

Facility Name & ID Number Holy Family Nursing & Rehab

0048652 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	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	37,332	1
2		Skilled Pediatric (SNF/PED)			2
3	149	Intermediate (ICF)	149	54,534	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,866	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,501	2,721	8,652	17,874	8
9	SNF/PED					9
10	ICF	32,199	9,690	1,211	43,100	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,700	12,411	9,863	60,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.37%

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

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 7,681

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number Holy Family Nursing & Rehab # 0048652 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	457,432	41,548		498,980		498,980		498,980		1
2	Food Purchase		404,251		404,251		404,251	(1,043)	403,208		2
3	Housekeeping	271,033	50,801	4,200	326,034		326,034		326,034		3
4	Laundry	172,595	48,601	2,097	223,293		223,293		223,293		4
5	Heat and Other Utilities			347,288	347,288		347,288		347,288		5
6	Maintenance	131,728	645	167,929	300,302		300,302	(5,306)	294,996		6
7	Other (specify):*										7
8	TOTAL General Services	1,032,788	545,846	521,514	2,100,148		2,100,148	(6,349)	2,093,799		8
	B. Health Care and Programs										
9	Medical Director			19,500	19,500		19,500		19,500		9
10	Nursing and Medical Records	3,869,430	257,921	191,326	4,318,677		4,318,677		4,318,677		10
10a	Therapy	221,335	8,910	217,585	447,830		447,830		447,830		10a
11	Activities	244,248	4,365	1,028	249,641		249,641		249,641		11
12	Social Services	63,325	40	2,000	65,365		65,365		65,365		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,398,338	271,236	431,439	5,101,013		5,101,013		5,101,013		16
	C. General Administration										
17	Administrative	114,378		731,593	845,971		845,971	(731,593)	114,378		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			23,140	23,140		23,140		23,140		20
21	Clerical & General Office Expenses	167,841	29,135	33,575	230,551		230,551	830,344	1,060,895		21
22	Employee Benefits & Payroll Taxes			1,954,005	1,954,005		1,954,005	264,020	2,218,025		22
23	Inservice Training & Education										23
24	Travel and Seminar			119	119		119		119		24
25	Other Admin. Staff Transportation			1,339	1,339		1,339		1,339		25
26	Insurance-Prop.Liab.Malpractice			188,738	188,738		188,738		188,738		26
27	Other (specify):*										27
28	TOTAL General Administration	282,219	29,135	2,932,509	3,243,863		3,243,863	362,771	3,606,634		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,713,345	846,217	3,885,462	10,445,024		10,445,024	356,422	10,801,446		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Holy Family Nursing & Rehab

#0048652

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			420,808	420,808		420,808	100,208	521,016			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			103,605	103,605		103,605		103,605			35
36	Other (specify):*											36
37	TOTAL Ownership			524,413	524,413		524,413	100,208	624,621			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	258,540	1,577,318	10,068	1,845,926		1,845,926		1,845,926			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,799	137,799		137,799		137,799			42
43	Other (specify):*			2,045	2,045		2,045	(2,045)				43
44	TOTAL Special Cost Centers	258,540	1,577,318	149,912	1,985,770		1,985,770	(2,045)	1,983,725			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,971,885	2,423,535	4,559,787	12,955,207		12,955,207	454,585	13,409,792			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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,043)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	177	30		9
10	Interest and Other Investment Income	(18,359)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See PG 5A</u>	(12,057)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,282)		\$	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)	485,867		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 485,867		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 454,585		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						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 Nursing & Rehab

ID# 0048652

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow non-allowable marketing events	\$ (2,045)	43	1
2	Disallow non-allowable marketing salaries	(4,706)	21	2
3	Reclass R&M to capitalize	(5,306)	6	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
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	(12,057)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Nursing & Rehab# 0048652

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	(1,043)	0	0	0	0	0	0	0	0	0	0	(1,043)	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	(5,306)	0	0	0	0	0	0	0	0	0	0	(5,306)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,349)	0	0	0	0	0	0	0	0	0	0	(6,349)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(731,593)	0	0	0	0	0	0	0	0	0	(731,593)	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	(4,706)	835,050	0	0	0	0	0	0	0	0	0	830,344	21
22	Employee Benefits & Payroll Taxes	0	264,020	0	0	0	0	0	0	0	0	0	264,020	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	(4,706)	367,477	0	362,771	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,055)	367,477	0	356,422	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Nursing & Rehab# 0048652

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	177	100,031	0	0	0	0	0	0	0	0	0	100,208	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,359)	18,359	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	(18,182)	118,390	0	100,208	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):*	(2,045)	0	0	0	0	0	0	0	0	0	0	(2,045)	43
44	TOTAL Special Cost Centers	(2,045)	0	0	0	0	0	0	0	0	0	0	(2,045)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(31,282)	485,867	0	454,585	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
<u>Resurrection Health Care</u>	<u>100</u>	<u>See Attached</u>		<u>See Attached</u>		

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	<u>21 Clerical & Data Processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	\$ <u>835,050</u>	\$ <u>835,050</u>	1
2	V	<u>22 Employee Benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>264,020</u>	<u>264,020</u>	2
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>100,031</u>	<u>100,031</u>	3
4	V	<u>32 Interest Expense</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>18,359</u>	<u>18,359</u>	4
5	V							5
6	V	<u>17 Intercompany Accrual</u>	<u>731,593</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(731,593)</u>	6
7	V	<u>39 Intercompany Pharmacy</u>	<u>1,576,266</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>1,576,266</u>		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>2,307,859</u>			\$ <u>2,793,726</u>	\$ * <u>485,867</u>	14

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

Facility Name & ID Number Holy Family Nursing & Rehab # 0048652 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	See Attached page 7A								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Nursing & Rehab

0048652

Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 Health Care/Medical Center
 Street Address 7435 W. Talcott
 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	21	Clerical & data processing			\$	\$		835,050	1
2	22	Employee benefits						264,020	2
3	30	Depreciation						100,031	3
4	32	Interest Expense						18,359	4
5									5
6									6
7	39	Intercompany Pharmacy						1,576,266	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				\$	\$		2,793,726	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Holy Family Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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						\$	\$				\$						
2																		
3																		
4																		
5																		
Working Capital																		
6	N/A																	
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
B. Non-Facility Related*																		
10	N/A																	
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ No Line # N/A

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

(See instructions.)

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 2007 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2008 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:	2003	_____	8	
	2004	_____	9	
	2005	_____	10	
	2006	_____	11	
	2007	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 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048652

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 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
2. _____	<u>N/A</u>	\$ _____	\$ _____
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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Holy Family Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending:

06/30/2008

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: N/A

(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	<u>Resident Use</u>		<u>1981</u>	<u>\$ 610,897</u>	<u>1</u>
2	<u>Resident Use</u>		<u>1984-2007</u>	<u>1,114,380</u>	<u>2</u>
3	TOTALS			\$ 1,725,277	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	251	1981	1963	\$ 5,610,288	\$	26	\$	\$	\$ 5,610,288	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Land Improvements		1981	39,944		various			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		10			6,944	15
16	Land Improvements: Utility pole		1996	1,908	127	15	127		1,525	16
17	Building Improvements		1981	30,116		various			30,116	17
18	Building Improvements		1982	38,889		20			38,889	18
19	Building Improvements		1983	137,540	686	various	686		107,560	19
20	Building Improvements		1984	161,928	6,281	various	6,281		161,928	20
21	Building Improvements		1985	140,002		various			140,002	21
22	Building Improvements		1986	74,495	1,510	15	1,510		73,702	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		various			209,393	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		various			55,142	30
31	Building Improvements		1993	7,044	466	15	466		7,044	31
32	Building Improvements		1994	86,489		various			86,489	32
33	Building Improvements: #20-4		1995	5,035		11			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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	\$	11	\$	\$	\$ 94,827	37
38	Building Improvement #21-5	1995	34,922		11			34,922	38
39	Building Improvement #21-5	1995	1,423		10			1,423	39
40	Building Improvement #26-4	1995	6,906	460	15	460		5,981	40
41	Building Improvement #26-5	1995	6,358	424	15	424		5,512	41
42	Building Improvements: Carpeting for facility	1996	43,550		5			43,550	42
43	Building Improvements: Rudd water heater tank	1996	825		10			825	43
44	Building Improvements:Rekey/Lock/Latches	1996	13,413	894	15	894		10,728	44
45	Building Improvements:Upgrade East elevator	1996	35,024	1,751	20	1,751		21,013	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		10			44,556	47
48	Building Improvements:Remodeling 3rd floor patient rooms	1996	316,547	21,103	15	21,103		253,237	48
49	Building Improvements:Tiling of shower room	1996	1,355	68	20	68		816	49
50	Building Improvements:Cabinets and shower doors	1996	15,698	785	20	785		9,420	50
51	Double face exterior sign	1997	5,174		10			5,174	51
52	Refurbish 2404 sign(Business Office)	1997	2,428		10			2,428	52
53	Sealcoating parking lot area	1997	3,804		10			3,804	53
54	Painting,wallcovering,tile replacement of nursing station	1997	102,440	6,829	15	6,829		75,120	54
55	Heaters convector	1997	3,240		10			3,240	55
56	Emergency phones in elevators - West	1997	1,264		10			1,264	56
57	Air Dampers - East Building	1997	2,099		10			2,099	57
58	Boilers for East Building	1997	4,310	287	15	287		3,158	58
59	Carpeting Room 215	1997	650		5			650	59
60	Air Handler of West Building	1997	1,450	37	10	37		1,450	60
61	Painting,wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		23,110	61
62	Painting,wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		51,551	62
63	Painting,wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		50,970	63
64	30 Ton Chiller	1998	17,670	1,178	15	1,178		12,400	64
65	Fire Dampers in bath rooms	1998	7,135	476	15	476		4,760	65
66	Repair water main from Department 300	1998	3,887	387	10	387		3,887	66
67	Gutter replacement of East Building	1999	6,400	640	10	640		5,760	67
68	Painting,wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		37,674	68
69	Replacement of Tran Compressor	1999	7,063	471	15	471		4,236	69
70	TOTAL (lines 4 thru 69)		\$ 8,083,317	\$ 61,609		\$ 61,609	\$	\$ 7,836,056	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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	\$ 61,609		\$ 61,609	\$	\$ 7,836,056	1
2	Call system upgrade 1 West	1999	33,238	3,324	10	3,324		29,916	2
3	Call system upgrade 3 West	1999	17,274	1,727	10	1,727		15,546	3
4	Painting,wallcovering,floor replacement of 4 West station	1999	2,082	139	15	139		1,248	4
5	Painting,wallcovering,floor replacement of Physical Therapy	1999	8,665	578	15	578		5,202	5
6	Construction of Parking Lot	2000	227,278	11,364	20	11,364		90,912	6
7	Landscaping	2000	7,208	721	10	721		5,767	7
8	Replace East elevator hydrolift	2000	33,472	2,231	15	2,231		17,850	8
9	Repair decking	2000	7,000	467	15	467		3,735	9
10	Door replacement	2000	3,035	304	10	304		2,432	10
11	Construction of Parking Lot	2001	15,451	813	19	813		5,692	11
12	2380 Building remodeling	2001	6,985	699	10	699		4,544	12
13	Freight elevator gate	2001	1,300	87	15	87		608	13
14	Door replacement	2001	3,378	282	12	282		1,974	14
15	Gas Steamer - connection with Booster	2001	7,507	500	15	500		3,500	15
16	Water Main Repair	2002	8,109	405	20	405		2,531	16
17	Building, Reception and office improvements	2002	199,513	13,301	15	13,301		83,131	17
18	Installation of new WEIL Pump	2002	3,438		5			3,438	18
19	Repair Flat Roof to Wood Deck	2002	9,445	945	10	945		5,906	19
20	Telephone cables	2002	16,900	1,690	10	1,690		10,563	20
21	Topographic Mapping of entire facility	2002	8,316	554	15	554		3,463	21
22									22
23	7 new signs	2002	7,744	774	10	774		4,257	23
24	1 new sign	2003	5,487	549	10	549		3,019	24
25	Norstar digital trunk cartridge, DTI/PRI assy.	2003	5,425	1,085	5	1,085		5,968	25
26	Programming - Direct TV	2003	15,000	1,500	5	1,500		15,000	26
27	Electrical equipment and labor	2002	24,029	1,602	15	1,602		8,811	27
28	Exterior & interior renov-From 3/30/02 to 4/26/02	2002	10,381	692	15	692		3,806	28
29	Install bumper/crash	2002	15,049	1,505	10	1,505		8,277	29
30	New circuit in basement	2002	6,155	410	15	410		2,255	30
31	Kronos clock - replace jack,install jack cord	2002	265	18	15	18		99	31
32	New door locks	2002	8,575	572	15	572		3,146	32
33	Overhead paging system	2002	2,500	250	10	250		1,375	33
34	TOTAL (lines 1 thru 33)		\$ 8,803,521	\$ 110,697		\$ 110,697	\$	\$ 8,190,027	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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	\$ 110,697		\$ 110,697	\$	\$ 8,190,027	1
2	Accounting Dept relocating to Des Plaines	2002	1,613	108	15	108		594	2
3	Disconnect furn. Re-wire at Holy Family-Des Pl.	2002	2,995	300	10	300		1,650	3
4	Wrought iron pipe rail	2003	1,820	91	20	91		501	4
5	Install raceways for voice data lines	2003	770	77	10	77		424	5
6	Basement office - data and voice cabling	2003	2,755	184	15	184		1,012	6
7	Redesign and constructions-1st fl. Office space	2002	127,916	3,280	39	3,280		18,040	7
8	Architect fees for exterior & interior renovation	2003	14,810	987	15	987		5,429	8
9	Sign	2003	10,000	1,000	10	1,000		5,500	9
10									10
11	Repair catch basin on North parking lot	2003	850	86	10	86		387	11
12	Install new 6" storm line from bldg to new inl	2003	8,614	862	10	862		3,879	12
13	Parking Patch project # 50950-04	2004	1,523	102	15	102		459	13
14	Data Cable for Res Info/Rooms 120 & 135	2004	1,041	208	5	208		936	14
15	Building renovation	2004	4,333	216	20	216		972	15
16	Res-info-ancillary bldg dev.	2004	1,444	206	7	206		927	16
17	HF/Res info-remove/relocate 2 voice & data	2004	450	64	7	64		288	17
18	Work performed - 2nd floor, room 203	2004	1,191	120	10	120		540	18
19	Landscaping design	2004	2,709	108	25	108		486	19
20	Exterior & interior renovation - SD	2004	25,855	1,724	15	1,724		7,758	20
21									21
22	Crackseal, sealcoat, restripe parking lots	2005	6,040	604	10	604		2,114	22
23	Landscaping improvements	2005	1,700	340	5	340		1,190	23
24	Lighting retrofit project	2005	32,463	2,164	15	2,164		7,574	24
25	Interior finishes renovation	2005	9,600	640	15	640		2,240	25
26	Cable wiring	2005	28,297	1,886	15	1,886		6,601	26
27	Siding, dormers, columns entrance ceiling	2005	24,875	2,488	10	2,488		8,708	27
28	Two new pumps in mechanical room	2005	8,445	564	15	564		1,974	28
29	Boiler maintenance	2005	15,795	1,580	10	1,580		5,530	29
30	Fire alarm panel replacement	2005	6,950	464	15	464		1,624	30
31	One Drop ceiling - 2nd floor of nursing home	2005	1,058	70	15	70		245	31
32	Shower trolley 1900mm electric universal shower	2005	8,303	554	15	554		1,939	32
33	Wiring across from room 218	2005	2,547	170	15	170		595	33
34	TOTAL (lines 1 thru 33)		\$ 9,160,283	\$ 131,944		\$ 131,944	\$	\$ 8,280,143	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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	\$ 131,944		\$ 131,944	\$	\$ 8,280,143	1
2	5 ton condensing unit for laundry area	2005	1,977	198	10	198		693	2
3	Roof work	2005	2,500	250	10	250		875	3
4	Materials for winter repairs	2005	7,365	736	10	736		2,576	4
5	Burner tray & burners on Rheem hot water boiler	2005	3,485	349	10	349		1,221	5
6	Casing, relief valve replacement	2005	3,142	448	7	448		1,568	6
7	Wiring room 215	2005	1,519	152	10	152		532	7
8	Wiring standard locations	2005	3,121	312	10	312		1,092	8
9									9
10	Engineering Services for new Driveway & Front Entrance	2005	11,347	756	15	756		1,890	10
11	Landscape Architectural Services	2006	5,517	276	20	276		690	11
12	Sign renovation and Installation	2006	21,214	2,121	10	2,121		5,303	12
13	Retaining Wall landscape work	2006	10,357	1,036	10	1,036		2,590	13
14	Underground irrigation system	2006	12,350	1,235	10	1,235		3,088	14
15	Exterior landscape work & clean up	2006	4,824	689	7	689		1,723	15
16	Magnabox DBNPA Biocide	2006	3,861	386	10	386		965	16
17	Main Entrance Studies & Construction	2005	1,421	284	5	284		710	17
18	Lobby, Reception - Finish & Furniture upgrade	2006	30,721	1,536	20	1,536		3,841	18
19	Renovation of Residential Floors	2006	104,781	5,239	20	5,239		13,098	19
20	Asbestos Removal	2006	191,375	9,569	20	9,569		23,787	20
21	Exterior entry renovation	2006	48,443	2,422	20	2,422		5,613	21
22	1st & 3rd floor mobilization, fees & materials	2006	70,000	3,500	20	3,500		8,750	22
23	Evacuation Plan Professional Services	2006	2,585	258	10	258		645	23
24	Asbestos Removal	2006	45,300	2,265	20	2,265		5,662	24
25	2nd Floor Dialysis Room Construction	2006	45,681	4,568	10	4,568		11,420	25
26	Internally installed ductwork to existing wall	2006	1,958	131	15	131		327	26
27	6" Waste Line in Basement	2006	6,560	328	20	328		820	27
28	Wanderguards	2006	16,504	1,100	15	1,100		2,750	28
29	Dryer Vent Upgrade	2006	9,817	982	10	982		2,455	29
30	TWP Elevator Doors & Installation	2006	1,960	131	15	131		327	30
31	Rooms 107R & 109R Cable Installation	2006	1,234	123	10	123		308	31
32	Trane Chiller Maintenance and Upgrade	2006	2,953	295	10	295		738	32
33	Building Ramps to Basement, E. Bldg, S. exit, W. Caretaker	2006	20,450	1,022	20	1,022		2,555	33
34	TOTAL (lines 1 thru 33)		\$ 9,854,605	\$ 174,641		\$ 174,641	\$	\$ 8,388,755	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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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	\$ 174,641		\$ 174,641	\$	\$ 8,388,755	1
2	Thermostats, Reciever/Controllers	2006	14,645	976	15	976		2,440	2
3	100Amp, 3 phase, 4 wire, Subfeed from EM Switchboard	2006	29,793	1,986	15	1,986		4,965	3
4	Repair frozen coil in air handler	2006	1,623	203	8	203		507	4
5	Monitor assembly w/bearings/labor/service call	2006	1,960	245	8	245		613	5
6	Medical Gas Evaluation	2006	2,000	200	10	200		500	6
7	Circuit Boards 16 Port Analog Card	2006	375	38	10	38		95	7
8	Kitchen Doors & Frame	2006	3,944	263	15	263		657	8
9	Fire Sprinkler Valve Replacement	2006	3,548	355	10	355		887	9
10	New Raypak Boiler	2006	3,657	244	15	244		610	10
11	5 - 20 Amp Circuits	2006	3,781	252	15	252		630	11
12	Replace Water Feeder, Clean burner	2006	5,438	544	10	544		1,360	12
13	Pharmacy Office Expansion	2006	2,463	164	15	164		425	13
14	ARJO Lifts	2006	2,204	315	7	315		787	14
15	Floor area & room sign	2006	4,847	242	20	242		613	15
16	Brick Ledge	2006	8,000	400	20	400		1,000	16
17	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	1,193,401	59,670	20	59,670		149,177	17
18									18
19	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	45,952	2,298	20	2,298		5,745	19
20	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	76,176	3,809	20	3,809		9,522	20
21	Concrete work	2006	3,150	158	20	158		395	21
22	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	1,728	173	10	173		432	22
23	Exterior landscape work & clean up	2006	4,500	450	10	450		1,125	23
24	Main Entrance Studies & Construction	2006	58,938	2,947	20	2,947		7,367	24
25	2nd Floor Dialysis Room Construction	2006	7,111	356	20	356		890	25
26									26
27	Roof Repairs	2006	5,330	533	10	533		799	27
28	Exterior Restoration & Tuckpointing of Brick	2006	4,975	332	15	332		498	28
29	1st Floor Renovation - Professional Services & Insulation	2007	2,367	270	7-10	270		405	29
30	Resurface Terrace	2007	38,736	4,842	8	4,842		7,263	30
31	Electrical Engineering for HFNRC	2007	2,500	167	15	167		250	31
32	Furnish & Install New Door & Apply Weatherstripping	2007	7,434	496	15	496		744	32
33	Replace Main Entrance Drive	2007	43,579	2,905	15	2,905		4,358	33
34	TOTAL (lines 1 thru 33)		\$ 11,438,760	\$ 260,474		\$ 260,474	\$	\$ 8,593,814	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 Nursing & Rehab

0048652

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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 12E, Carried Forward		\$ 11,438,760	\$ 260,474		\$ 260,474	\$	\$ 8,593,814	1
2	Replace Nurses Call Station on 3rd Floor	2006	38,700	4,838	8	4,838		7,257	2
3	Remove, Rebuild, Re-Install Pump	2006	7,106	711	10	711		1,066	3
4	Replace Chiller Tubes	2006	4,824	965	5	965		1,447	4
5	Remove & Install 3 Travelling Cables	2007	8,270	1,034	8	1,034		1,551	5
6	Purchase & Installation of 50 ARMM in Switchroom & 100 from 1	2006	15,352	1,919	8	1,919		2,879	6
7	Replace 2 Upright ejector pumps w/ new Submersible Pump	2006	14,354	1,794	8	1,794		2,691	7
8	Repair Generator - spark plug, current transformer, seal & o-ring	2006	5,799	1,160	5	1,160		1,740	8
9	Purchase & Installation of 2 Friedrich A/C's	2007	16,735	2,092	8	2,092		3,138	9
10	Auditorium Smoke Walls	2007	6,177	412	15	412		618	10
11	Purchase & Installation of 50 Doors in various locations	2007	8,713	871	10	871		1,307	11
12	Installation of New Freezer & Water Cooled System	2006	16,294	1,629	10	1,629		2,444	12
13	Salvajor 100 IHP Food Waste Disposer	2006	3,203	320	10	320		480	13
14									14
15	Replace Hot Water Heater	2007	7,199	240	15	240		240	15
16	Repair/Replace Pump & Check Valve	2007	3,072	154	10	154		154	16
17	Nurse Call System	2007	47,900	2,395	10	2,395		2,395	17
18	Install Circuit Panel for Dialysis System	2007	4,367	273	8	273		273	18
19	Major Landscaping Improvements	2008	17,254	1,725	5	1,725		1,725	19
20	Replace Hot Water Heater	2008	7,222	316	15	316		316	20
21	Fabricate & Install grading, ladder & platforms for North Patio	2008	7,958	265	15	265		265	21
22	Boiler Repair	2008	8,300	207	20	207		207	22
23	Repair water damage in elevators	2008	2,764	69	20	69		69	23
24	Replace shower valves	2008	12,470	891	7	891		891	24
25	Carpeting	2008	2,658	266	5	266		266	25
26	Emergency generator & auto switch	2008	3,707	371	5	371		371	26
27	Remove & Install new tubs	2008	9,136	457	10	457		457	27
28	R&M Reclass - Install new float & ball	2008	5,306		15	177	177	177	28
29									29
30									30
31									31
32	Allocated from Home Office					100,031	100,031		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,723,600	\$ 285,848		\$ 386,056	\$ 100,208	\$ 8,628,238	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	\$ 2,657,533	\$ 130,733	\$ 130,733	\$	5-15	\$ 1,582,845	71
72	Current Year Purchases	93,408	4,227	4,227		5-25	4,227	72
73	Fully Depreciated Assets	825,058					825,058	73
74								74
75	TOTALS	\$ 3,575,999	\$ 134,960	\$ 134,960	\$		\$ 2,412,130	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)	\$ 17,128,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 420,808	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 521,016	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 100,208	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,143,957	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
 07/01/2007 - 06/30/2008

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 by the length of the lease N/A.

N/A
N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 103,605 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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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

07/01/2007 - 06/30/2008

Schedule 14 A

XII - Rental Cost: Line 16 (Description)

Wound Vaccine	76,305
Specialty Beds	17,259
Copier	3,258
Postage Meter	2,604
Other Medical Eqpt.	4,179
TOTAL	<u>103,605</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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	10 A (1,2,3)	57	hrs	\$ 2,689	2,512	\$ 149,427	\$ 3,475	2,569	\$ 155,591	1					
2	Licensed Speech and Language Development Therapist	10 A (1,2,3)	510	hrs	24,267	14	895	891	524	26,053	2					
3	Licensed Recreational Therapist			hrs							3					
4	Licensed Physical Therapist	10 A (1,2,3)	4721	hrs	165,090	1,161	67,263	4,544	5,882	236,897	4					
5	Physician Care			visits							5					
6	Dental Care			visits							6					
7	Work Related Program			hrs							7					
8	Habilitation			hrs							8					
9	Pharmacy	39(2)		# of prescripts				1,576,266		1,576,266	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10					
11	Academic Education			hrs							11					
12	Other (specify):										12					
13	Other (specify): <u>Respiratory Therapist</u>	39 (1,3)	10766		258,540	224	10,068	1,052	10,990	269,660	13					
14	TOTAL				\$ 450,586	3,911	\$ 227,653	\$ 1,586,228	19,965	\$ 2,264,467	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 Nursing & Rehab

0048652

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(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	\$ 1,650,145	\$ 1,650,145	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>671,504</u>)	2,320,754	2,320,754	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,390	9,390	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,980,289	\$ 3,980,289	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,675,427	1,725,277	13
14	Buildings, at Historical Cost	7,740,849	5,610,288	14
15	Leasehold Improvements, at Historical Cost	534,834	6,113,312	15
16	Equipment, at Historical Cost	7,178,989	3,679,588	16
17	Accumulated Depreciation (book methods)	(11,143,368)	(11,143,957)	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)	\$ 5,986,731	\$ 5,984,508	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,967,020	\$ 9,964,797	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 231,464	\$ 231,464	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	<u>Deferred Liabilities</u>	2,160	2,160	36
37	<u>Due to Related Parties</u>	20,896,128	20,896,128	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 21,129,752	\$ 21,129,752	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)	\$ 21,129,752	\$ 21,129,752	46
47	TOTAL EQUITY (page 18, line 24)	\$ (11,162,732)	\$ (11,164,955)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,967,020	\$ 9,964,797	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,468,860)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	393,744	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,075,116)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,087,616)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,087,616)	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)	\$ (11,162,732)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Nursing & Rehab

0048652

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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	\$ 12,807,346	1
2	Discounts and Allowances for all Levels	(5,575,881)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,231,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,030,472	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,030,472	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,043	14
15	Telephone, Television and Radio	650	15
16	Rental of Facility Space	263,523	16
17	Sale of Drugs	1,857,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,656	19
20	Radiology and X-Ray		20
21	Other Medical Services	381,738	21
22	Laundry	26,667	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,540,203	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,648	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,648	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Admin - Other Revenue</u>	41,803	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 41,803	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,867,591	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,100,148	31
32	Health Care	5,101,013	32
33	General Administration	3,243,863	33
	B. Capital Expense		
34	Ownership	524,413	34
	C. Ancillary Expense		
35	Special Cost Centers	1,847,971	35
36	Provider Participation Fee	137,799	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,955,207	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,087,616)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,087,616)	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.

Facility Name & ID Number Holy Family Nursing & Rehab

0048652

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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	1,936	2,120	\$ 93,264	\$ 43.99	1
2	Assistant Director of Nursing	352	465	15,613	33.58	2
3	Registered Nurses	51,321	58,754	1,899,206	32.32	3
4	Licensed Practical Nurses	5,162	5,849	140,121	23.96	4
5	CNAs & Orderlies	103,343	117,994	1,567,868	13.29	5
6	CNA Trainees					6
7	Licensed Therapist	4,614	5,287	192,046	36.32	7
8	Rehab/Therapy Aides	1,808	2,247	29,289	13.03	8
9	Activity Director	1,696	2,120	44,022	20.77	9
10	Activity Assistants	5,846	6,358	80,600	12.68	10
11	Social Service Workers	3,608	4,113	63,325	15.40	11
12	Dietician	1,736	1,880	42,449	22.58	12
13	Food Service Supervisor	5,843	6,636	125,725	18.95	13
14	Head Cook	5,412	6,010	81,377	13.54	14
15	Cook Helpers/Assistants	18,506	20,406	207,881	10.19	15
16	Dishwashers					16
17	Maintenance Workers	5,414	6,279	131,728	20.98	17
18	Housekeepers	20,314	23,470	271,033	11.55	18
19	Laundry	13,303	15,110	172,595	11.42	19
20	Administrator	1,904	2,120	114,378	53.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,129	10,625	167,841	15.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,841	2,130	34,141	16.03	31
32	Other Health C: See Sch20A	12,465	14,537	377,757	25.99	32
33	Other(specify) <u>Spiritual Services</u>	6,174	6,421	119,626	18.63	33
34	TOTAL (lines 1 - 33)	281,727	320,931	\$ 5,971,885 *	\$ 18.61	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	19,500	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)		\$ 19,500	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	795	\$ 40,290	10(3) 50
51	Licensed Practical Nurses	202	8,844	10(3) 51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	997	\$ 49,134	53

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family Health Center
Provider # 0026286
07/01/07 - 06/30/08
Staffing & Salary Costs

Schedule 20A

Other Health Care Wages - Line 32:

	<u>Hours</u> <u>Worked</u>	<u>Hours</u> <u>Paid</u>	<u>Salary or</u> <u>Wages</u>	<u>Ave. Hrly.</u> <u>Wages</u>
MDS Care Plan Coordinator	3,105	3,771	119,217	31.61
Respiratory Therapist	9,360	10,766	258,540	24.01
TOTAL	12,465	14,537	377,757	25.99

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Eileen Bregianos	Administrator	0	\$ 114,378	Workers' Compensation Insurance	\$ 79,745	IDPH License Fee	\$		
				Unemployment Compensation Insurance	12,917	Advertising: Employee Recruitment			
				FICA Taxes	431,688	Health Care Worker Background Check			
				Employee Health Insurance	1,003,390	(Indicate # of checks performed <u>220</u>)	3,517		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	13,073		
				Employee Life Insurance	10,028	Life Services Network of Illinois Dues	2,625		
				Employee Dental Insurance	26,430	Miscellaneous Dues & Subscriptions	3,925		
				Retirement Programs	330,285				
				Group Disability	33,136				
				Employee Morale & Other Benefits	26,386	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
				Allocated from Home Office	264,020	Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,378	TOTAL (agree to Schedule V, line 22, col.8)		\$ 23,140			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees			\$ 731,593	N/A		\$	Out-of-State Travel	\$	
(Eliminated on P.3, Col. 7)									
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 731,593				In-State Travel		
C. Professional Services									
Vendor/Payee	Type		Amount				Seminar Expense	119	
N/A			\$						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 119

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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										
													Amount of Expense Amortized Per Year									
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										
2																						
3																						
4	N/A																					
5																						
6																						
7																						
8																						
9																						
10																						
11																						
12																						
13																						
14																						
15																						
16																						
17																						
18																						
19																						
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Nursing & Rehab# 0048652Report Period Beginning: 07/01/2007Ending: 06/30/2008**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. ICLTC - \$13,073; LSN - \$2,625
- (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? 15 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,401 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. \$ 137,799
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,043
- (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 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 complete
- (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