

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0034975</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Our Lady of Angels Ret Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</u> 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.	
Address: <u>1201 Wyoming Avenue</u> <u>Joliet</u> <u>60435</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Will</u>		Officer or Administrator of Provider Paid Preparer	
Telephone Number: <u>(815) 725-6631</u> Fax # <u>(815) 725-1451</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>8/1/1962</u>			
Type of Ownership:		(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____ (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____ ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			

Facility Name & ID Number Our Lady of Angels Ret Home

0034975 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 <u>N/A</u>					
	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>13,542</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5	<u>50</u>	Sheltered Care (SC)	<u>50</u>	<u>18,300</u>	5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,142	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>4,476</u>	<u>4,476</u>	8
9	SNF/PED					9
10	ICF	<u>11,243</u>	<u>12,236</u>		<u>23,479</u>	10
11	ICF/DD					11
12	SC		<u>12,027</u>		<u>12,027</u>	12
13	DD 16 OR LESS					13
14	TOTALS	11,243	24,263	4,476	39,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.74%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 8/10/1962

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 37 and days of care provided 3,854

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/20 Fiscal Year: 6/30/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/19 Ending: 6/30/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	478,425	50,625	14,709	543,759		543,759	(52,621)	491,138			1
2	Food Purchase		341,839		341,839		341,839	(37,096)	304,743			2
3	Housekeeping	176,600	65,221		241,821		241,821	(6,544)	235,277			3
4	Laundry	56,938	24,381		81,319		81,319	(9,398)	71,921			4
5	Heat and Other Utilities			223,690	223,690		223,690	(27,961)	195,729			5
6	Maintenance	143,035		259,647	402,682		402,682	(60,164)	342,518			6
7	Other (specify):* Trash Removal			29,933	29,933		29,933	(744)	29,189			7
8	TOTAL General Services	854,998	482,066	527,979	1,865,043		1,865,043	(194,528)	1,670,515			8
	B. Health Care and Programs											
9	Medical Director	31,702			31,702		31,702		31,702			9
10	Nursing and Medical Records	3,009,903	225,688	256,510	3,492,101		3,492,101		3,492,101			10
10a	Therapy											10a
11	Activities	126,985	6,931	11,488	145,404		145,404	(3,616)	141,788			11
12	Social Services	149,837		34,485	184,322		184,322	(3,726)	180,596			12
13	CNA Training											13
14	Program Transportation	28,946		6,424	35,370		35,370	(3,518)	31,852			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,347,373	232,619	308,907	3,888,899		3,888,899	(10,860)	3,878,039			16
	C. General Administration											
17	Administrative	89,707		401,560	491,267		491,267	(20,408)	470,859			17
18	Directors Fees											18
19	Professional Services			184,031	184,031		184,031	(170)	183,861			19
20	Dues, Fees, Subscriptions & Promotions			51,642	51,642		51,642		51,642			20
21	Clerical & General Office Expenses	296,057	19,032	60,580	375,669		375,669	(15,732)	359,937			21
22	Employee Benefits & Payroll Taxes			942,459	942,459		942,459	(18,025)	924,434			22
23	Inservice Training & Education			10,936	10,936		10,936		10,936			23
24	Travel and Seminar			809	809		809		809			24
25	Other Admin. Staff Transportation			1,811	1,811		1,811	(45)	1,766			25
26	Insurance-Prop.Liab.Malpractice			129,347	129,347		129,347	(10,675)	118,672			26
27	Other (specify):*											27
28	TOTAL General Administration	385,764	19,032	1,783,175	2,187,971		2,187,971	(65,055)	2,122,916			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,588,135	733,717	2,620,061	7,941,913		7,941,913	(270,443)	7,671,470			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			230,225	230,225		230,225	68,946	299,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,483	12,483		12,483	(650)	11,833			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			854,233	854,233		854,233	(854,233)				34
35	Rent-Equipment & Vehicles			24,293	24,293		24,293	(604)	23,689			35
36	Other (specify):*											36
37	TOTAL Ownership			1,121,234	1,121,234		1,121,234	(786,541)	334,693			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			891	891		891		891			38
39	Ancillary Service Centers		161,643	571,770	733,413		733,413		733,413			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		4,179		4,179		4,179		4,179			41
42	Provider Participation Fee			165,057	165,057		165,057		165,057			42
43	Other (specify):* Disallowed Costs			134,521	134,521		134,521	(134,521)				43
44	TOTAL Special Cost Centers		165,822	872,239	1,038,061		1,038,061	(134,521)	903,540			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,588,135	899,539	4,613,534	10,101,208		10,101,208	(1,191,505)	8,909,703			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,012)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,050)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,376)	4		8
9	Non-Straightline Depreciation	68,946	30		9
10	Interest and Other Investment Income	(650)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,341)	21		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	(361)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(170)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,796)	43		24
25	Fund Raising, Advertising and Promotional	(20,170)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(679)	43		28
29	Other-Attach Schedule See Page 5A	(343,613)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (337,272)		\$	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)	(854,233)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (854,233)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,191,505)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sisters Expenses	\$ (19,574)	43	1
2				2
3	Independent Living (Allocated Costs)			3
4	Dietary	(52,621)	1	4
5	Food	(31,084)	2	5
6	Housekeeping	(6,013)	3	6
7	Laundry	(2,022)	4	7
8	Heat & Other Utilities	(27,961)	5	8
9	Maintenance	(50,335)	6	9
10	Trash Removal	(744)	7	10
11	Activities	(3,616)	11	11
12	Social Services	(3,726)	12	12
13	Program Transportation	(3,518)	14	13
14	Administrative	(20,408)	17	14
15	Clerical & Office Expenses	(9,341)	21	15
16	Other Admin Staff Transportation	(45)	25	16
17	Insurance - Property	(9,311)	26	17
18	Insurance - Liability	(1,364)	26	18
19	Equipment Rental	(604)	35	19
20	Employee Benefits	(18,025)	22	20
21				21
22				22
23	Reclass Minor Capitalized Items to R&M	6,646	6	23
24	Capitalize R&M	(16,475)	6	24
25	Offset Housekeeping Income Against Expense	(531)	3	25
26	Disallow Cable TV	(72,941)	43	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(343,613)		49

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		N/A		N/A		
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	\$ 854,233	Sisters of St. Francis of Mary Immaculate	100.00%	\$	\$ (854,233)	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			\$ 854,233			\$	\$ * (854,233)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Board of Directors:							1
2	Kathryn Giegerich-President	0						2
3	Eileen Gutierrez-Vice Chair	0						3
4	Mary Jo Mackniskas-Finance Chair	0						4
5	Susan Batis-Secretary	0						5
6	Sr. Mary Jane Griffin, OSF-Board Membe	0						6
7	Sr. Dolores Zemont, OSF-Ethics Chair	0						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Our Lady of Angels Ret Home # 0034975 Report Period Beginning: 7/1/19 Ending: 6/30/20

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. Odelia Kloc, OSF	Enrichment Coord	Activities	See Below	0	25	100.00	Salary	25,292	11	1
2											2
3											3
4											4
5											5
6											6
7											7
8	Sister Kloc is a member of the Sisters of St Francis that sponsors Our Lady of Angels Retirement as a non-profit organization										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,292		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 6/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Cash Flows	Line of Credit		500,000					12,483	6
7													7
8													8
9	TOTAL Facility Related						\$ 500,000	\$				\$ 12,483	9
	B. Non-Facility Related*												
10													10
11							Offset Interest Income					(650)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$ (650)	14
15	TOTALS (line 9+line14)						\$ 500,000	\$				\$ 11,833	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		2019	\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 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:	2015		8	
	2016		9	
	2017		10	
	2018		11	
	2019		12	
This facility is a non-profit and does not pay real estate taxes				
		13	FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Our Lady of Angels Ret Home COUNTY Will

FACILITY IDPH LICENSE NUMBER 0034975

CONTACT PERSON REGARDING THIS REPORT Fred Struzyk

TELEPHONE (815) 725-6631 FAX #: (815) 725-1451

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.

A. Square Feet: 115,326

B. General Construction Type: Exterior BrickFrame Steel & BrickNumber 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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	137		1962	1962	\$ 1,572,423	\$	40	\$	\$	\$ 1,572,423	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1992		79,901		40			79,901	9
10	VARIOUS		1993		61,157	969	40	969		50,015	10
11	VARIOUS		1994		98,040	2,150	40	2,150		72,627	11
12	VARIOUS		1995		78,867	1,972	40	1,972		52,250	12
13	VARIOUS		1996		188,527	4,713	40	4,713		120,176	13
14	VARIOUS		1997		188,236	4,706	40	4,706		115,294	14
15	VARIOUS		1998		703,545	17,589	40	17,589		465,044	15
16	VARIOUS		1999		242,370	5,842	40	5,842		193,126	16
17	VARIOUS		2000		5,332	133	40	133		2,866	17
18	VARIOUS		2001		156,163	3,904	40	3,904		79,120	18
19	VARIOUS		2002		72,599	3,630	20	3,630		66,679	19
20	VARIOUS		2003		431,643	21,582	20	21,582		375,965	20
21	VARIOUS		2004		46,300	2,315	20	2,315		37,150	21
22	VARIOUS		2005		103,405	5,170	20	5,170		80,542	22
23	VARIOUS		2006		6,705	335	20	335		4,665	23
24	VARIOUS		2007		3,208,187	13,443	Various	80,205	66,762	1,042,661	24
25	VARIOUS		2008		73,616	4,468	Various	4,468		60,345	25
26	VARIOUS		2009		65,296	3,895	Various	3,895		47,770	26
27	VARIOUS		2010		69,161	4,298	Various	4,298		61,358	27
28	VARIOUS		2011		263,421	15,067	Various	15,067		173,112	28
29	VARIOUS		2012		8,247	575	Various	575		3,645	29
30	VARIOUS		2013		55,957	3,521	Various	3,521		38,328	30
31	VARIOUS		2014		149,917	1,716	Various	3,748	2,032	48,723	31
32	VARIOUS		2015		383,742	19,697	Various	19,697		114,700	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Our Lady of Angels Ret Home

0034975

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	Angels Café Remodel - carpet, paint, asbestos removal	2016	\$ 44,215	\$ 2,211	20	\$ 2,211	\$	\$ 9,014	37
38	Boiler Replacement	2016	4,947	247	20	247		1,010	38
39	Carpet - Offices - E Wing	2016	33,937	6,787	5	6,787		25,191	39
40	D-1 Copper Piping & Cover	2016	7,815	284	28	284		1,208	40
41	Air Conditioning repairs (main)	2016	3,628	363	10	363		1,482	41
42	A1/B1 Nurses Station - move & call light upgrade	2016	5,920	592	10	592		2,436	42
43	Camera/Wiring Closet Improvements	2017	10,804	878	10	878		3,290	43
44	Roof Replacement - B & D Wings	2017	134,860	6,743	28	6,743		24,724	44
45	Office Upgrades - Carpet & Paint - Upstairs Circle	2017	24,127	2,413	10	2,413		7,841	45
46	Electrical Work - A/C Outlet relocation- C Wings & Fire Alarms	2017	35,211	1,275	28	1,275		4,096	46
47	A/C Compressor - Chapel/Lobby/D-Wing	2017	8,936	596	15	596		1,837	47
48	Phone System Wiring	2017	3,804	136	28	136		419	48
49	Activity Room - Move - Asbestos removal, carpet, paint & electric	2017	33,978	2,265	15	2,265		6,796	49
50	Outdoor improvements - Pavers & sod	2017	8,045	536	15	536		1,609	50
51	Window screen replacement	2017	2,565	257	10	257		770	51
52	Activity Room - Remodel - acoustic ceilings, cabinets, A/C, window	2018	50,355	3,857	15	3,857		11,502	52
53	Electrical Work - Boiler Relief valve & Switch & Kitchen	2018	15,112	719	28	719		1,789	53
54	Roof Replacement - B & D Wings & Circle	2018	214,800	5,508	39	5,508		13,769	54
55	Carpet - Offices - Second floor	2018	7,092	1,418	5	1,418		3,198	55
56	Replacement of Main water pipe - D1	2018	18,932	757	25	757		1,704	56
57	Fire Door Improvements - Skilled Unit	2018	6,434	428	15	428		929	57
58	Mold Remediation - C Unit	2019	15,248	454	28	454		908	58
59	Copper Pipe & Fittings - B1	2019	7,754	180	25	180		388	59
60	EPDM Membrane - Main entry & Canopies	2019	32,800	350	39	350		771	60
61	Burner Repairs - Boiler	2019	7,806	82	20	82		180	61
62	Asbestos Removal - B1	2019	3,495	19	15	19		39	62
63	Auditorium Remodel-Carpeting/Flooring, Draperies, Designer	2019	9,098	31	20	455	424	455	63
64	Leaking Pipes-A1 Wing	2019	2,900		20	145	145	145	64
65	Lighting-Chapel and Rear of Building	2019	4,148		20	207	207	207	65
66	Repair AC Unit-Chapel	2019	3,072		20	154	154	154	66
67	Painting-C1 and C2 Dining Area and Pantry	2020	3,100		20	155	155	155	67
68	Repair Boiler	2020	3,255		20	163	163	163	68
69	Financial Basis Depreciation-Non Medicaid Assets			2,042			(2,042)		69
70	TOTAL (lines 4 thru 69)		\$ 9,080,950	\$ 183,118		\$ 251,118	\$ 68,000	\$ 5,086,664	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 351,154	\$ 39,235	\$ 39,235	\$	3-15 Yrs	\$ 185,463	71
72	Current Year Purchases	41,622	452	452		5-10 Yrs	452	72
73	Fully Depreciated Assets	569,842					569,842	73
74								74
75	TOTALS	\$ 962,618	\$ 39,687	\$ 39,687	\$		\$ 755,757	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	Fully Depreciated Vehicles		\$ 95,085	\$	\$	\$		\$ 95,085	76
77	Facility	Repairs	2012	3,038					3,038	77
78	Facility	Tires & Suspension	2015	2,965	247	247		5	2,965	78
79	Facility	Ford Bus	2015	53,798	7,173	8,119	946	5	53,798	79
80	TOTALS			\$ 154,886	\$ 7,420	\$ 8,366	\$ 946		\$ 154,886	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)	\$ 10,198,454	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 230,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,171	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 68,946	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,997,307	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related Party Rent is Eliminated-N/A
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 leaseN/A.
9. Option to Buy:☐ YES☒ NOTerms: N/A*

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:\$23,689Description:Copiers - \$19,061, Therapy Equip - \$4,966, Other - \$266, IL Offset - (\$604)
(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

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

ALLOCATION OF COSTS (d)

		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$		\$ 229,572	\$		\$ 229,572	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			63,346			63,346	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs			242,409	6,991		249,400	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				151,773		151,773	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Attached PG16A					36,443	2,879		39,322	12
13	Other (specify):									13
14	TOTAL			\$		\$ 571,770	\$ 161,643		\$ 733,413	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Our Lady of Angels Ret Home

Period Beginning 7/1/19
Period End 6/30/20

Schedule 16A

Page 16 Line 12 Columns 5 and 6: Other Ancillary Supplies and Services

	Outside Practitioner Supplies	
Respiratory		2,879
Laboratory	26,136	
Radiology	10,307	
TOTAL	36,443	2,879

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,449,417	\$ 1,449,417	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 747,910)	906,667	906,667	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,816	20,816	6
7	Other Prepaid Expenses	30,855	30,855	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,407,755	\$ 2,407,755	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		1,572,423	14
15	Leasehold Improvements, at Historical Cost	4,518,492	7,508,527	15
16	Equipment, at Historical Cost	1,122,792	1,117,504	16
17	Accumulated Depreciation (book methods)	(3,601,877)	(5,997,307)	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)	\$ 2,039,407	\$ 4,201,147	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,447,162	\$ 6,608,902	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 451,749	\$ 451,749	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	353,159	353,159	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 804,908	\$ 804,908	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PPP Loan	874,798	874,798	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 874,798	\$ 874,798	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,679,706	\$ 1,679,706	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,767,456	\$ 4,929,196	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,447,162	\$ 6,608,902	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,520,555	1
2	Restatements (describe):		2
3	Post Closing Adjustments-Bad Debt Expense	(434,975)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,085,580	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	681,876	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)	\$ 681,876	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,767,456	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Our Lady of Angels Ret Home

0034975

Report Period Beginning: 7/1/19

Ending:

6/30/20

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,633,937	1
2	Discounts and Allowances for all Levels	(1,687,019)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,946,918	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,603	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 175,603	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	381,476	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,249	12
13	Barber and Beauty Care	2,112	13
14	Non-Patient Meals	6,012	14
15	Telephone, Television and Radio	4,050	15
16	Rental of Facility Space	42,773	16
17	Sale of Drugs	31,555	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	56,374	21
22	Laundry	7,376	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 533,977	23
	D. Non-Operating Revenue		
24	Contributions	92,098	24
25	Interest and Other Investment Income***	650	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92,748	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19A</u>	33,838	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33,838	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,783,084	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,865,043	31
32	Health Care	3,888,899	32
33	General Administration	2,187,971	33
	B. Capital Expense		
34	Ownership	1,121,234	34
	C. Ancillary Expense		
35	Special Cost Centers	873,004	35
36	Provider Participation Fee	165,057	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,101,208	40
41	Income before Income Taxes (line 30 minus line 40)**	681,876	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 681,876	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,626,830	44
45	Private Pay - Net Inpatient Revenue	4,929,493	45
46	Medicare - Net Inpatient Revenue	2,242,077	46
47	Other-(specify) <u>Independent Living</u>	488,119	47
48	Other-(specify) <u>Managed Care</u>	660,399	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,946,918	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Our Lady of Angels Ret Home

Period Beginning 7/1/19
Period End 6/30/20

Schedule 19A

Page 19 Line 28 Columns 1: Other Revenues

Housekeeping Fees	531
Discounts Earned	2,341
Chapel Income	30,966

TOTAL	<u>33,838</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	1,996	2,202	\$ 86,817	\$ 39.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,578	24,155	771,301	31.93	3
4	Licensed Practical Nurses	19,469	21,159	552,102	26.09	4
5	CNAs & Orderlies	77,308	82,108	1,287,333	15.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,098	4,436	74,968	16.90	8
9	Activity Director	1,931	2,077	39,281	18.91	9
10	Activity Assistants	6,643	7,120	87,704	12.32	10
11	Social Service Workers	3,693	4,222	93,970	22.26	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,160	52,126	24.13	13
14	Head Cook	15,245	16,386	215,287	13.14	14
15	Cook Helpers/Assistants	17,972	18,480	186,027	10.07	15
16	Dishwashers	2,318	2,378	24,985	10.51	16
17	Maintenance Workers	6,318	7,280	143,035	19.65	17
18	Housekeepers	14,983	16,492	176,600	10.71	18
19	Laundry	4,934	5,877	56,938	9.69	19
20	Administrator	1,744	2,143	89,707	41.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,041	16,515	296,057	17.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	654	654	31,702	48.47	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,956	2,162	33,734	15.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	11,509	12,937	288,461	22.30	33
34	TOTAL (lines 1 - 33)	232,414	250,943	\$ 4,588,135 *	\$ 18.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,825	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	Quarterly	715	L10, C3	37
38	Nurse Consultant	Intermittent	4,566	L10, 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	Monthly	1,144	L11, C3	44
45	Social Service Consultant	Quarterly	691	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,941		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	252	\$ 8,771	L10, C3	50
51	Licensed Practical Nurses	1,031	52,776	L10, C3	51
52	Certified Nurse Assistants/Aides	4,958	172,222	L10, C3	52
53	TOTAL (lines 50 - 52)	6,241	\$ 233,769		53

SEE ACCOUNTANTS' PREPARATION REPORT

Our Lady of Angels Ret Home

Period Beginning	7/1/19
Period End	6/30/20

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nurse Scheduler	2,090	2,350	57,396	24.42
Care Plan Coordinator	1,729	1,877	32,010	17.05
MDS Coordinator	2,232	2,412	87,519	36.28
Resident Aides	1,880	2,249	26,723	11.88
Driver	1,647	1,856	28,946	15.60
Chapel	1,931	2,193	55,867	25.48
TOTAL	11,509	12,937	288,461	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
George Block	Administrator	0	\$ 10,265	Workers' Compensation Insurance		\$ 191,934	IDPH License Fee	\$ 995	
Diane Simon	Administrator	0	36,006	Unemployment Compensation Insurance		9,035	Advertising: Employee Recruitment	38,604	
Dane Moscatelli	Administrator	0	11,036	FICA Taxes		332,137	Health Care Worker Background Check		
Lucille Judith Hoffman	Administrator	0	32,400	Employee Health Insurance		330,548	(Indicate # of checks performed 440)	3,702	
				Employee Meals		30,890	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Dues	1,321	
				Employee Life Insurance		3,658	Leading Age Illinois	5,354	
				Employee Physicals		18,824	Miscellaneous Licenses and Fees	1,666	
				Pension Plan		9,901			
				Employee Relations		14,392			
				Uniforms		1,140			
				Less IL Allocation		(18,025)			
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		\$ 924,434	TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 89,707	line 22, col.8)			line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Premier Health Care Management			\$ 401,560				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 401,560				In-State Travel		
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Leaderstat	Consultant		\$ 31,659						
Plante Moran	Consultant		18,436						
Risk Mgmt Serv	Consultant		100	N/A					
Personnel Planners	Unemployment		1,800						
Wermer, Rogers, Doran & Ruzan	Accounting		5,000						
Templin Healthcare Accounting	Accounting		2,419						
Pointclick Care	Data Processing		49,568						
Ability Network	Data Processing		9,230				Seminar Expense	809	
AT&T	Data Processing		947						
Smartlinx	Data Processing		25,902						
Cantata Health	Data Processing		3,628						
See Attached PG21A			35,342						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	()	
(For legal fee disclosure, see page 39 of instructions)			\$ 184,031				(agree to Sch. V,		
							line 24, col. 8)	\$ 809	

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Our Lady of Angels Ret Home

Period Beginning **7/1/19**
Period End **6/30/20**

Schedule 21A

Page 21 Section C: Other Professional Fees

Careworx Corp	Data Processing	2,807
Telusys	Data Processing	62
DTW	Computer	8,152
Hilltop Healthcare Center	Consultant	833
Tom Opatz	Consultant	16,463
See Attached Legal Schedule	Legal Fees	7,025
TOTAL		<u><u>35,342</u></u>

XX. GENERAL INFORMATION:

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. 5,354 Leading Age Illinois
- (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?
What was the average life used for new equipment added during this period? Yes
5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ 38,654 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (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. \$ 165,057
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes-See Att Sch 22A 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. \$ 30,890 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,012
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 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? N/A
- 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 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Our Lady of Angels Ret Home
Schedule 22A
Period Beginning
Period End

7/1/19
6/30/20

Cost Centers	Allocation Basis	Independent Living	Facility Total	Factor	% IL to Facility	Salary / Expense	IL Total	
Dietary Wages	Meals Served	13,248	133,194	100.00%	9.95%	478,425	47,586	50-6003
Dietary Supplies	Meals Served	13,248	133,194	100.00%	9.95%	50,625	5,035	50-6220
Food (not supplements or tube feedings)	Meals Served	13,248	133,194	100.00%	9.95%	312,511	31,084	50-6200
Housekeeping Wages	Census Factored	4,416	44,398	25.00%	2.49%	176,600	4,391	52-6010
Housekeeping Supplies	Census Factored	4,416	44,398	25.00%	2.49%	65,221	1,622	52-6220
Laundry Wages	Census Factored	4,416	44,398	25.00%	2.49%	56,938	1,416	56-6002
Laundry Supplies	Census Factored	4,416	44,398	25.00%	2.49%	24,381	606	56-6220
Heat and Other Utilities	Square Feet	1	8	100.00%	12.50%	223,690	27,961	54-6730
Maintenance Wages	Square Feet	1	8	100.00%	12.50%	143,035	17,879	54-6003
Maintenance Other	Square Feet	1	8	100.00%	12.50%	259,647	32,456	54-6632
Trash Removal	Census Factored	4,416	44,398	25.00%	2.49%	29,933	744	54-6770
Activities Wages	Census	4,416	44,398	25.00%	2.49%	126,985	3,158	24-6010
Activities Supplies	Census	4,416	44,398	25.00%	2.49%	6,931	172	24-6220
Activities Other	Census	4,416	44,398	25.00%	2.49%	11,488	286	24-6222
Social Services Wages	Census	4,416	44,398	25.00%	2.49%	149,837	3,726	22-6001
Program Transportation Wages	Census	4,416	44,398	100.00%	9.95%	28,946	2,879	10-6009
Program Transportation Other	Census	4,416	44,398	100.00%	9.95%	6,424	639	10-7001
Administrator Wages	Census	4,416	44,398	25.00%	2.49%	89,707	2,231	10-6000
Management Fees	Revenues	488,119	#####	100.00%	4.53%	401,560	18,177	90-6990
Clerical and Office Wages	Census	4,416	44,398	25.00%	2.49%	296,057	7,362	10-6007
Clerical and Office Supplies	Census	4,416	44,398	25.00%	2.49%	19,032	473	10-6220
Clerical and Office Other	Census	4,416	44,398	25.00%	2.49%	60,580	1,506	10-6700
Travel and Seminar	Census	4,416	44,398	25.00%	2.49%		-	
Other Admin Staff Transportation	Census	4,416	44,398	25.00%	2.49%	1,811	45	10-7000
Insurance - Property	Square Feet	1	8	100.00%	12.50%	74,489	9,311	90-6842
Insurance - Liability	Census	4,416	44,398	25.00%	2.49%	54,858	1,364	90-6840
Equipment Rental	Census	4,416	44,398	25.00%	2.49%	24,293	604	10-6810
Employee Benefits	Allocated Wages	87,749	4,588,135	100.00%	1.91%	942,459	18,025	80-0170
							<u>4,116,463</u>	<u>240,738</u>

The Independent Living Square Feet comprises about 1/8 of the total campus
A factor of 25% has been applied to various expense groups because of less complexity/workload for IL residents