FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0048652

Facility Name: Holy Family Nursing & Rehab Center

Address: 2380 E. Dempster Street (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847) 296-3335 **Fax #** (847) 296-2027

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1981

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
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 07/01/2009 to 06/30/2010 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) 10/29/2010 (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) 10/29/2010 (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Fax # 630-530-7106

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 Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	149	Intermediate (ICF)	149	54,385	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,503	1,879	12,878	24,260	8
9	SNF/PED					9
10	ICF	25,769	5,274	1,371	32,414	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,272	7,153	14,249	56,674	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.86%

D. How many bed-hold days during this year were paid by the Department?
None (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)
None

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/01/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1981 NO [ ]

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	465,689		63,507	529,196		529,196		529,196			1
2	Food Purchase		329,303		329,303		329,303	(474)	328,829			2
3	Housekeeping	271,128	46,546	24,166	341,840		341,840		341,840			3
4	Laundry	175,751	56,664	1,762	234,177		234,177		234,177			4
5	Heat and Other Utilities			265,900	265,900		265,900		265,900			5
6	Maintenance	131,073	61,288	260,293	452,654		452,654		452,654			6
7	Other (specify):*											7
8	TOTAL General Services	1,043,641	493,801	615,628	2,153,070		2,153,070	(474)	2,152,596			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,057,083	397,352	438,782	4,893,217		4,893,217	(3,106)	4,890,111			10
10a	Therapy	677,920	988	191,990	870,898		870,898		870,898			10a
11	Activities	139,298	4,454	4,500	148,252		148,252		148,252			11
12	Social Services	167,056	1,419	5,504	173,979		173,979		173,979			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,041,357	404,213	658,776	6,104,346		6,104,346	(3,106)	6,101,240			16
	C. General Administration											
17	Administrative			1,393,023	1,393,023		1,393,023	(380,910)	1,012,113			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			8,314	8,314		8,314		8,314			20
21	Clerical & General Office Expenses	513,133	27,831	(504,338)	36,626		36,626	588,199	624,825			21
22	Employee Benefits & Payroll Taxes			2,440,313	2,440,313		2,440,313	103,836	2,544,149			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			307	307		307		307			25
26	Insurance-Prop.Liab.Malpractice			(8,699)	(8,699)		(8,699)		(8,699)			26
27	Other (specify):*											27
28	TOTAL General Administration	513,133	27,831	3,328,920	3,869,884		3,869,884	311,125	4,181,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,598,131	925,845	4,603,324	12,127,300		12,127,300	307,545	12,434,845			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holy Family Nursing & Rehab Center #0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			511,812	511,812		511,812	107,063	618,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,650	127,650		127,650	(104,177)	23,473			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			639,462	639,462		639,462	2,886	642,348			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,853,341		1,853,341		1,853,341		1,853,341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,789	137,789		137,789		137,789			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,853,341	137,789	1,991,130		1,991,130		1,991,130			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,598,131	2,779,186	5,380,575	14,757,892		14,757,892	310,431	15,068,323			45

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	(474)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,637)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	585,093			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 582,982		$	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)	(272,551)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (272,551)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 310,431		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

Holy Family Nursing & Rehab Center

ID# 0048652

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Charegabel Supplies - Other Rev	$ (3,106)	10	1
2	Admin- Other Revenue	(40,460)	21	2
3	Admin- Telephone Communication Negative Rev	59	21	3
4	Charity Operating Rev - Recorded as Negative Exp	628,600	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	585,093		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(474)	0	0	0	0	0	0	0	0	0	0	(474)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(474)	0	0	0	0	0	0	0	0	0	0	(474)	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	(3,106)	0	0	0	0	0	0	0	0	0	0	(3,106)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,106)	0	0	0	0	0	0	0	0	0	0	(3,106)	16
	C. General Administration													
17	Administrative	0	(380,910)	0	0	0	0	0	0	0	0	0	(380,910)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	588,199	0	0	0	0	0	0	0	0	0	0	588,199	21
22	Employee Benefits & Payroll Taxes	0	103,836	0	0	0	0	0	0	0	0	0	103,836	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	588,199	(277,074)	0	0	0	0	0	0	0	0	0	311,125	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	584,619	(277,074)	0	0	0	0	0	0	0	0	0	307,545	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	107,063	0	0	0	0	0	0	0	0	0	107,063	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,637)	(102,540)	0	0	0	0	0	0	0	0	0	(104,177)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,637)	4,523	0	0	0	0	0	0	0	0	0	2,886	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	582,982	(272,551)	0	0	0	0	0	0	0	0	0	310,431	45

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	Please Refer to Attached Page 6A		Please Refer to Attached Page 6A		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	17	Administration	1,393,023	Resurrrection Health Care	100.00%	1,012,113	(380,910)	2
3	V	22	Employee Benefits		Resurrrection Health Care	100.00%	103,836	103,836	3
4	V	30	Depreciation		Resurrrection Health Care	100.00%	107,063	107,063	4
5	V	32	Interest	127,650	Resurrrection Health Care	100.00%	25,110	(102,540)	5
6	V								6
7	V								7
8	V								8
9	V	39	Intercompany Rx	1,853,341	Resurrrection Health Care	100.00%	1,853,341		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,374,014			$ 3,101,463	$ * (272,551)	14

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

Resurrection Health Care
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2010

Related Organizations	Fed Tax ID No	Tax Status
Family Medical Network	36-3961066	Non-Exempt
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Nursing & Rehab Center	36-3121158	Exempt
Holy Family Medical Center	36-2439318	Exempt
Key Opportunities Inc.	36-3499869	Non-Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Mount Loretto Nursing Home	14-1363014	Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Foundation	36-3466794	Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Rest Home	14-1348691	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt
Saint Mary of Nazareth PHO	36-4006358	Non-Exempt
Stamana, Inc.	36-3314912	Non-Exempt
Westlake Community Hospital	36-1649520	Exempt
West Suburban Health Providers	36-3980942	Non-Exempt
West Suburban Health Services	36-4286236	Exempt
West Suburban Medical Center	36-2182170	Exempt

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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

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

RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS

	Office
Sandra Bruce *Ex Officio*	President & CEO Resurrection Health Care 7435 W. Talcott Avenue Suite 520 Chicago, IL 60631 Phone: 773-792-5555 Fax: 773-990-8601 SBruc01@reshealthcare.org
John Baird	Executive Vice President/CEO Holy Family Medical Center 100 N. River Road Des Plaines, IL 60016 Phone: 847-813-3161 Fax: 847-297-1863 John.Baird@reshealthcare.org
Connie March	President Provena Senior Services 19065 Hickory Creek Drive Suite 310 Mokena, IL 60448-8507 Phone: 708-478-7922 Fax: 708-478-5143 Connie.march@provena.org
Michael J. Nabolotny, M.D.	Resurrection Medical Center 7447 W. Talcott Avenue Suite 262 Chicago, IL 60631 Phone: 773-775-1900 Fax: 773-775-8034 Timc262@sbcglobal.net
Lawrence Pankau, M.D.	132 S. Prospect Park Ridge, IL 60068 Phone: 847-825-6631 Fax: 847-825-8684 Lawrence.Pankau@reshealthcare.org
Sr. Elizabeth Trem, CSFN	Executive Director Casa San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-562-4300 Fax: 708-492-0548 ETrem@reshealthcare.org
Sr. Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Medical Center 7435 W. Talcott Avenue Chicago, IL 60631 Phone: 773-774-8000 Fax: 773-990-7626 Sdonna@reshealthcare.org
John Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 Fax: 847-813-3876 Jwalton@reshealthcare.org

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2009

Title	Name
President	Mr. Joseph F. Toomey
Group Vice President and EVP/CEO	Mr. John R. Walton
Secretary	Mr. Jeannie C. Frey
Treasurer	Mr. Tom Capobianco
Assistance Secretary	Mr. John R. Walton

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

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 [X] NO [ ]

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

Name of Related Organization: Resurrection Health Care
Street Address: 7435 W Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	17	Adminstration							1,012,113	2
3	22	Employee Benefits\							103,836	3
4	30	Depreciation							107,063	4
5	32	Interest							25,110	5
6										6
7										7
8										8
9	39	Intercompany Rx							1,853,341	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					$	$		$ 3,101,463	25

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12	Interest							Interest Income			1,637	12
13								Interest Income Offset			(1,637)	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. $ No Line # N/A

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

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2010 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:		
2005		8
2006		9
2007		10
2008		11
2009	N/A	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048652

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald, Controller

TELEPHONE (773) 813-3722 FAX #: (773) 813-3785

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.		N/A	$	$
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 N/A 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 136,250 B. General Construction Type: Exterior Face Brick Frame Steel Number of Stories 6

C. Does the Operating Entity? [X] (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? [X] (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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 610,897	1
2	Resident Use		1984-2007	1,064,530	2
3	TOTALS			$ 1,675,427	3

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	251		1981	1963	$ 11,005,165	$		$	$	$ 11,005,165	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	!st Floor Renovation - Professional Services & Insulation			2007	2,367	270	7-10	270			9
10	Resurface Terrace			2007	38,736	4,842	8	4,842			10
11	Electrical Engineering for HFNRC			2007	2,500	167	15	167			11
12	Furnish & Install New Door & Apply Weatherstripping			2007	7,434	496	15	496			12
13	Replace Main Entrance Drive			2007	43,579	2,905	15	2,905			13
14	Remove & Install 3 Travelling Cables			2007	8,270	1,034	8	1,034			14
15	Purchase & Installation of 2 Friedrich A/C's			2007	16,735	2,092	8	2,092			15
16	Auditorium Smoke Walls			2007	6,177	412	15	412			16
17	Purchase & Installation of 50 Doors in various locations			2007	8,713	871	10	871			17
18	Replace Hot Water Heater			2007	7,199	480	15	480			18
19	Repair/Replace Pump & Check Valve			2007	3,072	307	10	307			19
20	Nurse Call System			2007	47,900	4,790	10	4,790			20
21	Install Circuit Panel for Dialysis System			2007	4,367	546	8	546			21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Major Landscaping Improvements	2008	$ 17,254	$ 3,451	5	$ 3,451	$	$	37
38	Replace Hot Water Heater	2008	7,222	481	15	481			38
39	Fabricate & Install grading, ladder & platforms for North Patio	2008	7,958	531	15	531			39
40	Boiler Repair	2008	8,300	415	20	415			40
41	Repair water damage in elevators	2008	2,764	138	20	138			41
42	Replace shower valves	2008	12,470	1,781	7	1,781			42
43	Carpeting	2008	2,658	532	5	532			43
44	Emergency generator & auto switch	2008	3,707	741	5	741			44
45	Remove & Install new tubs	2008	9,136	914	10	914			45
46	R&M Reclass - Install new float & ball	2008	5,306		15	177	177		46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,278,989	$ 28,196		$ 28,373	$ 177	$ 11,005,165	70

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,278,989	$ 28,196		$ 28,373	$ 177	$ 11,005,165	1
2	Boiler Room Piping Room Repairs	2009	3,176	227	7	227	(0)		2
3	Automatic Transfer Switch	2009	17,458	727	12	727	(0)		3
4	ComEd Smart Ideas Program - Lighting Retrofit	2009	7,210	360	10	360	(0)		4
5	L& M to install Remote Generator Annuniator and Transfer Switch #2	2009	7,244	241	15	241	(0)		5
6	Install Fire Dampers	2009	40,080	2,004	10	2,004			6
7	ComEd Smart Ideas Program - Lighting Retrofit	2009	9,029	451	10	451			7
8	Expand Sprinkler System	2009	13,363	267	25	267			8
9	Install Guard Rails	2009	7,176	449	8	449			9
10	ComEd Smart Ideas Program - Lighting Retrofit	2009	220	-	10	11	11		10
11	ComEd Smart Ideas Program - Lighting Retrofit	2009	13,840	692	10	692			11
12	Canopy Repairs	2009	8,890	445	10	445			12
13	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,091	55	10	55			13
14	Repair roof flashing & leaking areas, Install new modified Bitumen	2009	10,000	500	10	500			14
15	Expansion of Dialysis Stations	2009	19,020	1,902	5	1,902			15
16	Piston & Cylinder replacement on lobby elevator	2009	17.869	893	10	893	(0)		16
17									17
18									18
19									19
20	ComEd Smart Ideas Program - Lighting Retrofit	2010	586	29	10	29	0		20
21	ComEd Smart Ideas Program - Lighting Retrofit	2010	553	28	10	28	(0)		21
22	Beds + Life Gate	2010	15,232	635	12	635	(0)		22
23	Piston & Cylinder replacement on lobby elevator FINAL BILLING	2010	17,869	893	10	893	(0)		23
24	Installation of OXEQUIP DISS Outlets on 2nd & 3rd floors	2010	19,550	652	15	652	(0)		24
25	Stairwell Ceiling Spray Fireproofing	2010	6,935	347	10	347			25
26	Oxygen Flowmeters and Piping	2010	20,275	1,267	8	1,267	(0)		26
27	EDWARDS FIRE ALARM SYSTEM - INSTALLATION	2010	25,200	1,260	10	1,260			27
28									28
29	Home Office Allocation			(11,271)		(11,271)			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,560,855	$ 31,250		$ 31,438	$ 188	$ 11,005,165	34

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 4,539,213	$ 454,778	$ 454,778	$	5-15	$ 3,000,811	71
72	Current Year Purchases	281,866	14,325	14,325			14,325	72
73	Fully Depreciated Assets							73
74	Home Office Allocation		118,334	118,334				74
75	TOTALS	$ 4,821,079	$ 587,437	$ 587,437	$		$ 3,015,136	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 18,057,361	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 618,687	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 618,875	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 188	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,020,301	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			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. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 290,334 Description: See Attached Page 14A For The Details
    (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.

Holy Family Nursing and Rehab Center

Provider Number: 0026286

FYE: 30-Jun-10

Attachment to Schedule XII, Line 16- Equipment Rental Cost

(Sub Acct 70200

Equipment	Amount
Copiers	12,913
Medical Equipment	96,554
Postage Services	846
Special Beds	52,094
Therapeutic Equipment	127,927
Total Equipment Lease Exp	290,334

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		680	hrs	$ 34,916	1,448	$ 93,862	$	2,128	$ 128,778	1
2	Licensed Speech and Language Development Therapist		1020	hrs	35,683	313	20,513		1,333	56,196	2
3	Licensed Recreational Therapist			hrs		6	296		6	296	3
4	Licensed Physical Therapist		3251	hrs	140,819				3,251	140,819	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				1,853,341		1,853,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Respiratroy Thearapist		14081		365,504				14,081	365,504	12
13	Other (specify):										13
14	TOTAL				$ 576,922	1,767	$ 114,671	$ 1,853,341	20,799	$ 2,544,934	14

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

Facility Name & ID Number Holy Family Nursing & Rehab Center **#** 0048652 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,135,073	$ 1,135,073	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,405,193))	1,274,486	1,274,486	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,717	8,717	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,418,276	$ 2,418,276	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,675,427	1,675,427	13
14	Buildings, at Historical Cost	14,370,863	14,370,863	14
15	Leasehold Improvements, at Historical Cost	217,016	217,016	15
16	Equipment, at Historical Cost	1,794,055	1,794,055	16
17	Accumulated Depreciation (book methods)	(11,803,426)	(11,803,426)	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)**	$ 6,253,935	$ 6,253,935	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,672,211	$ 8,672,211	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 133,785	$ 133,785	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,852	31,852	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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		24,429,345	24,429,345	36
37	Payable to Medicare & Other differed Lia	63,863	63,863	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 24,658,845	$ 24,658,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 24,658,845	$ 24,658,845	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,986,634)	$ (15,986,634)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,672,211	$ 8,672,211	48

***(See instructions.)**

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (12,879,189)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (12,879,189)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,122,677)	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)**	$ (3,122,677)	17
	B. Transfers (Itemize):		
18	**Net Asset Released**	15,232	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 15,232	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (15,986,634)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,555,853	1
2	Discounts and Allowances for all Levels	(5,716,170)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,839,683	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	474	14
15	Telephone, Television and Radio	(59)	15
16	Rental of Facility Space	260,412	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	3,106	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	7,538	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 271,471	23
	D. Non-Operating Revenue		
24	Contributions	250	24
25	Interest and Other Investment Income***	1,637	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,887	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Asset Released	14	28
28a	Other Misc Admin. Rev	40,460	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,474	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,153,515	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,153,070	31
32	Health Care	6,104,346	32
33	General Administration	3,869,884	33
	B. Capital Expense		
34	Ownership	639,462	34
	C. Ancillary Expense		
35	Special Cost Centers	1,853,341	35
36	Provider Participation Fee	137,789	36
	D. Other Expenses (specify):		
37	Provision for Bad Debts	518,300	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,276,192	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,122,677)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,122,677)	43

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

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

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

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

Holy Family Nursing and Rehab Center

Medicaid Provider Number: 0026286

FYE 6/30/2010

Attchment to Line 28, Schedule XVII - Other Revenue

	FY 2010	Remark
Housekeeping	1,305	
Admin - Other Revenue	615	
Medical Records	1,710	
Rental Income	36,830	
Total - Other Revenue	40,460	Offset on Page 5A

Attchment to Line 25, Schedule XVII - Interest Income

Interest Income	1,639
Interest Expense thru home office cost repor	25,110
Interest income offset (limited to interest exp	1,639

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,720	1,934	$ 88,198	$ 45.60	1
2	Assistant Director of Nursing	1,904	2,080	82,030	39.44	2
3	Registered Nurses	56,268	62,939	2,247,192	35.70	3
4	Licensed Practical Nurses	4,244	4,607	120,554	26.17	4
5	CNAs & Orderlies	89,652	101,662	1,418,334	13.95	5
6	CNA Trainees					6
7	Licensed Therapist	17,966	19,326	593,488	30.71	7
8	Rehab/Therapy Aides	4,395	4,806	86,461	17.99	8
9	Activity Director	1,896	2,127	51,502	24.21	9
10	Activity Assistants	6,406	7,009	89,331	12.75	10
11	Social Service Workers	3,296	3,681	64,226	17.45	11
12	Dietician	1,944	2,072	48,465	23.39	12
13	Food Service Supervisor	4,829	5,519	117,745	21.33	13
14	Head Cook	5,436	5,739	76,860	13.39	14
15	Cook Helpers/Assistants	19,110	20,314	215,469	10.61	15
16	Dishwashers					16
17	Maintenance Workers	5,683	6,194	130,428	21.06	17
18	Housekeepers	20,327	22,280	267,135	11.99	18
19	Laundry	12,912	14,419	172,753	11.98	19
20	Administrator	1,880	2,268	184,837	81.50	20
21	Assistant Administrator	1,016	1,136	25,188	22.17	21
22	Other Administrative	11,031	12,279	182,562	14.87	22
23	Office Manager					23
24	Clerical					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	5,804	6,683	227,721	34.07	31
32	Other Health Care(specify)	4,566	4,867	107,652	22.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	282,285	313,941	$ 6,598,131 *	$ 21.02	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bregianos, Eileen	Administrator		$ 47,677
Madl, Tony	Administrator		137,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 184,837

B. Administrative - Other

Description	Amount
Management Fees	$ 1,393,023
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,393,023
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,808
Unemployment Compensation Insurance	36,919
FICA Taxes	472,136
Employee Health Insurance	1,230,394
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Ins	40,760
Employee Asst	31,212
Retirement	554,028
Life Insurance	12,056
Home Office Allocation	103,836
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,544,149

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
All Script	1,043
IC On LTC	2,706
Ladra Sta	100
LSN Subscription	2,430
Northern	2,035
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,314

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	N/A	N/A	N/A										
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Holy Family Nursing & Rehab Center # 0048652 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 : $ 2,430 & ICLTC $2,706**

(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? **N/A**
What was the average life used for new equipment added during this period? **15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,180** Line **4 Col 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? 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. $ **137,789**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate Records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **Yes**
Firm Name: **KPMG**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Holy Family Nursing and Rehab Center

Provider Number: 0026286

FYE: 30-Jun-10

S:\Medicare Division\Raj\Resurr

Attachment to Schedule XX-Question No. 18 - Legal Fees

(Sub Acct 7020

Description	Amount
L D Backer & Associates, Attorneys at Law	10,325
Employee law suit settlement and legal fees.	
Total Equipment Lease Exp	10,325