20	738		12,177	51
52	New door stops, exits	1998	15,989		15			15,989	52
53	Painting Decorating Adm Bldg	1998	25,548		5			25,548	53
54	Handrails	1998	6,132		15			6,132	54
55	New Boiler, ht. coils, D. #1	1998	53,531	2,676	20	2,676		44,210	55
56	Painting decorating Dorms	1999	18,294		5			18,294	56
57	Handicap handrails installed	1999	14,174	472	15	472		14,174	57
58	Install walk-in kitchen freezer	1999	17,409	1,161	15	1,161		17,996	58
59	Reconfigure office & handicap ramp & washroom	1999	54,060	2,703	20	2,703		41,897	59
60	Replace broker sewer & sidewalk	1999	17,168	859	20	859		13,314	60
61	New wallcovering and decorating G. Hall	1999	23,831		10			23,831	61
62	Installation of fire pump	1999	8,300	415	20	415		6,433	62
63	Pip in new heads re fire system	1999	2,060	73	15	73		2,060	63
64	Chapel roof repair & Piping	1999	2,939		10			2,939	64
65	Carpeting Chapel	2000	1,511		5			1,511	65
66	Painting, wall covering re hallways	2000	1,742		10			1,742	66
67	New heaters hallways	2000	656	40	15	40		656	67
68	Remodel ramp, kitchen windows	2000	35,464	1,773	20	1,773		26,579	68
69	Pavement repair and replace	2000	10,527	526	20	526		7,625	69
70	TOTAL (lines 4 thru 69)		\$ 4,431,558	\$ 71,949		\$ 71,949	\$	\$ 4,151,655	70

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

Facility Name &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,431,558	\$ 71,949		\$ 71,949	\$	\$ 4,151,655	1
2	Install water supply valves	2000	21,820	1,091	20	1,091		15,819	2
3	Windows replaced in dorms	2000	85,550	4,278	10	4,278		62,031	3
4	Roof repair dorms	200	13,520		20			13,520	4
5	Replace kitchen windows	2000	10,553	528	20	528		7,920	5
6	Brickwork, concrete re damaged walls	2000	8,885	444	20	444		6,238	6
7	New freezer to cooler	2000	63,982	3,199	20	3,199		46,401	7
8	Electric HVAC re freezer	2000	13,022	651	20	651		9,440	8
9	New water line piping	2000	11,006	550	20	550		7,975	9
10	Electric outlets emergency lights	2000	6,858	457	15	457		6,626	10
11	Asphalt paving lot	2001	5,141		5			5,141	11
12	Fire alarm system	2001	6,938		10			6,938	12
13	G.Hall decorating hallways	2001	5,540		5			5,540	13
14	remove asbestos tile/replace	2001	5,192		10			5,192	14
15	Fire wall door framing	2001	22,631	1,508	15	1,508		20,358	15
16	new hot water tanks re piping	2001	24,801	1,654	15	1,654		22,362	16
17	Shower door, replacae drain	2001	11,732	782	15	782		10,558	17
18	Outdoor Pavillion, gazebo	2001	41,095	2,740	15	2,740		36,989	18
19	Balcony roof repair	2001	5,803		5			5,803	19
20	Fire alarm system	2001	4,496		10			4,496	20
21	Plumbing work	2002	42,173	(2,112)	10	(2,112)		42,173	21
22	Sidewalk replacement	2002	23,012	1,534	15	1,534		19,175	22
23	Electric re HVAC	2002	15,700	1,046	15	1,046		13,075	23
24	Tuckpointing	2002	11,585		10			11,585	24
25	Doors re Chapel	2003	1,642		10			1,642	25
26	Plumbing, water tanks, sm. Basin	2003	16,551		10			16,551	26
27	Roof curbs	2003	12,430	829	10	829		9,533	27
28	Elec., wiring abd smoke detectors	2003	5,327		15			5,327	28
29	Insulate pipes, door	2003	4,378		10			3,723	29
30	Windows, tuckpointing, Nenco	2003	25,922		10			25,922	30
31	Gas generator	2004	189,933	12,662	10	12,662		132,951	31
32	Roof tiles, decorating	2004	21,956		5			21,956	32
33	New laauaaandry area	2004	17,227	1,148	15	1,148		12,054	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,187,959	\$ 104,938		\$ 104,938	\$	\$ 4,766,669	34

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

Facility Name &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,187,959	\$ 104,938		\$ 104,938	\$	\$ 4,766,669	1
2	Corridor rails, stairs	2004	26,110	1,741	15	1,741		18,403	2
3	Base parking lot, underground melt	2004	52,967	2,850	10	2,850		52,967	3
4	New fire alarm system	2004	68,500	4,587	15	4,587		47,953	4
5	A/C kitchen	2004	9,890	454	10	454		9,850	5
6	Gym building elevator	2004	84,205	4,210	20	4,210		46,310	6
7	Handicap ramp re Gym	2004	34,730	1,736	250	1,736		19,096	7
8	Gym windows	2004	8,245	550	15	550		6,050	8
9	Gym roof	2004	17,997		5			25,200	9
10	Plumbing, washroom remodel	2004	6,468		10			6,468	10
11	Exterior masonry, joints	2004	32,686	2,180	15	2,180		22,864	11
12	Gas generator balance	2005	26,180	1,745	15	1,745		16,578	12
13	Complete roof replacement	2005	380,077	19,004	20	19,004		180,538	13
14	Installation attic exhaust	2005	99,968	4,998	20	4,998		47,481	14
15	Complete new fire system	2005	130,900	6,545	20	6,545		62,177	15
16	Sewer & gas lines	2005	47,795	2,390	20	2,390		23,505	16
17	Paving lot	2005	31,920	2,128	15	2,128		20,216	17
18	Wall covering, tiles, painting	2005	69,115	6,911	10	6,911		65,655	18
19	Electrical repair, security	2005	30,411	3,041	10	3,041		28,889	19
20	Laundry, Kitchen repairs	2005	30,103	2,007	15	2,007		18,712	20
21	Hot water gas line	2006	5,380	538	10	538		4,447	21
22	Painting, caulking	2006	16,065		5			16,065	22
23	Generator adjust	2006	5,545	370	15	370		3,144	23
24	Pool house camp	2006	13,574	1,357	10	1,357		11,535	24
25	Replace tiles, laundry	2006	4,900	490	10	490		4,165	25
26	Masonry repairs	2007	101,462	6,764	15	6,764		50,730	26
27	Bott roofing	2007	17,577	1,172	15	1,172		8,790	27
28	Painting, wall covering	2007	4,184	418	10	418		3,135	28
29	Air system gym	2007	19,381	1,292	15	1,292		9,693	29
30	Walk-in refrig., & painting	2007	12,200		5			12,200	30
31	Bott roof tiles	2007	28,526	1,902	15	1,902		14,265	31
32	Walk-in tubs installed	2007	67,631	3,382	20	3,382		25,357	32
33	Indoor & Outdoor filters and repairs	2007	83,721	3,660	10	3,660		27,450	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,756,372	\$ 193,360		\$ 193,360	\$	\$ 5,676,557	34

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

Facility Name &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,756,372	\$ 193,360		\$ 193,360	\$	\$ 5,676,557	1
2	Gate wallpack & Fixtures	2008	7,322	732		732		3,898	2
3	Reinsulate pipes	2008	7,351	735		735		3,915	3
4	Install whirlpool, tubs	2008	32,157	1,608		1,608		10,452	4
5	New Boiler system Hadronic piping	2008	134,986	6,749		6,749		43,869	5
6	Kitchen air handler	2008	29,500	1,967		1,967		12,785	6
7	New flooring carpeting	2008	75,553	5,036		5,036		32,734	7
8	Roof repair	2009	9,789	978		978		5,167	8
9	Water pipe - pipin	2009	7,248	725		725		3,988	9
10	Wall covering dorms	2009	11,125	1,112		1,112		6,116	10
11	Tile Block wall	2009	37,896	2,526		2,526		13,893	11
12	New flooring& carpeting Apts	2009	121,350	8,090		8,090		42,926	12
13	Sprinklers, valves	2010	9,311	931		931		4,189	13
14	Concrete masonry	2010	10,400	1,040		1,040		4,680	14
15	Water heater	2010	5,565	1,113		1,113		5,008	15
16	Roof repair/ptg. Eaves	2010	9,137	1,827		1,827		8,221	16
17	Seal coating parking lot	2010	3,445	689		689		3,101	17
18	U.S. fire protect.Complete sprinkler Sys.Activ.	2011	221,255	14,750		14,750		51,625	18
19	New water service for sprinklers, pumps	2011	25,655	1,283		1,283		4,455	19
20	New soffits re pipes, ceiling tiles, dry wall.Sprlr	2011	42,593	2,130		2,130		7,453	20
21	New fire panels and devices re Sprinkler System	2011	55,000	3,667		3,667		12,834	21
22	ElectricalShunt Trip & fan shutdown	2011	4,400	293		293		1,026	22
23	Painting for all intrusions re Sprinkler System	2011	26,000	5,200		5,200		18,200	23
24	Snow melt system	2011	7,953	1,590		1,590		5,500	24
25	Nurses station	2011	6,925	692		692		2,422	25
26	Fire alarm & electric	2011	7,825	782		782		2,737	26
27	Steel Top/steam valve	2011	7,620	762		762		2,667	27
28	A/C kitchen	2011	13,750	1,375		1,375		4,813	28
29	Wiring re tubs & lights	2012	4,274	427		427		1,068	29
30	A/C recreation camp	2012	16,310	1,631		1,631		4,078	30
31	work & railing	2012	28,500	1,900		1,900		5,700	31
32	Install showers, faucets	2012	19,500	1,300		1,300		3,250	32
33	Install roof shelter	2012	11,950	1,195		1,195		2,780	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,768,017	\$ 268,195		\$ 268,195	\$	\$ 6,012,107	34

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

Facility Name &amp; ID Number Rose Angela Hall

# 0033761

Report Period Beginning:

7/01/13

Ending:

6/30/14

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	<b>Totals from Page 12D, Carried Forward</b>		\$ 7,768,017	\$ 268,195		\$ 268,195	\$	\$ 6,012,107	1
2	Install Water heaters	2012	8,651	865	10	865		2,163	2
3	Install new flooring, residential bedrooms	2012	13,666	1,367	10	1,367		3,873	3
4	Painting Nurses stations retrofit fire dampers	2012	3,555	710	5	710		1,775	4
5	Retrofit fire dampers	2012	9,080	908	10	908		2,724	5
6	Power tempering valves	2012	9,366	936	10	936		2,808	6
7	Install gym sprinkler system	2012	140,377	9,358	15	9,358		23,395	7
8	Bulkheads, ACT ceiling re Sprinkler system	2012	35,249	1,762	20	1,762		4,405	8
9	Fire Alarm update re gym	2012	47,429	3,162	15	3,162		7,905	9
10	Heater vestibule	2012	5,550	555	10	555		1,388	10
11	Painting ceiling soffits	2013	4,865	973	5	973		1,459	11
12	Painting stairwells	2013	4,730	946	5	946		1,419	12
13	Hall server	2013	6,671	667	10	667		1,001	13
14	Reconfigure conduits	2013	9,519	635	15	635		952	14
15	Drywall re doors	2013	5,837	1,167	5	1,167		1,751	15
16	Millwork re sills	2013	2,905	194	15	194		291	16
17	Masonry walls	2031	7,837	522	15	522		783	17
18	Install kitchen hoods	2013	18,122	1,208	15	1,208		1,812	18
19	Install soffits re sprinkler, valves	2013	12,154	1,215	10	1,215		1,823	19
20	Install automatic door openers	2014	38,152	1,272	15	1,272		1,272	20
21	Nurses stations in apartments	2014	17,415	581	15	581		581	21
22	Natural gas generator	2014	12,250	408	15	408		408	22
23	Stairwells, masonry and railings	2014	66,916	1,673	20	1,673		1,673	23
24	Basement Sprinkler System	2014	8,828	221	20	221		221	24
25	Concrete RE gym and Courtyard	2014	9,690	323	15	323		323	25
26	Install acrovyn doors in Apartments	2014	6,534	218	15	218		218	26
27	Install cooling system for server	2014	11,411	380	15	380		380	27
28	Wiring & Cabling for Apts, & Nurses station	2014	80,318	2,677	5	2,677		2,677	28
29	Electronic charting system	2014	38,808	3,881	15	3,881		3,881	29
30	Wiring and cabling for smart boards	2014	68,575	2,286	15	2,286		2,286	30
31	Smart Boards	2014	56,344	5,634	5	5,634		5,634	31
32	Wiring and cabling for Center	2014	37,580	1,253	15	1,253		1,253	32
33	Concrete replacement for camp pool	2014	18,880	629	15	629		629	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,585,281	\$ 316,781		\$ 316,781	\$	\$ 6,095,270	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:

7/01/13

Ending:

6/30/14

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,585,281	\$ 316,781		\$ 316,781	\$	\$ 6,095,270	1
2	Courtyard shelter for Apts. 1-4	2014	54,576	1,364	20	1,364		1,364	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,639,857	\$ 318,145		\$ 318,145	\$	\$ 6,096,634	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,102,783	\$ 60,783	\$ 60,783	\$		\$ 918,826	71
72	Current Year Purchases	30,700	3,435	3,435			3,435	72
73	Fully Depreciated Assets	138,169						73
74								74
75	TOTALS	\$ 1,271,652	\$ 64,218	\$ 64,218	\$		\$ 922,261	75

D. Vehicle Costs. (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	White Transit 2012	2013	\$ 40,282	\$ 10,070	\$ 10,070	\$	4	\$ 15,105	76
77										77
78										78
79										79
80	TOTALS			\$ 40,282	\$ 10,070	\$ 10,070	\$		\$ 15,105	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)	\$ 10,027,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 392,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 392,433	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)	\$ 7,034,000	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: 7/01/13

Ending: 6/30/14

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2015	\$ _____
-----	-------------	----------

13.	_____ /2016	\$ _____
-----	-------------	----------

14.	_____ /2017	\$ _____
-----	-------------	----------

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	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Rose Angela Hall # 0033761 Report Period Beginning: 7/01/13 Ending: 6/30/14  
**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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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				
3	Classroom Wages (a)		17,620		17,620
4	Clinical Wages (b)		35,299		35,299
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 52,919	\$	\$ 52,919
10	SUM OF line 9, col. 1 and 2 (e)	\$	52,919		

**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	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>28</b>

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

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

Facility Name & ID Number Rose Angela Hall

# 0033761

Report Period Beginning: 7/01/13

Ending:

6/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 1,828,476	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		654,675	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		55,754	6
7	Other Prepaid Expenses		7,022	7
8	Accounts Receivable (owners or related parties)	(3,577,271)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (3,577,271)	\$ 2,545,927	10
<b>B. Long-Term Assets</b>				
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	3,916,807	5,227,200	15
16	Equipment, at Historical Cost	1,311,934	1,641,646	16
17	Accumulated Depreciation (book methods)	(3,130,929)	(3,561,471)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,097,812	\$ 3,307,375	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (1,479,459)	\$ 5,853,302	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 64,663	\$ 183,286	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,392	122,178	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,232	17,804	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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 138,287	\$ 323,268	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 138,287	\$ 323,268	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,617,746)	\$ 5,530,034	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,479,459)	\$ 5,853,302	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (1,031,196)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (1,031,196)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(586,550)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (586,550)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>		23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,617,746)	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,758,788	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,758,788	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	52,919	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 52,919	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	8,100	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,100	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,819,807	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	900,933	31
32	Health Care	2,088,774	32
33	General Administration	807,736	33
<b>B. Capital Expense</b>			
34	Ownership	392,434	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	216,480	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,406,357	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(586,550)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (586,550)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 3,108,744	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SSA Benefits</u>	649,154	47
48	Other-(specify) <u>Workshop Earned Income</u>	890	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,758,788	49

\* 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:

7/01/13

Ending:

6/30/14

**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	1,850	1,894	\$ 54,796	\$ 28.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,910	11,267	224,530	19.93	3
4	Licensed Practical Nurses	8,516	8,964	204,195	22.78	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,028	2,080	36,688	17.64	9
10	Activity Assistants					10
11	Social Service Workers	647	647	31,868	49.26	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	54,544	26.22	13
14	Head Cook	156	156	3,348	21.46	14
15	Cook Helpers/Assistants	10,914	11,488	113,638	9.89	15
16	Dishwashers					16
17	Maintenance Workers	6,352	6,836	108,185	15.83	17
18	Housekeepers	5,793	6,068	46,426	7.65	18
19	Laundry	1,879	2,071	17,181	8.30	19
20	Administrator	1,950	2,080	50,918	24.48	20
21	Assistant Administrator	1,820	2,080	58,500	28.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,673	16,673	200,398	12.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	200	200	30,600	153.00	27
28	Qualified MR Prof. (QMRP)	10,075	10,604	177,517	16.74	28
29	Resident Services Coordinator	17,800	18,200	308,376	16.94	29
30	Habilitation Aides (DD Homes)	103,555	107,002	922,405	8.62	30
31	Medical Records	2,776	2,096	31,554	15.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,894	212,486	\$ 2,675,667 *	\$ 12.59	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	n/a	\$ 5,354	Lin 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	n/a	5,950	Line 10 C3	37
38	Nurse Consultant	n/a	1,920	Line 10 C3	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	n/a	6,000	Line 10 C3	44
45	Social Service Consultant				45
46	Other(specify) <u>Dentist</u>	n/a	4,544	Line 10 C3	46
47	<u>Psychiatrist</u>	27	6,750	Line 10 C3	47
48	<u>Food Service Professional Mgmt Fee</u>	n/a	23,678	Line 1 C3	48
49	TOTAL (lines 35 - 48)	27	\$ 54,196		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



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Rose Angela Hall# 0033761Report Period Beginning: 7/01/13Ending: 6/30/14**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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,810 Line \_\_\_\_\_
- (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. \$ 216,480  
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: Bansley, Brescia & Co., P.C.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. n/a  
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME & ID number - Rose Angela Hall #0333731  
Report period July 1, 2013 --June 30, 2014

NAME	OFFICE
Sr. Patricia McCafferty (1)	Vice President
Sr. Rita Butler	President
Sr. Florine Licavoli	Director
Sr. Janet Kosman	Secretary Treasurer
Sr. Mercy Secida	Director

(1) St. Paricia McCafferty approves invoices for payment  
and oversees Maintenaance of Buildings.

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

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SCHEDULE VIII - Allocations of Indirect Costs SEE ATTACHED WORKSHEETS