

Facility Name & ID Number Holy Family Health Center

0026286 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 April 20, 2006

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	235	Intermediate (ICF)	149	79,583	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	337	TOTALS	251	116,813	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,312	3,557	8,675	16,544	8
9	SNF/PED					9
10	ICF	28,032	10,758		38,790	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,344	14,315	8,675	55,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.37%

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

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

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

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

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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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

Date started 05/01/1981

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

YES Date 05/01/1981 NO

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

YES NO If YES, enter number

of beds certified 51 and days of care provided 8,675

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	26,786	3,938	894,569	925,293	925,293		925,293			1
2	Food Purchase		60,331		60,331	60,331	(978)	59,353			2
3	Housekeeping	242,897	38,528	4,630	286,055	286,055		286,055			3
4	Laundry	179,821	35,147	175	215,143	215,143		215,143			4
5	Heat and Other Utilities			328,423	328,423	328,423		328,423			5
6	Maintenance	170,168	33,786	98,147	302,101	302,101		302,101			6
7	Other (specify):*										7
8	TOTAL General Services	619,672	171,730	1,325,944	2,117,346	2,117,346	(978)	2,116,368			8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000	18,000		18,000			9
10	Nursing and Medical Records	3,335,236	141,048	36,198	3,512,482	3,512,482	8,142	3,520,624			10
10a	Therapy	301,009	1,825	27,988	330,822	330,822		330,822			10a
11	Activities	137,664	4,150	70	141,884	141,884		141,884			11
12	Social Services	57,568		2,400	59,968	59,968		59,968			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,831,477	147,023	84,656	4,063,156	4,063,156	8,142	4,071,298			16
	C. General Administration										
17	Administrative	107,120		944,695	1,051,815	1,051,815	(944,695)	107,120			17
18	Directors Fees										18
19	Professional Services			23,790	23,790	23,790	(22,640)	1,150			19
20	Dues, Fees, Subscriptions & Promotions			9,169	9,169	9,169	(668)	8,501			20
21	Clerical & General Office Expenses	305,616	18,431	57,467	381,514	381,514	576,522	958,036			21
22	Employee Benefits & Payroll Taxes			1,610,587	1,610,587	1,610,587	53,143	1,663,730			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,913	2,913	2,913		2,913			24
25	Other Admin. Staff Transportation			77	77	77		77			25
26	Insurance-Prop.Liab.Malpractice			134,282	134,282	134,282	15,030	149,312			26
27	Other (specify):*										27
28	TOTAL General Administration	412,736	18,431	2,782,980	3,214,147	3,214,147	(323,308)	2,890,839			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,863,885	337,184	4,193,580	9,394,649	9,394,649	(316,144)	9,078,505			29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Holy Family Health Center

#0026286

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			384,219	384,219		384,219	73,102	457,321			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			64,886	64,886		64,886		64,886			35
36	Other (specify):*											36
37	TOTAL Ownership			449,105	449,105		449,105	73,102	522,207			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,146	2,146		2,146		2,146			38
39	Ancillary Service Centers		961,969		961,969		961,969		961,969			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,220	175,220		175,220		175,220			42
43	Other (specify):* Nonallowable Cost			39,101	39,101		39,101	(39,101)				43
44	TOTAL Special Cost Centers		961,969	216,467	1,178,436		1,178,436	(39,101)	1,139,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,863,885	1,299,153	4,859,152	11,022,190		11,022,190	(282,143)	10,740,047			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(978)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,162)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(16,304)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,444)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(262,699)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (262,699)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (282,143)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center

ID# 0026286

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2	Disallow Convent expense	(2,322)	43	2
3	Disallow Marketing expense	(130)	43	3
4	Disallow Med A labs	(36,649)	43	4
5	Disallow non-allowable dues	(668)	20	5
6	Pension expense adjustment	44,952	22	6
7	Disallow non-allowable legal fees	(22,640)	19	7
8	Offset miscellaneous revenue against related expense	(13,877)	21	8
9	Malpractice Insurance Expense Adjustment	15,030	26	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	(16,304)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Health Center# 0026286 Report Period Beginning:07/01/2005Ending: 06/30/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(978)	0	0	0	0	0	0	0	0	0	0	(978)	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	(978)	0	0	0	0	0	0	0	0	0	0	(978)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	8,142	0	0	0	0	0	0	0	0	0	8,142	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	0	8,142	0	8,142	16								
	C. General Administration													
17	Administrative	0	(944,695)	0	0	0	0	0	0	0	0	0	(944,695)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,640)	0	0	0	0	0	0	0	0	0	0	(22,640)	19
20	Fees, Subscriptions & Promotions	(668)	0	0	0	0	0	0	0	0	0	0	(668)	20
21	Clerical & General Office Expenses	(16,039)	592,561	0	0	0	0	0	0	0	0	0	576,522	21
22	Employee Benefits & Payroll Taxes	44,952	8,191	0	0	0	0	0	0	0	0	0	53,143	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	15,030	0	0	0	0	0	0	0	0	0	0	15,030	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	20,635	(343,943)	0	(323,308)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	19,657	(335,801)	0	(316,144)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Health Center# 0026286

Report Period Beginning:

07/01/2005 Ending:06/30/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	73,102	0	0	0	0	0	0	0	0	0	73,102	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	73,102	0	0	0	0	0	0	0	0	0	73,102	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):*	(39,101)	0	0	0	0	0	0	0	0	0	0	(39,101)	43
44	TOTAL Special Cost Centers	(39,101)	0	0	0	0	0	0	0	0	0	0	(39,101)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(19,444)	(262,699)	0	0	0	0	0	0	0	0	0	(282,143)	45

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	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10 Nursing Supplies	\$	Resurrection Health Care	100.00%	\$ 8,142	\$ 8,142	1
2	V	21 Clerical & Data Processing		Resurrection Health Care	100.00%	265,631	265,631	2
3	V	21 Other Administrative & General		Resurrection Health Care	100.00%	326,930	326,930	3
4	V	22 Employee Benefits		Resurrection Health Care	100.00%	8,191	8,191	4
5	V	30 Depreciation		Resurrection Health Care	100.00%	73,102	73,102	5
6	V							6
7	V	17 Intercompany Accrual	944,695	Resurrection Health Care	100.00%		(944,695)	7
8	V	39 Intercompany Pharmacy	961,969	Resurrection Health Care	100.00%	961,969		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,906,664			\$ 1,643,965	\$ * (262,699)	14

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

Facility Name & ID Number

Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	See Attached Pg 7A										2
3											3
4											4
5											5
6											6
7	Sister Elizabeth Trembczynski	Director & Facility Administrator	Board of Directors	0.00	None	40	100.00	Salary	107,120	17(1)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 107,120		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005

Ending: 6/30/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Resurrection HC/Medical Ctr.
 Street Address 7435 Talcott Ave.
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies			\$	\$		\$ 8,142	1
2	21	Clerical & Data Processing						265,631	2
3	21	Other Administrative & General						326,930	3
4	22	Employee Benefits						8,191	4
5	30	Depreciation						73,102	5
6									6
7	39	Intercompany Pharmacy						961,969	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				\$	\$		\$ 1,643,965	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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												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. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 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 2006 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:	2001	_____	8
	2002	_____	9
	2003	_____	10
	2004	_____	11
	2005	N/A	12

Facility is a not-for-profit entity and does not pay real estate taxes.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$ _____	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026286

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	<u>N/A</u>	\$ _____	\$ _____
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 NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Health Center

0026286

Report Period Beginning:

07/01/2005 Ending:

06/30/2006

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

1. Total Amount Incurred: 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Use</u>		<u>1981</u>	<u>\$ 610,897</u>	<u>1</u>
2	<u>Resident Use</u>		<u>1984 - 2000</u>	<u>312,530</u>	<u>2</u>
3	TOTALS			\$ 923,427	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	337	1981	1963	\$ 5,610,288	\$ 45,206	26	\$ 45,206	\$	\$ 5,610,288	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Land Improvements		1981	39,944	220	various	220		39,944	9
10	Land Improvements		1982	3,300		15			3,300	10
11	Land Improvements		1983	16,546		15			16,546	11
12	Land Improvements		1985	2,758		15			2,758	12
13	Land Improvements		1987	26,060		10			26,060	13
14	Land Improvements		1991	2,934		8			2,934	14
15	Land Improvements: Repaving Dempster lot		1996	6,944	694	10	694		6,941	15
16	Land Improvements: Utility pole		1996	1,908	127	15	127		1,271	16
17	Building Improvements		1981	30,116	1,503	various	1,503		29,142	17
18	Building Improvements		1982	38,889		20			38,889	18
19	Building Improvements		1983	137,540	686	various	686		106,188	19
20	Building Improvements		1984	161,928	8,084	various	8,084		147,563	20
21	Building Improvements		1985	140,002		various			140,002	21
22	Building Improvements		1986	74,495	1,510	15	1,510		70,682	22
23	Building Improvements		1987	81,758		various			81,758	23
24	Building Improvements		1988	9,477		various			9,477	24
25	Building Improvements		1989	29,180		various			29,180	25
26	Building Improvements		1990	119,639		various			119,639	26
27	Building Improvements		1991	209,393	12,221	various	12,221		207,469	27
28	Building Improvements		1992	47,000		10			47,000	28
29	Building Improvements		1992	79,513		various			79,513	29
30	Building Improvements		1993	55,142	3,941	various	3,941		51,234	30
31	Building Improvements		1993	7,044	470	15	470		6,108	31
32	Building Improvements		1994	86,489	3,825	various	3,825		86,489	32
33	Building Improvements: #20-4		1995	5,035	456	11	456		5,035	33
34	Building Improvements: #20-5		1995	5,469		5			5,469	34
35	Building Improvements: #20-5		1995	7,988		11			7,988	35
36	Building Improvements: #20-5		1995	3,648		10			3,648	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Building Improvement #21-4	1995	\$ 94,827	\$ 8,618	11	\$ 8,618	\$	\$ 94,827	37
38	Building Improvement #21-5	1995	34,922	3,175	11	3,175		34,924	38
39	Building Improvement #21-5	1995	1,423	2	10	2		1,423	39
40	Building Improvement #26-4	1995	6,906	460	15	460		5,061	40
41	Building Improvement #26-5	1995	6,358	424	15	424		4,664	41
42	Building Improvements: Carpeting for facility	1996	43,550		5			43,550	42
43	Building Improvements: Rudd water heater tank	1996	825	79	10	79		825	43
44	Building Improvements:Rekey/Lock/Latches	1996	13,413	894	15	894		8,940	44
45	Building Improvements:Upgrade East elevator	1996	35,024	1,751	20	1,751		17,511	45
46	Building Improvements:Wall covering in dining room	1996	7,240		5			7,240	46
47	Building Improvements:Phone system and call system	1996	44,556	4,452	10	4,452		44,556	47
48	Building Improvements:Remodeling 3rd floor patient rooms	1996	316,547	21,103	15	21,103		211,031	48
49	Building Improvements:Tiling of shower room	1996	1,355	68	20	68		680	49
50	Building Improvements:Cabinets and shower doors	1996	15,698	785	20	785		7,850	50
51	Double face exterior sign	1997	5,174	517	10	517		4,654	51
52	Refurbish 2404 sign(Business Office)	1997	2,428	243	10	243		2,186	52
53	Sealcoating parking lot area	1997	3,804	380	10	380		3,420	53
54	Painting,wallcovering,tile replacement of nursing station	1997	102,440	6,829	15	6,829		61,462	54
55	Heaters convector	1997	3,240	324	10	324		2,916	55
56	Emergency phones in elevators - West	1997	1,264	126	10	126		1,134	56
57	Air Dampers - East Building	1997	2,099	210	10	210		1,890	57
58	Boilers for East Building	1997	4,310	287	15	287		2,584	58
59	Carpeting Room 215	1997	650		5			650	59
60	Air Handler of West Building	1997	1,450	145	10	145		1,268	60
61	Painting,wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		18,488	61
62	Painting,wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		41,241	62
63	Painting,wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		40,776	63
64	30 Ton Chiller	1998	17,670	1,178	15	1,178		10,044	64
65	Fire Dampers in bath rooms	1998	7,135	476	15	476		3,808	65
66	Repair water main from Department 300	1998	3,887	389	10	389		3,111	66
67	Gutter replacement of East Building	1999	6,400	640	10	640		4,480	67
68	Painting,wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		29,302	68
69	Replacement of Tran Compressor	1999	7,063	471	15	471		3,294	69
70	TOTAL (lines 4 thru 69)		\$ 8,083,317	\$ 149,718		\$ 149,718	\$	\$ 7,702,305	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,083,317	\$ 149,718		\$ 149,718	\$	\$ 7,702,305	1
2	Call system upgrade 1 West	1999	33,238	3,324	10	3,324		23,268	2
3	Call system upgrade 3 West	1999	17,274	1,727	10	1,727		12,092	3
4	Painting,wallcovering,floor replacement of 4 West station	1999	2,082	139	15	139		970	4
5	Painting,wallcovering,floor replacement of Physical Therapy	1999	8,665	578	15	578		4,046	5
6	Construction of Parking Lot	2000	227,278	11,364	20	11,364		68,184	6
7	Landscaping	2000	7,208	721	10	721		4,325	7
8	Replace East elevator hydrolift	2000	33,472	2,231	15	2,231		13,388	8
9	Repair decking	2000	7,000	467	15	467		2,801	9
10	Door replacement	2000	3,035	304	10	304		1,824	10
11	Construction of Parking Lot	2001	15,451	813	19	813		4,066	11
12	2380 Building remodeling	2001	6,985	699	10	699		3,146	12
13	Freight elevator gate	2001	1,300	87	15	87		434	13
14	Door replacement	2001	3,378	282	12	282		1,410	14
15	Gas Steamer - connection with Booster	2001	7,507	500	15	500		2,500	15
16	Water Main Repair	2002	8,109	405	20	405		1,721	16
17	Building, Reception and office improvements	2002	199,513	13,301	15	13,301		56,529	17
18	Installation of new WEIL Pump	2002	3,438	688	5	688		2,924	18
19	Repair Flat Roof to Wood Deck	2002	9,445	945	10	945		4,016	19
20	Telephone cables	2002	16,900	1,690	10	1,690		7,183	20
21	Topographic Mapping of entire facility	2002	8,316	554	15	554		2,355	21
22									22
23	7 new signs	2002	7,744	774	10	774		2,709	23
24	1 new sign	2003	5,487	549	10	549		1,921	24
25	Norstar digital trunk cartridge, DTI/PRI assy.	2003	5,425	1,085	5	1,085		3,798	25
26	Programming - Direct TV	2003	15,000	3,000	5	3,000		10,500	26
27	Electrical equipment and labor	2002	24,029	1,602	15	1,602		5,607	27
28	Exterior & interior renov-From 3/30/02 to 4/26/02	2002	10,381	692	15	692		2,422	28
29	Install bumper/crash	2002	15,049	1,505	10	1,505		5,267	29
30	New circuit in basement	2002	6,155	410	15	410		1,435	30
31	Kronos clock - replace jack,install jack cord	2002	265	18	15	18		63	31
32	New door locks	2002	8,575	572	15	572		2,002	32
33	Overhead paging system	2002	2,500	250	10	250		875	33
34	TOTAL (lines 1 thru 33)		\$ 8,803,521	\$ 200,994		\$ 200,994	\$	\$ 7,956,086	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,803,521	\$ 200,994		\$ 200,994	\$	\$ 7,956,086	1
2	Accounting Dept relocating to Des Plaines	2002	1,613	108	15	108		378	2
3	Disconnect furn. Re-wire at Holy Family-Des Pl.	2002	2,995	300	10	300		1,050	3
4	Wrought iron pipe rail	2003	1,820	91	20	91		319	4
5	Install raceways for voice data lines	2003	770	77	10	77		270	5
6	Basement office - data and voice cabling	2003	2,755	184	15	184		644	6
7	Redesign and constructions-1st fl. Office space	2002	127,916	3,280	39	3,280		11,480	7
8	Architect fees for exterior & interior renovation	2003	14,810	987	15	987		3,455	8
9	Sign	2003	10,000	1,000	10	1,000		3,500	9
10									10
11	Repair catch basin on North parking lot	2003	850	86	10	86		215	11
12	Install new 6" storm line from bldg to new inl	2003	8,614	862	10	862		2,155	12
13	Parking Patch project # 50950-04	2004	1,523	102	15	102		255	13
14	Data Cable for Res Info/Rooms 120 & 135	2004	1,041	208	5	208		520	14
15	Building renovation	2004	4,333	216	20	216		540	15
16	Res-info-ancillary bldg dev.	2004	1,444	206	7	206		515	16
17	HF/Res info-remove/relocate 2 voice & data	2004	450	64	7	64		160	17
18	Work performed - 2nd floor, room 203	2004	1,191	120	10	120		300	18
19	Landscaping design	2004	2,709	108	25	108		270	19
20	Exterior & interior renovation - SD	2004	25,855	1,724	15	1,724		4,310	20
21									21
22	Crackseal, sealcoat, restripe parking lots	2005	6,040	604	10	604		906	22
23	Landscaping improvements	2005	1,700	340	5	340		510	23
24	Lighting retrofit project	2005	32,463	2,164	15	2,164		3,246	24
25	Interior finishes renovation	2005	9,600	640	15	640		960	25
26	Cable wiring	2005	28,297	1,886	15	1,886		2,829	26
27	Siding, dormers, columns entrance ceiling	2005	24,875	2,488	10	2,488		3,732	27
28	Two new pumps in mechanical room	2005	8,445	564	15	564		846	28
29	Boiler maintenance	2005	15,795	1,580	10	1,580		2,370	29
30	Fire alarm panel replacement	2005	6,950	464	15	464		696	30
31	One Drop ceiling - 2nd floor of nursing home	2005	1,058	70	15	70		105	31
32	Shower trolley 1900mm electric universal shower	2005	8,303	554	15	554		831	32
33	Wiring across from room 218	2005	2,547	170	15	170		255	33
34	TOTAL (lines 1 thru 33)		\$ 9,160,283	\$ 222,241		\$ 222,241	\$	\$ 8,003,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,160,283	\$ 222,241		\$ 222,241	\$	\$ 8,003,708	1
2	5 ton condensing unit for laundry area	2005	1,977	198	10	198		297	2
3	Roof work	2005	2,500	250	10	250		375	3
4	Materials for winter repairs	2005	7,365	736	10	736		1,104	4
5	Burner tray & burners on Rheem hot water boiler	2005	3,485	349	10	349		523	5
6	Casing, relief valve replacement	2005	3,142	448	7	448		672	6
7	Wiring room 215	2005	1,519	152	10	152		228	7
8	Wiring standard locations	2005	3,121	312	10	312		468	8
9									9
10	Engineering Services for new Driveway & Front Entrance	2005	11,347	378	15	378		378	10
11	Landscape Architectural Services	2006	5,517	138	20	138		138	11
12	Sign renovation and Installation	2006	21,214	1,061	10	1,061		1,061	12
13	Retaining Wall landscape work	2006	10,357	518	10	518		518	13
14	Underground irrigation system	2006	12,350	618	10	618		618	14
15	Exterior landscape work & clean up	2006	4,824	345	7	345		345	15
16	Magnabox DBNPA Biocide	2006	3,861	193	10	193		193	16
17	Main Entrance Studies & Construction	2005	1,421	142	5	142		142	17
18	Lobby, Reception - Finish & Furniture upgrade	2006	30,721	769	20	769		769	18
19	Renovation of Residential Floors	2006	104,781	2,620	20	2,620		2,620	19
20	Asbestos Removal	2006	191,375	4,649	20	4,649		4,649	20
21	Exterior entry renovation	2006	48,443	769	20	769		769	21
22	1st & 3rd floor mobilization, fees & materials	2006	70,000	1,750	20	1,750		1,750	22
23	Evacuation Plan Professional Services	2006	2,585	129	10	129		129	23
24	Asbestos Removal	2006	45,300	1,132	20	1,132		1,132	24
25	2nd Floor Dialysis Room Construction	2006	45,681	2,284	10	2,284		2,284	25
26	Internally installed ductwork to existing wall	2006	1,958	65	15	65		65	26
27	6" Waste Line in Basement	2006	6,560	164	20	164		164	27
28	Wanderguards	2006	16,504	550	15	550		550	28
29	Dryer Vent Upgrade	2006	9,817	491	10	491		491	29
30	TWP Elevator Doors & Installation	2006	1,960	65	15	65		65	30
31	Rooms 107R & 109R Cable Installation	2006	1,234	62	10	62		62	31
32	Trane Chiller Maintenance and Upgrade	2006	2,953	148	10	148		148	32
33	Building Ramps to Basement, E. Bldg, S. exit, W. Caretaker	2006	20,450	511	20	511		511	33
34	TOTAL (lines 1 thru 33)		\$ 9,854,605	\$ 244,237		\$ 244,237	\$	\$ 8,026,926	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,854,605	\$ 244,237		\$ 244,237	\$	\$ 8,026,926	1
2	Thermostats, Reciever/Controllers	2006	14,645	488	15	488		488	2
3	100Amp, 3 phase, 4 wire, Subfeed from EM Switchboard	2006	29,793	993	15	993		993	3
4	Repair frozen coil in air handler	2006	1,623	101	8	101		101	4
5	Monitor assembly w/bearings/labor/service call	2006	1,960	123	8	123		123	5
6	Medical Gas Evaluation	2006	2,000	100	10	100		100	6
7	Circuit Boards 16 Port Analog Card	2006	375	19	10	19		19	7
8	Kitchen Doors & Frame	2006	3,944	131	15	131		131	8
9	Fire Sprinkler Valve Replacement	2006	3,548	177	10	177		177	9
10	New Raypak Boiler	2006	3,657	122	15	122		122	10
11	5 - 20 Amp Circuits	2006	3,781	126	15	126		126	11
12	Replace Water Feeder, Clean burner	2006	5,438	272	10	272		272	12
13	Pharmacy Office Expansion	2006	2,463	97	15	97		97	13
14	ARJO Lifts	2006	2,204	157	7	157		157	14
15	Floor area & room sign	2006	4,847	129	20	129		129	15
16	Brick Ledge	2006	8,000	200	20	200		200	16
17	Construction/Renovation project to bring facility up to code	2006	1,193,401	29,837	20	29,837		29,837	17
18	Construction/Renovation project to bring facility up to code	2006	80,028	2,001	20	2,001		2,001	18
19	Construction/Renovation project to bring facility up to code	2006	45,952	1,149	20	1,149		1,149	19
20	Construction/Renovation project to bring facility up to code	2006	76,176	1,904	20	1,904		1,904	20
21	Construction/Renovation project to bring facility up to code	2006	3,150	79	20	79		79	21
22	Construction/Renovation project to bring facility up to code	2006	1,728	86	10	86		86	22
23	Exterior landscape work & clean up	2006	4,500	225	10	225		225	23
24	Main Entrance Studies & Construction	2006	58,938	1,473	20	1,473		1,473	24
25	2nd Floor Dialysis Room Construction	2006	7,111	178	20	178		178	25
26									26
27									27
28									28
29									29
30	Home Office Allocation					73,102	73,102		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,413,867	\$ 284,404		\$ 357,506	\$ 73,102	\$ 8,067,093	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 1,638,417	\$ 71,629	\$ 71,629	\$	5-15	\$ 1,309,445	71
72	Current Year Purchases	810,241	28,186	28,186		5-15	28,186	72
73	Fully Depreciated Assets	825,058					825,058	73
74								74
75	TOTALS	\$ 3,273,716	\$ 99,815	\$ 99,815	\$		\$ 2,162,689	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	Maintenance	1987 Ford Van	1992	\$ 5,000	\$	\$	\$	5	\$ 5,000	76
77	Maintenance	1992 Ford F250	1992	18,860				5	18,860	77
78	Facility	1998 Saturn Wagon	1997	10,891				5	10,891	78
79	See attached schedule Sch. 13A			68,838				4	68,838	79
80	TOTALS			\$ 103,589	\$	\$	\$		\$ 103,589	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)	\$ 15,714,599	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 384,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 457,321	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,102	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,333,371	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider # 0026286
07/01/2005 - 06/30/2006

Schedule 13A

Vehicle Depreciation

<u>Description</u>	<u>Model</u>	<u>Year</u>	<u>Cost</u>	<u>Current</u> <u>Bk Depr</u>	<u>St. Line</u> <u>Depr</u>	<u>Adjs</u>	<u>Life in</u> <u>Years</u>	<u>Accum</u> <u>Depr</u>	<u>Line</u> <u>Ref</u>
Resident	Dodge Caravan SS w/resident T-wheel chair	1998	38,811				4	38,811	79
Facility	Dodge 10 Passenger Van	1999	30,027				4	30,027	79
Total			<u>68,838</u>	-	-			<u>68,838</u>	

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ \$64,886 Description: See Attached

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* 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 Health Center
Provider # 0026286
7/1/2005 - 6/30/2006

Schedule 14A

XII - Rental Cost: Line 16 (Description)

Mattresses	7,759
IV pumps	18,250
Oxygen tanks	2,830
Maintenance equipment	272
Nursing equipment	153
Other office equipment	1,159
Postage meter	3,894
Copiers	7,397
Wound vac	<u>23,172</u>
Total	<u><u>64,886</u></u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A (1,2)	3823 hrs	\$ 100,240	35	\$ 1,910		3,858	\$ 102,150	1
2	Licensed Speech and Language Development Therapist	10A (1,2,3)	3 hrs	88	177	9,463	100	180	9,651	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	6189 hrs	200,681	386	16,615	1,725	6,575	219,021	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				961,969		961,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 301,009	598	\$ 27,988	\$ 963,794	10,613	\$ 1,292,791	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 938,741	\$ 938,741	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 598,538)	1,376,143	1,376,143	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	87,287	87,287	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,402,171	\$ 2,402,171	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	923,427	923,427	13
14	Buildings, at Historical Cost	7,718,628	7,729,868	14
15	Leasehold Improvements, at Historical Cost	467,730	3,683,999	15
16	Equipment, at Historical Cost	6,604,814	3,377,305	16
17	Accumulated Depreciation (book methods)	(10,333,371)	(10,333,371)	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)	\$ 5,381,228	\$ 5,381,228	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,783,399	\$ 7,783,399	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 110,068	\$ 110,068	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			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 Related Parties	15,161,227	15,161,227	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 15,271,295	\$ 15,271,295	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)	\$ 15,271,295	\$ 15,271,295	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,487,896)	\$ (7,487,896)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,783,399	\$ 7,783,399	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,023,168)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,023,168)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,464,730)	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) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,464,728)	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)	\$ (7,487,896)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,952,672	1
2	Discounts and Allowances for all Levels	(3,352,736)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,599,936	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,184,858	6
7	Oxygen	19,293	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,204,151	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	191	13
14	Non-Patient Meals	978	14
15	Telephone, Television and Radio	2,162	15
16	Rental of Facility Space	23,760	16
17	Sale of Drugs	1,139,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,680	20
21	Other Medical Services	240,122	21
22	Laundry	56,930	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,467,065	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,510	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,510	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	274,798	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 274,798	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,557,460	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,117,346	31
32	Health Care	4,063,156	32
33	General Administration	3,214,147	33
	B. Capital Expense		
34	Ownership	449,105	34
	C. Ancillary Expense		
35	Special Cost Centers	1,003,216	35
36	Provider Participation Fee	175,220	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,022,190	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,464,730)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,464,730)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Holy Family Health Center
Provider # 0026286
7/1/2005 - 6/30/2006

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

NOTE: Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

XVII - Income Statement: Line 28 - Other Revenue	<u>Amount</u>
Rental Income	260,701
Vending Income	220
Miscellaneous	<u>13,877</u>
	<u><u>274,798</u></u>

Facility Name & ID Number Holy Family Health Center

0026286

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,872	2,080	\$ 84,988	\$ 40.86	1
2	Assistant Director of Nursing	1,682	1,920	55,983	29.16	2
3	Registered Nurses	44,944	51,458	1,530,561	29.74	3
4	Licensed Practical Nurses	4,651	5,128	115,508	22.52	4
5	CNAs & Orderlies	101,511	113,973	1,495,787	13.12	5
6	CNA Trainees					6
7	Licensed Therapist	8,862	10,015	301,009	30.06	7
8	Rehab/Therapy Aides	1,408	1,559	17,589	11.28	8
9	Activity Director	1,904	2,158	42,164	19.54	9
10	Activity Assistants	7,380	8,296	95,500	11.51	10
11	Social Service Workers	3,728	4,150	57,568	13.87	11
12	Dietician	72	76	1,729	22.75	12
13	Food Service Supervisor	364	364	7,163	19.68	13
14	Head Cook	403	403	5,189	12.88	14
15	Cook Helpers/Assistants	1,347	1,347	12,705	9.43	15
16	Dishwashers					16
17	Maintenance Workers	7,616	8,686	170,168	19.59	17
18	Housekeepers	23,009	25,358	242,897	9.58	18
19	Laundry	14,670	16,590	179,821	10.84	19
20	Administrator	2,000	2,080	107,120	51.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,447	16,196	305,616	18.87	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	2,029	2,132	34,820	16.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	243,899	273,969	\$ 4,863,885 *	\$ 17.75	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			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	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	31	\$ 1,602	10(3)	50
51	Licensed Practical Nurses	8	187	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	39	\$ 1,789		53

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider # 0026286
7/1/2005 - 6/30/2006

Schedule 21A

XIX - Support Schedules - Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Diversified Health Resources	Legal	22,640
Kris Daniel	Legal	150
IL. Dept. of Public Health	Review Svcs	1,000
		<u>23,790</u>
Less: Disallowed legal fees		(22,640)
Total (agrees to Schedule V, Line 19, Col. 8)		<u><u>1,150</u></u>

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Facility Name & ID Number Holy Family Health Center# 0026286Report Period Beginning: 07/01/2005 Ending: 06/30/2006**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. Life Services Network - \$6,244
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,349 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 175,220
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A 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. \$ 978
- (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? 0
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (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 \$2500, 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