

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0034975

Facility Name: Our Lady of Angels Retirement Home

Address: 1201 Wyoming Avenue Joliet 60435
Number City Zip Code

County: Will

Telephone Number: (815)725-6631 Fax # (815)725-1451

HFS ID Number:

Date of Initial License for Current Owners: 8/10/62

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501c(3)

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: Diane Simon Telephone Number: (815)553-4124
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/11 to 06/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Carol Shaw-Burns
(Title) Administrator

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975 Report Period Beginning: 07/01/11 Ending: 06/30/12

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>5,324</u>	<u>5,324</u>	8
9	SNF/PED					9
10	ICF	<u>13,350</u>	<u>9,948</u>		<u>23,298</u>	10
11	ICF/DD					11
12	SC		<u>13,138</u>		<u>13,138</u>	12
13	DD 16 OR LESS					13
14	TOTALS	13,350	23,086	5,324	41,760	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.51%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Independent Living

F. Does the facility maintain a daily midnight census?

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

YES

☒

NO

☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☒

NO

☐

I. On what date did you start providing long term care at this location?

Date started

08/10/62

J. Was the facility purchased or leased after January 1, 1978?

YES

☐

Date

NO

☒

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

and days of care provided

5,324Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐Tax Year: 06/30/12Fiscal Year: 06/30/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	502,742	32,050	10,296	545,088	(3,690)	541,398	(50,627)	490,771		1
2	Food Purchase		308,762		308,762		308,762	(49,543)	259,219		2
3	Housekeeping	253,453	35,650		289,103		289,103	(7,593)	281,510		3
4	Laundry	91,835	8,200		100,035		100,035	(2,653)	97,382		4
5	Heat and Other Utilities			229,340	229,340		229,340	(35,100)	194,240		5
6	Maintenance	239,829		168,157	407,986		407,986	(92,271)	315,715		6
7	Other (specify):*										7
8	TOTAL General Services	1,087,859	384,662	407,793	1,880,314	(3,690)	1,876,624	(237,787)	1,638,837		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,788,178	122,175	3,485	2,913,838		2,913,838		2,913,838		10
10a	Therapy										10a
11	Activities	181,617	7,735	3,232	192,584		192,584	(32,443)	160,141		11
12	Social Services	117,196		3,018	120,214		120,214	(3,144)	117,070		12
13	CNA Training										13
14	Program Transportation	22,311		10,984	33,295		33,295	(4,347)	28,948		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,109,302	129,910	44,719	3,283,931		3,283,931	(39,934)	3,243,997		16
	C. General Administration										
17	Administrative	99,268			99,268		99,268	(2,600)	96,668		17
18	Directors Fees										18
19	Professional Services			126,389	126,389		126,389	(2,775)	123,614		19
20	Dues, Fees, Subscriptions & Promotions			28,206	28,206		28,206	(9,662)	18,544		20
21	Clerical & General Office Expenses	308,978	22,090	121,458	452,526		452,526	(105,907)	346,619		21
22	Employee Benefits & Payroll Taxes			1,105,509	1,105,509	3,690	1,109,199	(29,583)	1,079,616		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,663	6,663		6,663	(489)	6,174		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			113,340	113,340		113,340	(9,627)	103,713		26
27	Other (specify):*										27
28	TOTAL General Administration	408,246	22,090	1,501,565	1,931,901	3,690	1,935,591	(160,643)	1,774,948		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,605,407	536,662	1,954,077	7,096,146		7,096,146	(438,364)	6,657,782		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.

Our Lady of Angels Retirement Home
Medicaid Cost Report - Employee Meal Reclass
07/01/11 - 06/30/12

Allowable Food Cost

Food Cost	308,762
Non-Resident Meal Income	17,590
Total	326,352

Meals Served

Residents - Licensed Beds	125,280
Residents - Independent Living	14,664
Employee Meals (Prorated at .50 / meal - different meal	3,690
Total	143,634

Allocated Food Cost

Residents - Licensed Beds	284,650
Residents - Independent Living	33,318
Employee Meals	8,384
Total	326,352

Our Lady of Angels Retirement Home
Non-Allowable Expenses
Independent Living

Cost Centers	Allocation Basis	Independent Living	Facility Total	Factor	% IL to Facility	Salary	Remaining Adjusted	IL Salary	IL Remaining Adjusted	IL Total
Dietary	Meals Served	14,664	143,634	100.00%	10.21%	502,742	(6,855)	51,326	(700)	50,627
Food	Meals Served	14,664	143,634	100.00%	10.21%	-	312,983	-	31,953	31,953
Housekeeping	Census Factored	4,888	46,648	25.00%	2.62%	253,453	36,395	6,640	953	7,593
Laundry	Census Factored	4,888	46,648	25.00%	2.62%	91,835	9,438	2,406	247	2,653
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%		280,802	-	35,100	35,100
Maintenance	Square Feet	1	8	100.00%	12.50%	239,829	158,565	29,979	19,821	49,799
Activities	Census	4,888	46,648	25.00%	2.62%	181,617	36,849	4,758	965	5,723
Social Services	Census	4,888	46,648	25.00%	2.62%	117,196	2,806	3,070	74	3,144
Program Transportation	Census	4,888	46,648	100.00%	10.48%	22,311	19,173	2,338	2,009	4,347
Administrative	Census	4,888	46,648	25.00%	2.62%	99,268	-	2,600	-	2,600
Professional Fees	Census	4,888	46,648	25.00%	2.62%		105,930	-	2,775	2,775
Dues, Fees, Subscriptions and Promotions	Census	4,888	46,648	25.00%	2.62%		18,404	-	482	482
Clerical and Office Expenses	Census	4,888	46,648	25.00%	2.62%	308,978	112,344	8,094	2,943	11,037
Travel and Seminar	Census	4,888	46,648	25.00%	2.62%		18,667	-	489	489
Insurance - Property	Square Feet	1	8	100.00%	12.50%		63,865	-	7,983	7,983
Insurance - Liability	Census	4,888	46,648	25.00%	2.62%		62,746	-	1,644	1,644
Depreciation	Square Feet	1	8	100.00%	12.50%		175,654	-	21,957	21,957
Equipment Rental	Census	4,888	46,648	25.00%	2.62%		17,502	-	458	458
Employee Benefits	Census	4,888	46,648	25.00%	2.62%		1,129,289	-	29,583	29,583
						1,817,229	2,554,557	111,210	158,737	269,947

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			201,805	201,805		201,805	(22,097)	179,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,115	13,115		13,115	(13,115)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			847,873	847,873		847,873	(847,873)				34
35	Rent-Equipment & Vehicles			18,505	18,505		18,505	(458)	18,047			35
36	Other (specify):*											36
37	TOTAL Ownership			1,081,298	1,081,298		1,081,298	(883,543)	197,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,255	545,662	810,917		810,917		810,917			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,062	5,062		5,062		5,062			41
42	Provider Participation Fee			228,998	228,998		228,998		228,998			42
43	Other (specify):* Devel. / Chapel	37,464		62,502	99,966		99,966	(103,437)	(3,471)			43
44	TOTAL Special Cost Centers	37,464	265,255	842,224	1,144,943		1,144,943	(103,437)	1,041,506			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,642,871	801,917	3,877,599	9,322,387		9,322,387	(1,425,344)	7,897,043			45

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

		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	(17,590)	02		4
5	Telephone, TV & Radio in Resident Rooms	(54,774)	21		5
6	Rented Facility Space	(40,194)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,115)	32		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	(3,925)	21		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	(30,341)	21		24
25	Fund Raising, Advertising and Promotional	(5,246)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,934)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (169,119)		\$	30

BHF USE ONLY							
48		49		50		51	52

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (169,119)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
Our Lady of Angels Retirement Home

Page 5A

Report Period Beginning: ID# 0034975
Ending: 07/01/11
06/30/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Chapel Income	\$ (26,720)	11	1
2	Bank Charges	(3,470)	43	2
3	Theft Loss	(20)	21	3
4	Board Gifts	(92)	21	4
5	Memorial Expense	(406)	21	5
6	Chapel Expense (Non-Adjusted for Income)	(23,426)	43	6
7	Development Salary	(37,464)	43	7
8	Development Expenses	(39,077)	43	8
9	OLA Village - Maintenance	(7,153)	06	9
10	OLA Village - Cable	(5,312)	21	10
11	Capitalized Asset - Under \$2,500 Threshold	4,875	06	11
12	Capitalized Asset - Depreciation ADJ	(140)	30	12
13				13
14	Independent Living Units (Allocated Costs)			14
15	Dietary	(50,627)	01	15
16	Food	(31,953)	02	16
17	Housekeeping	(7,593)	03	17
18	Laundry	(2,653)	04	18
19	Heat & Other Utilities	(35,100)	05	19
20	Maintenance	(49,799)	06	20
21	Activities	(5,723)	11	21
22	Social Services	(3,144)	12	22
23	Program Transportation	(4,347)	14	23
24	Administrative	(2,600)	17	24
25	Professional Fees	(2,775)	19	25
26	Dues, Fees, Subscriptions & Promotions	(482)	20	26
27	Clerical & Office Expenses	(11,037)	21	27
28	Travel & Seminar	(489)	24	28
29	Insurance - Property	(7,983)	26	29
30	Insurance - Liability	(1,644)	26	30
31	Depreciation	-21957	30	31
32	Equipment Rental	-458	35	32

33	Employee Benefits	-29583	22	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	(408,352)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/11 Ending: 06/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(50,627)	0	0	0	0	0	0	0	0	0	0	(50,627)	1
2	Food Purchase	(49,543)	0	0	0	0	0	0	0	0	0	0	(49,543)	2
3	Housekeeping	(7,593)	0	0	0	0	0	0	0	0	0	0	(7,593)	3
4	Laundry	(2,653)	0	0	0	0	0	0	0	0	0	0	(2,653)	4
5	Heat and Other Utilities	(35,100)	0	0	0	0	0	0	0	0	0	0	(35,100)	5
6	Maintenance	(92,271)	0	0	0	0	0	0	0	0	0	0	(92,271)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(237,787)	0	0	0	0	0	0	0	0	0	0	(237,787)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	(32,443)	0	0	0	0	0	0	0	0	0	0	(32,443)	11
12	Social Services	(3,144)	0	0	0	0	0	0	0	0	0	0	(3,144)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,347)	0	0	0	0	0	0	0	0	0	0	(4,347)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(39,934)	0	0	0	0	0	0	0	0	0	0	(39,934)	16
	C. General Administration													
17	Administrative	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,775)	0	0	0	0	0	0	0	0	0	0	(2,775)	19
20	Fees, Subscriptions & Promotions	(9,662)	0	0	0	0	0	0	0	0	0	0	(9,662)	20
21	Clerical & General Office Expenses	(105,907)	0	0	0	0	0	0	0	0	0	0	(105,907)	21
22	Employee Benefits & Payroll Taxes	(29,583)	0	0	0	0	0	0	0	0	0	0	(29,583)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(489)	0	0	0	0	0	0	0	0	0	0	(489)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,627)	0	0	0	0	0	0	0	0	0	0	(9,627)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(160,643)	0	0	0	0	0	0	0	0	0	0	(160,643)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(438,364)	0	0	0	0	0	0	0	0	0	0	(438,364)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(22,097)	0	0	0	0	0	0	0	0	0	0	(22,097)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,115)	0	0	0	0	0	0	0	0	0	0	(13,115)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(847,873)	0	0	0	0	0	0	0	0	0	(847,873)	34
35	Rent-Equipment & Vehicles	(458)	0	0	0	0	0	0	0	0	0	0	(458)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(35,670)	(847,873)	0	0	0	0	0	0	0	0	0	(883,543)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	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):*	(103,437)	0	0	0	0	0	0	0	0	0	0	(103,437)	43
44	TOTAL Special Cost Centers	(103,437)	0	0	0	0	0	0	0	0	0	0	(103,437)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(577,471)	(847,873)	0	0	0	0	0	0	0	0	0	(1,425,344)	45

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
Sisters of St. Francis of Mary Immaculate	100					
The Congregation sponsors OLA as a non-profit organization.						

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	34	Rent	\$ 847,873	Sisters of St. Francis of Mary Immaculate	100.00%	\$	\$ (847,873)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 847,873			\$	\$ * (847,873)	14

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

Facility Name & ID Number

Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/11

Ending:

06/30/12

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	Lora McGuire	BOD						1
2	Pete Collins	BOD						2
3	Don Cordano	BOD						3
4	Sr. Mary Rose Lieb, OSF	BOD						4
5	Sr. Sue Bruno, OSF	BOD						5
6	Scott Czerkies	BOD						6
7	Susan Martin	BOD						7
8	George Block	BOD						8
9	Fr. William Dewan	BOD						9
10	Susan Parker	BOD						10
11	Sr. Marcian Deisenroth, OSF	BOD						11
12	Melodee Easton	BOD						12
13	Sr. Mary Frances Seeley, OSF	BOD						13
14	Kathy Birsas-Smith	BOD						14
15	Sr. M.J. Griffin, OSF	BOD						15
16	Steve Vanisko	BOD						16
17	Lee Bailey	BOD						17
18	Sr. Meg Guider, OSF	BOD						18
19	Carol Shaw-Burns	BOD						19
20	Diane Habinger	BOD						20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	Sr. Rita Vahling, OSF	Dir - Pastoral Care	Administrative	See Below	0	36	100.00	Salary	\$ 37,103	12 - 01	1
2	Sr. Donna Marie Baier, OSF	Volunteer Coord.	Administrative	See Below	0	35	100.00	Salary	29,740	11 - 01	2
3	Sr. Odelia Kloc, OSF	Enrichment Coord.	Administrative	See Below	0	40	100.00	Salary	37,909	11 - 01	3
4	Sr. Jane Nienaber	Pastoral Care	Administrative	See Below	0	16	100.00	Salary	3,904	12 - 01	4
5											5
6	The Sisters are members of										6
7	the Sisters of St. Francis that										7
8	sponsors OLA as a non-profit										8
9	organization.										9
10											10
11											11
12											12
13								TOTAL	\$ 108,656		13

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

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

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/11 Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2011 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 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007		8	
	2008		9	
	2009		10	
	2010		11	
	2011		12	

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Our Lady of Angels Retirement Home

COUNTY
Will

FACILITY IDPH LICENSE NUMBER
0034975

CONTACT PERSON REGARDING THIS REPORT
Diane M. Simon

TELEPHONE
(815) 553-4124
FAX #:
(815) 725-1451

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	N/A		\$	\$
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 X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326

B. General Construction Type: Exterior BrickFrame Steel & Brick

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

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	137		1962	1962	\$ 1,572,423	\$	40	\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		62593		15-40				9
10	Various		1993		149990		15-40				10
11	Various		1994		34476		15-40				11
12	Various		1995		89923		15-40				12
13	Various		1996		204209		15-40				13
14	Various		1997		365084		15-40				14
15	Various		1998		34996		15-40				15
16	Various		1999		5332		15-40				16
17	Various		2000		123450		15-40				17
18	Various		2001		54,577		15-40				18
19	Various		2002		398,917		15-40				19
20	Various		2003		83,462		15-40				20
21	Various		2004		133,665		15-40				21
22	Various		2005		80,832		15-40				22
23	Various		2006		78,669		15-40				23
24	Various		2007		3,208,187		15-40				24
25	Various		2008		73,616		15-40				25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	Various - Financial Statement Depreciation					108,042	15-40	108,042		1,346,372	35
36											36

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

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

See Page 12A, Line 70 for total

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	
37	Construction Renovations	2009	\$ 2,450	\$ 490	5 - 15	\$ 490	\$	\$ 1,225	37
38	Electrical Work	2009	4,423	442	5 - 15	442		1,769	38
39	Lighting Project - New Energy Efficient Fixtures	2009	58,423	3,895	5 - 15	3,895		9,737	39
40	AC Compressor	2010	29,546	2,955	5 - 15	2,955		7,387	40
41	Wired Glass for Doors	2010	3,682	245	5 - 15	245		613	41
42	Wired Glass for Doors	2010	1,395	93	5 - 15	93		186	42
43	New Doors - IDPH Survey Finding with Wired Glass	2010	1,274	85	5 - 15	85		163	43
44	Parking Lot Reseal	2010	3,400	680	5 - 15	680		1,360	44
45	Kitchen Hood System and Alarms	2010	8,399	840	5 - 15	840		1,610	45
46	Walk In Freezer Condensing unit	2010	4,900	490	5 - 15	490		939	46
47	Activity Room - Paint, Cabinents, Countertop, and Blinds	2010	5,692	453	5 - 15	453		869	47
48	Therapy Room - Tile, Blinds, Cabinents, Cubicle Curtains	2010	10,873	725	5 - 15	725		1,329	48
49	Elevator Upgrades	2011	97,951	6,530	5 - 15	6,530		9,257	49
50	Driveway - Paving and Drainage	2011	118,504	10,154	5 - 15	10,154		11,113	50
51	Lobby Renovations	2011	23,975	1,171	5 - 15	1,171		1,171	51
52	Heat & Smoke Detectors	2011	4,324	340	5 - 15	340		340	52
53	Boiler Work	2011	12,566	1,603	5 - 15	1,603		1,603	53
54	Model Room Renovations	2011	2,836	312	5 - 15	312		312	54
55	Parking Lot Reseal	2011	3,265	435	5 - 15	435		435	55
56	Roof Repair	2012	5,000	94	5 - 15	94		94	56
57	Air Conditioning Work	2012	3,247	27	5 - 15	27		27	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,160,526	\$ 140,101		\$ 140,101	\$	\$ 1,397,911	70

**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	\$509,862	\$57,116	\$57,116	\$		\$297,296	71
72	Current Year Purchases	14,863	2,582	2,582			2,582	72
73	Fully Depreciated Assets	546,305	2,006	2,006			605,255	73
74								74
75	TOTALS	\$1,071,030	\$61,704	\$61,704	\$		\$905,133	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	Facility	Freedom Van	1999	\$35,909	\$	\$	\$	5	\$35,909	76
77	Facility	Glaval Universal Bus	2002	54,750				5	54,750	77
78	Facility	Ford Five Hundred	2006	21,359				5	21,359	78
79	Facility	Chevy Truck	1997	26,820				5	26,820	79
80	TOTALS			\$138,838	\$	\$	\$		\$138,838	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$8,370,39481
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$201,80582
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$201,80583**
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)	\$2,441,88285

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	D2 Improvements	\$6,872	92
93			93
94			94
95		\$6,872	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sisters of St. Francis of Mary Immaculate
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								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: \$ 17,502
- Description: Copiers \$16,354 & Postage Machine \$1,148
- (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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist			hrs	\$		\$ 186,926	\$		\$ 186,926
2	Licensed Speech and Language Development Therapist	39 - 3	hrs			26,217			26,217	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 3	hrs			233,893			233,893	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 2	# of prescrpts				264,864		264,864	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs				2,211		2,211	11
12	Other (specify): See Supplemental	39 - 2								12
13	Other (specify): See Supplemental	39 - 2				96,805			96,805	13
14	TOTAL			\$		\$ 543,841	\$ 267,075		\$ 810,916	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.

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 16 Supplemental
07/01/11 - 06/30/12

Page 16 Line 12 Column 6: Other Ancillary Supplies

Oxygen	1,961
Medical Supplies	250
Total	<u>2,211</u>

Page 16 Line 12 Column 6: Other Ancillary Expense

Laboratory	39,491
Radiology	30,530
Ambulance	87
Other Hospital Services	26,696
Total	<u>96,805</u>

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	\$ 238,037	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,434)	1,227,057		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	6,065		5
6	Prepaid Insurance	179,144		6
7	Other Prepaid Expenses	21,485		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,671,788	\$	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	3,335,960		15
16	Equipment, at Historical Cost	1,222,543		16
17	Accumulated Depreciation (book methods)	(2,453,020)		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)	\$ 2,105,483	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,777,271	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 940,862	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	483,273		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,135		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)	\$ 1,426,270	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	700,000		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)	\$ 700,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,126,270	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,651,001	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,777,271	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,291,577	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,291,577	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(640,576)	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)	\$ (640,576)	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)	\$ 1,651,001	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Our Lady of Angels Retirement Home# 0034975Report Period Beginning: 07/01/11Ending: 06/30/12

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 8,413,185	1	
2 Discounts and Allowances for all Levels	()	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,413,185	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy		6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements		11	
12 Gift and Coffee Shop	5,659	12	
13 Barber and Beauty Care	5,189	13	
14 Non-Patient Meals	17,590	14	
15 Telephone, Television and Radio	2,250	15	
16 Rental of Facility Space	40,194	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)	\$ 70,882	23	
D. Non-Operating Revenue			
24 Contributions	143,485	24	
25 Interest and Other Investment Income***	2,952	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 146,437	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 <u>See Supplemental Schedule</u>	51,307	28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 51,307	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,681,811	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	1,880,314	31	
32 Health Care	3,283,931	32	
33 General Administration	1,931,901	33	
B. Capital Expense			
34 Ownership	1,081,298	34	
C. Ancillary Expense			
35 Special Cost Centers	915,945	35	
36 Provider Participation Fee	228,998	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,322,387	40	
41 Income before Income Taxes (line 30 minus line 40)**	(640,576)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (640,576)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 1,733,204	44	
45 Private Pay - Net Inpatient Revenue	3,854,992	45	
46 Medicare - Net Inpatient Revenue	2,381,326	46	
47 Other-(specify) <u>Independent Living</u>	443,663	47	
48 Other-(specify)		48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,413,185	49	

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

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

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

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

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 19 Supplemental
07/01/11 - 06/30/12

Page 19 Line 28 Column 1: Other Miscellaneous Income

Laundry and Vending Commissions	1,101
Activity / Ceramic Income (Adjusted Out Page 5)	-
Chapel Income (Adjusted Out Page 5)	26,720
Miscellaneous Income	11,021
OLA Village (Adjusted Out Page 5)	12,465
Total	<u>51,307</u>

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	1,859	2,080	\$ 77,233	\$ 37.13	1
2	Assistant Director of Nursing	1,836	2,010	65,340	32.51	2
3	Registered Nurses	32,896	34,779	997,765	28.69	3
4	Licensed Practical Nurses	17,763	19,505	482,116	24.72	4
5	CNAs & Orderlies	78,683	82,058	967,657	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,600	5,826	108,115	18.56	8
9	Activity Director	1,868	2,080	51,253	24.64	9
10	Activity Assistants	10,892	12,470	130,364	10.45	10
11	Social Service Workers	6,527	7,136	117,196	16.42	11
12	Dietician					12
13	Food Service Supervisor	1,824	2,080	59,716	28.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,963	33,375	372,405	11.16	15
16	Dishwashers	6,191	6,538	70,621	10.80	16
17	Maintenance Workers	10,247	11,327	239,829	21.17	17
18	Housekeepers	20,414	22,859	253,453	11.09	18
19	Laundry	8,599	10,334	91,835	8.89	19
20	Administrator	1,856	2,080	99,268	47.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,690	18,039	308,978	17.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,869	2,082	30,614	14.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplement</u>	4,888	5,289	119,113	22.52	33
34	TOTAL (lines 1 - 33)	259,465	281,947	\$ 4,642,871 *	\$ 16.47	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,296	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	Quarterly	1,560	10-03	37
38	Nurse Consultant	Quarterly	1,400	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	3,232	11-03	44
45	Social Service Consultant	Quarterly	3,018	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,506		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 20 Supplemental
07/01/11 - 06/30/12

Page 20 Line 33 Column 3: Other Salaries

MDS Clerk	CC 10	8,611
Central Supply Clerk	CC 10	50,727
Driver	CC 14	22,311
Development Director	CC 43	37,464
Total		<u>119,113</u>

STATE OF ILLINOIS

Facility Name & ID Number

Our Lady of Angels Retirement Home

0034975

Report Period Beginning:

07/01/11

Page 21

Ending:

06/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Carol Shaw-Burns

Administrator

0

\$ 99,268

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 99,268

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

DTW

Computer Consultant

\$ 45,914

SureQuest Systems

Data Processing

1,176

Barracuda Networks

Data Processing

2,237

NTT Data

Data Processing

20,747

Telusys

Data Processing

839

Nebo Systems

Data Processing

264

Ivans

Data Processing

3,733

Qquest Software Systems

Data Processing

3,242

CareTracker

Data Processing

9,438

Comcast

Internet Provider

1,718

Google Apps

Data Processing

1,436

See Supplemental Schedule

35,645

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$ 126,389

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 173,610

Unemployment Compensation Insurance

34,366

FICA Taxes

395,899

Employee Health Insurance

408,848

Employee Meals

3,690

Illinois Municipal Retirement Fund (IMRF)*

Employee Physicals

7,070

Pension

72,725

Other Employee Welfare

6,833

Pg. 5A Non-Allowable IL Costs

(29,583)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 1,073,458

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

315

Health Care Worker Background Check

(Indicate # of checks performed 42)

3,176

Patient Background Checks

Dues - Associations

9,735

Licenses & Fees

3,810

Advertising & Promotion

9,180

Pg 5A Non-Allowable IL Costs

(482)

Less: Public Relations Expense

(1,721)

Non-allowable advertising

(3,525)

Yellow page advertising

(3,934)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 18,544

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

6,663

Pg. 5A Non-Allowable IL Costs

(489)

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 6,174

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 21 Supplemental
07/01/11 - 06/30/12

Seminar Schedule

Seminar Title	Date	Location	Attendee	Attendee Title	Amount
Understanding the Impact of Health Care Reform on Employers	07/08/11	Naperville, IL	K. Baker	Payroll Clerk	329.00
MDS For Activites & Social Services	09/21/11	Chicago, IL	P. Mathiew	Social Services	179.00
SNF PPS Final Rule: Immediate Attention Required	9/16/2011 & 9/19/11	Webinar	D. Disera	Social Services	139.00
SNF PPS Final Rule: Immediate Attention Required	9/16/2012 & 9/19/12	Webinar	D. Hlavacik	MDS	139.00
HR Academy	10/15/11	Woodridge, IL	H. Klima	HR Director	189.00
Conflict Management Skills for Women	11/29/11	Oak Brook, IL	D. Lyle	R.N.	99.00
AICPA's 2011 1040 Tax Return	11/14 - 11/15/11	Chicago, IL	J. Brune	CFO	445.00
2011 Midwest Accounting	8/23 - 8/24/11	Rosemont, IL	J. Brune	CFO	285.00
Compilation & Review Update	08/31/11	Joliet, IL	J. Brune	CFO	210.00
Accounting & Auditing Update	09/14/11	Webinar	J. Brune	CFO	210.00
HR Law 2012 Seminar	01/24/12	Joliet, IL	K. Baker	Payroll Clerk	149.00
Payroll Law 2012	02/28/12	Joliet, IL	K. Baker	Payroll Clerk	199.00

Critical MDS Updates	03/15/12	Webinar	D. Disera	Social Services	100.00
Critical MDS Updates	03/15/12	Webinar	D. Hlavacik	MDS	100.00
Continuing the Care: Infection Prevention in the LT Care	3/8 - 3/9/12	Lisle, IL	S. Metes	DON	75.00
AMTA: Changing Winds: Innovation in Music Therapy	10/11 - 10/14/12	St. Charles, IL	O. Kloc	Enrichment Coordinator	525.00
CareTracker: Training Implementatio	07/14/11	Joliet, IL	Nursing All	Nursing All	1,034.05
Emergency Pamphlet	07/29/11	Joliet, IL	Employees	Department	317.84

Our Lady of Angels Retirement Home
Medicaid Cost Report - Page 21 Supplemental
07/01/11 - 06/30/12

Seminar Schedule

Seminar Title	Date	Location	Attendee	Attendee Title	Amount
Upstairs Solutions -On line Staff Training	07/13/11	Joliet, IL	Nursing	Nursing	250.00
Pharmacology Update	08/24/11	Kankakee, IL	S. Metes	DON	79.00
Wheelchair Seating & Positioning	10/20/11	Naperville, IL	K. Greer	Nursing	199.00
MDS 3.0 Navigator	02/03/12	Joliet, IL	Nursing	Nursing	56.00
Sanitation Seminar	6/5 &6/12/12	Joliet, IL	C. Adams	Dietary	170.00
Extinguishmen t Training	06/18/12	Joliet, IL	All Employees	All Department	1,185.00
Non-Allowable - Allocated					(489.00)
Total					6,173.89

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

LSN / AAHSA - \$8,292

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(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 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

30,997

Line

10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

X

YES

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

X

NO

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.

\$

228,998

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?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

3,690

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

17,590

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

Ln 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.