FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048652

Facility Name: Holy Family Nursing and Rehab Center

Address: 2380 East Dempster (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	501C(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 07/01/2010 to 06/30/2011 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) 10/28/2011 (Date)
(Type or Print Name) Nicola Byrne
(Title) Vice President, Finance

Paid Preparer

(Signed) (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 Ext 107 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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 N/A

	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	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	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	15,222	1,706	12,151	29,079	8
9	SNF/PED					9
10	ICF	23,263	4,583	715	28,561	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,485	6,289	12,866	57,640	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.92%

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 5/1/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 153 and days of care provided 29,079

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: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	470,631		49,215	519,846		519,846		519,846			1
2	Food Purchase		338,837		338,837		338,837	(451)	338,386			2
3	Housekeeping	288,725	46,099	23,977	358,801		358,801		358,801			3
4	Laundry	193,426	68,496	435	262,357		262,357	(13,223)	249,134			4
5	Heat and Other Utilities			295,882	295,882		295,882		295,882			5
6	Maintenance	137,480	61,668	292,615	491,763		491,763		491,763			6
7	Other (specify):*											7
8	TOTAL General Services	1,090,262	515,100	662,124	2,267,486		2,267,486	(13,674)	2,253,812			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,444,110	454,373	374,610	5,273,093		5,273,093	(10,555)	5,262,538			10
10a	Therapy	993,962	(68)	62,461	1,056,355		1,056,355		1,056,355			10a
11	Activities	155,384	5,802	7,268	168,454		168,454		168,454			11
12	Social Services	150,925	5,797	389	157,111		157,111		157,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,744,381	465,904	462,728	6,673,013		6,673,013	(10,555)	6,662,458			16
	C. General Administration											
17	Administrative			1,394,916	1,394,916		1,394,916	(46,754)	1,348,162			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			3,621	3,621		3,621		3,621			20
21	Clerical & General Office Expenses	655,314	36,865	(379,953)	312,226		312,226	500,011	812,237			21
22	Employee Benefits & Payroll Taxes			2,331,271	2,331,271		2,331,271		2,331,271			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			808	808		808		808			25
26	Insurance-Prop.Liab.Malpractice			121,546	121,546		121,546		121,546			26
27	Other (specify):* Emp benefit	5,594			5,594		5,594		5,594			27
28	TOTAL General Administration	660,908	36,865	3,472,209	4,169,982		4,169,982	453,257	4,623,239			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,495,551	1,017,869	4,597,061	13,110,481		13,110,481	429,028	13,539,509			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 and Rehab Center #0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			702,147	702,147		702,147		702,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			177,765	177,765		177,765		177,765			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			879,912	879,912		879,912		879,912			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,999,401		1,999,401		1,999,401		1,999,401			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,423	137,423		137,423		137,423			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,999,401	137,423	2,136,824		2,136,824		2,136,824			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,495,551	3,017,270	5,614,396	16,127,217		16,127,217	429,028	16,556,245			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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	(451)	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	(13,223)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	442,702			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 429,028		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 429,028		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 and Rehab Center

ID# 0048652

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Charity Care CR from hosp-reported as -ve exp on W	$ 530,400	21	1
2	Other Operating Revenue	(46,754)	17	2
3	Beauty/Barber Services Revenue	(10,555)	10	3
4	Marketing Exp	(30,389)	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**	442,702		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	(451)	0	0	0	0	0	0	0	0	0	0	(451)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(13,223)	0	0	0	0	0	0	0	0	0	0	(13,223)	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	(13,674)	0	0	0	0	0	0	0	0	0	0	(13,674)	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	(10,555)	0	0	0	0	0	0	0	0	0	0	(10,555)	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	(10,555)	0	0	0	0	0	0	0	0	0	0	(10,555)	16
	C. General Administration													
17	Administrative	(46,754)	0	0	0	0	0	0	0	0	0	0	(46,754)	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	500,011	0	0	0	0	0	0	0	0	0	0	500,011	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	453,257	0	0	0	0	0	0	0	0	0	0	453,257	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	429,028	0	0	0	0	0	0	0	0	0	0	429,028	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	429,028	0	0	0	0	0	0	0	0	0	0	429,028	45

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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
Resurrection Health Care	100	See Attached Page 6A		See 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	17	Administrative	$ 1,394,916	Resurrection Health Care	100.00%	$ 1,394,916	$	1
2	V								2
3	V	30	Depreciation	186,094	Resurrection Health Care	100.00%	186,094		3
4	V	32	Interest	177,765	Resurrection Health Care	100.00%	177,765		4
5	V	39	Intercompany Pharmacy	1,999,401	Resurrection Health Care	100.00%	1,999,401		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			$ 3,758,176			$ 3,758,176	$ *	14

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Resurrection Holy Family & Rehab Center
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2011

Related Organizations	Fed Tax ID No	Tax Status
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Medical Center	36-2439318	Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Ambulatory Services	36-4286236	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care Corporation	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Ministries of New York	14-1720818	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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	See Attached Pages 7A & 7B								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

RESURRECTION HEALTH CARE CORPORATION

BOARD OF DIRECTORS

October, 2010

	OFFICE
Mr. Thomas D. Settles Chairperson	1424 West Old Bay Road Johnsburg, IL 60051 847/925-1300 (FAX 847/214-6012) tsettles@pcec.net
Ms. Sandra Bruce, FACHE	President & CEO Resurrection Health Care 7435 West Talcott Avenue Chicago, IL 60631 773-792-5555 (FAX 773-990-8601) Email: sbruc01@reshealthcare.org
Janis Atkinson, M.D.	Saint Francis Hospital 355 Ridge Avenue Evanston, IL 60201 Cell: (847) 502-5800 Home: (847) 256-0932 FAX: (847) 316-2943 E-Mail: jatkinson@reshealthcare.org
Mr. Kenneth Bauwens	Co-President Jamerson & Bauwens Electric Co. 3055 MacArthur Boulevard Northbrook, Illinois 60062 847/291-2000 (FAX 847/291-2008) kbauwens@jbelectric.com
Haven Cockerham	President & CEO Cockerham & Associates LLC 10130 Mallard Creek Road Suite 300 Charlotte, NC 28262 704-944-5520 (Charlotte Office- Audra Miller) 312-253-4037 (Chicago office) Email: Haven@cockerhamassociates.com Email assistant: audra@cockerhamassociates.com
Michael D. Connelly	President & CEO Catholic Healthcare Partners 615 Elsinore Place Cincinnati, OH 45202 513/639-2809 (FAX 513/639-2804) Email: mdconnelly@health-partners.org Assistant's email: cmross@health-partners.org
Anthony DeFurio	Vice President and CFO University of Colorado Hospital P.O. Box 6510, Mail Stop F417 Aurora, CO 80045-6510 720/848-7816 (FAX 720-848-5542) Email: Anthony.defurio@uch.edu Via FedEX: University of Colorado Hospital Leprino Building, 10th floor 12401 E. 17th Avenue, #1043 Aurora, CO 80045
Sister Loretta Theresa Felici, C.S.F.N.	4001 Grant Avenue Philadelphia, PA 19114-2999 215/268-1035 Email: ltfelici@aol.com
Stephen Klasko, M.D.	17717 Gulf Blvd. #701 Redington Shores, FL 33708 813-760-5642 –cell (FAX 813-974-4207) Email: sklasko2@gmail.com
Sister Patricia Ann Koschalke, C.S.F.N.	Chairperson Sponsorship Board

RESURRECTION HEALTH CARE CORPORATION

BOARD OF DIRECTORS

October, 2010

	OFFICE Holy Family Medical Center 150 North River Road, Ste. 210 847/813-3451 (FAX: 847/813-3482) Email: pkoschalke@reshealthcare.org
Susan McDonough	Vice President, Strategy & System Development Covenant Health Systems, Inc. 100 Ames Pond Drive, Suite 102 Tewksbury, MA 01876 978/654-6363 (FAX: 978/851-0828) Susan_mcdonough@covenanths.org Linda_donaghue@covenanths.org (assistant)
Victor Orler	121 west 9th street Hinsdale, IL 60521 630/654-0615 (FAX 630/654-2030) Email: Vic@Orler. Net
Jeffrey M. Silver, M.D.	7447 West Talcott Avenue Suite 512 Chicago, IL 60631 847/788-1553 (FAX 773-577-8187) DJsilver@msn.com
Mr. Chester Stewart	703 N. East Avenue Oak Park, IL 60302 708/383-7167 Email: clstewy@aol.com
James Winikates	619 Keystone Avenue River Forest, IL 60305-1613 708-771-9371 (voice and fax) Email: jwinikates@comcast.net
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Medical Center 7435 West Talcott Avenue Chicago, Illinois 60631 773/792-5153 (FAX 773/792-9926) Email: sdonna@reshealthcare.org

OFFICERS
EFFECTIVE AS OF SEPTEMBER 30, 2010

TITLE	NAME
Executive Vice President/CEO, Continuum Care Services	John Baird
Vice President	Peter Goschy
Treasurer	John Orsini
Assistant Treasurer	Nicola Byrne
Secretary	Jeannie C. Frey
Assistant Secretary	John Walton

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 813-3722
Fax Number: (847) 813-3785

	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	17	Administrative				$	$		$ 1,394,916	1
2										2
3	30	Depreciation							186,094	3
4	32	Interest							177,765	4
5	39	tercompany Pharmacy							1,999,401	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,758,176	25

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

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

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

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2011 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:		
2006		8
2007		9
2008		10
2009		11
2010	N/A	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Nursing and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048652

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE 847) 813-3722 FAX #: 847) 813-3785

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility is not profit entity and does	not pay real estate taxes	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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. [X] (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:
3. Current Period Amortization: N/A
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 610,897	1
2	Resident Use		1984-2006	1,064,530	2
3	TOTALS			$ 1,675,427	3

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 5,859,065	$		$	$	$ 5,803,891	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1982	78,316	-	3-20	-		78,316	9
10	Various			1983	173,656	-	8-25	-		173,656	10
11	Various			1984	217,435	-	10-21	-		217,435	11
12	Various			1985	63,291	-	10-20	-		63,291	12
13	Various			1986	26,470	-	3-15	-		26,470	13
14	Various			1987	115,568	-	3-15	-		113,014	14
15	Various			1988	26,770	-	10-15	-		26,472	15
16	Various			1989	17,435	-	15-17	-		16,872	16
17	Various			1990	118,518	-	3-16	-		114,782	17
18	Various			1991	207,174	581	3-20	581		201,566	18
19	Various			1992	153,607	-	5-15	-		147,885	19
20	Various			1993	86,540	-	5-15	-		83,479	20
21	Various			1994	147,450	104	2-20	104		141,182	21
22	Various			1995	170,776	-	5-15	-		163,627	22
23	Various			1996	563,355	15,862	5-20	15,862		537,512	23
24	Various			1997	137,754	7,463	5-15	7,463		128,922	24
25	Various			1998	225,216	14,216	10-15	14,216		196,187	25
26	Various			1999	146,522	5,374	5-15	5,374		126,830	26
27	Various			2000	281,547	14,062	10-20	14,062		167,789	27
28	Various			2001	72,520	4,175	0-20	4,175		51,605	28
29	Various			2002	391,268	21,561	10-39	21,561		195,948	29
30	Various			2003	41,799	3,208	5-15	3,208		29,087	30
31	Various			2004	63,078	3,382	5-25	3,382		42,033	31
32	Various			2005	255,858	18,242	5-20	18,242		124,347	32
33	Various			2006	2,524,835	153,695	5-50	153,695		822,890	33
34	Various			2007	229,408	21,085	5-20	21,085		88,465	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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	VULCAN HART CONVECTION GAS OVEN	2008	9,612	961	10	961		2,403	38
39	TRAVELING CABLE FOR SIDEWALK LIFT	2008	3,200	640	5	640		1,600	39
40	SERVICE CALLS ON WATER IN BASEMENT AREA, ROD OUT ALL	2008	8,502	1,700	5	1,700		4,251	40
41	SERVICE CALL TO REPLACE 1"90 THAT CRACKED(SPRINKLER S	2008	950	38	25	38		133	41
42	SERVICE CALL ON ELEVATOR #2	2008	4,200	840	5	840		2,100	42
43	REPLACEMENT OF SHOWER VALVE	2008	1,660	237	7	237		830	43
44	REPLACED DOMESTIC HOT WATER PUMP ON RETURN LINES	2008	2,722	181	15	181		635	44
45	REPLACE OLD FLOORING/ CEILING TILES & GRID	2008	32,020	2,668	12	2,668		6,671	45
46	REPLACE 7 MOEN SHOWER VALVES	2008	8,360	1,194	7	1,194		4,180	46
47	REPAIR 2 O2 SERVICE OUTLETS IN PATIENT ROOMS	2008	2,179	436	5	436		1,526	47
48	REMOVED/BYPASSED SMOKE SENSOR IN ELEVATOR	2008	1,086	109	10	109		380	48
49	REMOVE/INSTAL NEW CARPET IN SEVERAL AREAS	2008	2,658	532	5	532		1,860	49
50	REMOVE/ REPLACE SHOWER VALVE, TEST/CERTIFY BACK FLO	2008	2,450	350	7	350		1,225	50
51	NEW DOOR RESTRICTOR ON 3 ELEVATORS, 2 NEW ACCORDION	2008	25,578	2,558	10	2,558		6,395	51
52	Landscaping Services-Long Term	2008	17,254	3,451	5	3,451		12,078	52
53	INSTALL VALVES, REMOVE TUB & INSTALL NEW TUB, INSTALL	2008	9,136	914	10	914		3,198	53
54	INSTALL PUMP FOR DOMESTIC BOILER	2008	4,500	450	10	450		1,575	54
55	INSTALL NEW RAYPAK BOILER IN LAUNDRY	2008	8,300	415	20	415		1,453	55
56	FLOOD DAMAGE CONTROL	2008	4,500	1,500	3	1,500		3,750	56
57	FABRICATED & INSTALLED GRADING, LADDER AND PLATFOMS	2008	7,958	531	15	531		1,857	57
58	EMERGENCY SERVICE REPAIR FOR 2 ELEVATORS DUE TO WAT	2008	2,764	138	20	138		484	58
59	EMERGENCY GENERATOR & AUTOMATIC TRANSFER SWITCH	2008	3,707	741	5	741		2,595	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)		$ 12,558,527	$ 303,593		$ 303,593	$	$ 9,944,729	70

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,558,527	$ 303,593		$ 303,593	$	$ 9,944,729	1
2	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	1,344	3	1,344		3,359	2
3	Survey of 11 facilities for electrical equipment	2009	4,000	1,333	3	1,333		3,333	3
4	STORAGE TANK REPLACEMENT	2009	7,156	358	20	358		895	4
5	Repair roof flashing & leaking areas, Install new modified Bitumen	2009	10,000	1,000	10	1,000		1,500	5
6	REMOVE & REPLACE THERMOSTATIC MIXING VALVE	2009	2,506	251	10	251		627	6
7	Removal & Installation of New Edwards Fire Alarm System	2009	24,668	2,467	10	2,467		6,167	7
8	Piston & Cylinder replacement on lobby elevator	2009	17,869	1,787	10	1,787		2,680	8
9	L& M to install Remote Generator Annuniator and Transfer Switch	2009	7,244	483	15	483		724	9
10	INSTALLATION OF AMICO AIR COMPRESSOR SYSTEM	2009	50,034	3,336	15	3,336		8,339	10
11	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	21,701	2,170	10	2,170		5,425	11
12	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	60,534	6,053	10	6,053		15,134	12
13	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	6,377	638	10	638		1,594	13
14	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	21,231	2,123	10	2,123		5,308	14
15	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	146,886	14,689	10	14,689		36,722	15
16	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	122,127	12,213	10	12,213		30,532	16
17	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	147,706	14,771	10	14,771		36,927	17
18	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	142,768	14,277	10	14,277		35,692	18
19	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	57,012	5,701	10	5,701		14,253	19
20	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	21,510	2,151	10	2,151		5,378	20
21	Install Guard Rails	2009	7,176	897	8	897		1,346	21
22	Install Fire Dampers	2009	40,080	4,008	10	4,008		6,012	22
23	FURNISH & INSTALL PARKER US26D VERTICAL ROD PANIC DEV	2009	3,558	356	10	356		890	23
24	FIRE ALARM UPGRADE - IDPH HEALTH PLAN REVIEW	2009	7,898	790	10	790		1,975	24
25	Expansion of Dialysis Stations	2009	19,020	3,804	5	3,804		5,706	25
26	Expand Sprinkler System	2009	13,363	535	25	535		802	26
27	ELECTRICAL ENGINEERING SERVICES - FIRE ALARM SYSTEM	2009	2,578	258	10	258		644	27
28	ELECTRICAL ENGINEERING SERVICES - FIRE ALARM SYSTEM	2009	5,000	500	10	500		1,250	28
29	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,091	109	10	109		164	29
30	ComEd Smart Ideas Program - Lighting Retrofit	2009	13,840	1,384	10	1,384		2,076	30
31	ComEd Smart Ideas Program - Lighting Retrofit	2009	9,029	903	10	903		1,354	31
32	ComEd Smart Ideas Program - Lighting Retrofit	2009	7,210	721	10	721		1,081	32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,563,730	$ 405,000		$ 405,000	$	$ 10,182,616	34

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,563,730	$ 405,000		$ 405,000	$	$ 10,182,616	1
2	Canopy Repairs	2009	8,890	889	10	889		1,334	2
3	Boiler Room Piping Room Repairs	2009	3,176	454	7	454		681	3
4	Automatic Transfer Switch	2009	17,458	1,455	12	1,455		2,182	4
5	ELECTRICAL ENGINEERING SERVICES - FIRE ALARM SYSTEM	2009	12,500	1,250	10	1,250		3,125	5
6									6
7									7
8	Stairwell Ceiling Spray Fireproofing	2010	6,935	694	10	694		1,040	8
9	Piston & Cylinder replacement on lobby elevator FINAL BILLING	2010	17,869	1,787	10	1,787		2,680	9
10	Oxygen Flowmeters and Piping	2010	20,275	2,534	8	2,534		3,802	10
11	Installation of OXEQUIP DISS Outlets on 2nd & 3rd floors	2010	19,550	1,303	15	1,303		1,955	11
12	INSTALLATION OF 8 FIRE DAMPERS IN PATIENT ROOM EXHAUS	2010	3,205	284	10	284		444	12
13	INSTALLATION OF 2 HOUR SHAFTWALL BOARD SYSTEM	2010	22,569	2,031	10	2,031		3,160	13
14	ComEd Smart Ideas Program - Lighting Retrofit	2010	220	11	10	11		11	14
15	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIO	2010	362	20	10	20		20	15
16	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIO	2010	921	61	10	61		61	16
17	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIO	2010	1,248	62	10	62		62	17
18	ComEd Smart Ideas Program - Lighting Retrofit	2010	553	55	10	55		83	18
19	ComEd Smart Ideas Program - Lighting Retrofit	2010	586	59	10	59		88	19
20	SLIDING PATIO DOOR / MOTOR SENSOR	2010	9,766	866	10	866		1,354	20
21	EDWARDS FIRE ALARM SYSTEM - INSTALLATION	2010	25,200	2,520	10	2,520		3,780	21
22									22
23									23
24	ENVE VENTILATOR W/STAND & NON-INVASIVE PACKAGE	2011	200,000	10,000	10	10,000		10,000	24
25	REPLACED HOT WATER STORAGE TANK	2011	8,866	222	20	222		222	25
26	REPLACE 2 EJECTOR PUMPS	2011	4,660	233	10	233		233	26
27	REPAIR OF DRIVEWAY TO OXYGEN STORAGE TANKS	2011	7,901	395	10	395		395	27
28									28
29	Home Office Allocation	2011		186,094		186,094			29
30	Reconcile to Working Trial Balance	2011		1,778		1,778			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,956,440	$ 620,057		$ 620,057	$	$ 10,219,328	34

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 2,904,221	$ 81,014	$ 81,014	$	10-20	$ 2,326,909	71
72	Current Year Purchases	16,005	1,076	1,076		5-12	1,076	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,920,226	$ 82,090	$ 82,090	$		$ 2,327,985	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	Residence	1992 FORD F250 W/PLOW,1	1992	$ 18,860	$	$	$	4	$ 18,860	76
77	Residence	1998 SATURN STATION WA	1997	10,891				4	10,891	77
78	Residence	1998 DODGE CARAVAN SS	1998	38,811				4	33,960	78
79	Residence	1998 DODGE 10 PASSENGA	1998	30,027				4	26,274	79
80	TOTALS			$ 98,589	$	$	$		$ 89,985	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)	$ 18,650,682	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 702,147	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 702,147	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,637,298	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	Accured Fixed Assets	$ 2,760	92
93			93
94			94
95		$ 2,760	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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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				N/A			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 N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 206,428 Description: Please refer to 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.

Provider Number: 0048652

FYE: 6/30/2011

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment	Amount
Copier	11,827
Medical Equipment	193,321
Ambulance	1,280
Total Equipment Lease Exp	206,428

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	10A	1346	hrs	$ 69,609	808	$ 52,524	$	2,154	$ 122,133	1
2	Licensed Speech and Language Development Therapist	10A	1529	hrs	53,908	20	1,314		1,549	55,222	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	3351	hrs	148,908	8	489		3,359	149,397	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				1,999,401		1,999,401	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$ 272,425	836	$ 54,327	$ 1,999,401	7,062	$ 2,326,153	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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011 (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	$ 2,162,717	$ 2,162,717	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,519,228)	891,404	891,404	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,231	3,231	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Sundry Receivable	23,057	23,057	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,080,409	$ 3,080,409	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	534,834	534,834	15
16	Equipment, at Historical Cost	2,072,317	2,072,317	16
17	Accumulated Depreciation (book methods)	(12,637,297)	(12,637,297)	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)**	$ 6,016,144	$ 6,016,144	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,096,553	$ 9,096,553	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,180	$ 45,180	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,065	32,065	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	Due To Affiliates	27,961,717	27,961,717	36
37	Medicare Settlement etc	45,955	45,955	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 28,084,917	$ 28,084,917	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)**	$ 28,084,917	$ 28,084,917	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (18,988,364)	$ (18,988,364)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,096,553	$ 9,096,553	48

***(See instructions.)**

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,986,635)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,986,635)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,017,745)	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) **cont.allowance to agree with income stmt**	16,016	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,001,729)	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)**	$ (18,988,364)	24 *

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

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 19,114,172	1
2	Discounts and Allowances for all Levels	(6,204,288)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,909,884	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	10,555	13
14	Non-Patient Meals	451	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	13,223	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,229	23
	D. Non-Operating Revenue		
24	Contributions	785	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 785	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		174,574	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 174,574	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,109,472	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,267,486	31
32	Health Care	6,673,013	32
33	General Administration	4,169,982	33
	B. Capital Expense		
34	Ownership	879,912	34
	C. Ancillary Expense		
35	Special Cost Centers	1,999,401	35
36	Provider Participation Fee	137,423	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,127,217	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,017,745)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,017,745)	43

* **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.**

Resurrection Holy Family Nursing and Rehab Center

Medicaid Provider Number: 0048652

FYE 6/30/2011

Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	16,016	Not an income
Admin - Other Revenue	46,754	Offset on Page 5A
Rental Income	111,804	Intercompany - Not subject to ofset
Total - Other Revenue	174,574	

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	1,880	2,080	$ 91,578	$ 44.03	1
2	Assistant Director of Nursing	1,832	2,080	88,773	42.68	2
3	Registered Nurses	62,073	69,380	2,554,216	36.81	3
4	Licensed Practical Nurses	4,022	4,591	124,091	27.03	4
5	CNAs & Orderlies	100,322	113,099	1,603,273	14.18	5
6	CNA Trainees					6
7	Licensed Therapist	27,273	28,921	860,905	29.77	7
8	Rehab/Therapy Aides	7,035	7,671	139,721	18.21	8
9	Activity Director	1,896	2,080	55,016	26.45	9
10	Activity Assistants	7,309	8,164	102,324	12.53	10
11	Social Service Workers	3,624	3,996	64,889	16.24	11
12	Dietician	1,896	2,080	50,016	24.05	12
13	Food Service Supervisor	4,562	5,055	115,018	22.75	13
14	Head Cook	6,308	7,038	94,016	13.36	14
15	Cook Helpers/Assistants	18,529	20,424	219,876	10.77	15
16	Dishwashers					16
17	Maintenance Workers	5,924	6,570	138,981	21.15	17
18	Housekeepers	20,696	22,996	278,632	12.12	18
19	Laundry	13,922	15,443	193,099	12.50	19
20	Administrator	1,944	2,080	134,328	64.58	20
21	Assistant Administrator	1,704	1,776	31,653	17.82	21
22	Other Administrative	10,751	12,879	230,325	17.88	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					31
32	Other Health C: Helathcare	6,121	6,807	240,313	35.30	32
33	Other(specify) Religious	4,137	4,367	84,508	19.35	33
34	TOTAL (lines 1 - 33)	313,760	349,577	$ 7,495,551 *	$ 21.44	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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Madl, Tony	Administrator	0	$ 134,328
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,328

B. Administrative - Other

Description	Amount
Management Fees	$ 1,394,916
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,394,916
(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	$ 135,544
Unemployment Compensation Insurance	25,450
FICA Taxes	530,295
Employee Health Insurance	971,253
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	14,537
Employee Group Disablility	44,289
Employee Retirement Plan	582,044
Employee Assistance and Other Benefits	27,859
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,331,271

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,247
Health Care Worker Background Check	
(Indicate # of checks performed)	
All Script	2,337
Med-Pass	37
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,621

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)	$

**See instructions.

Facility Name & ID Number Holy Family Nursing and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	N/A	N/A											
3													
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 and Rehab Center # 0048652 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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? **No**
If YES, give association name and amount.

(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?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,665** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? 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. $ **137,423**
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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **451**

(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 LLP**

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

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