



Facility Name & ID Number Holy Family Nursing & Rehab

# 0048652 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	149	Intermediate (ICF)	149	54,385	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 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	6,139	2,274	7,759	16,172	8
9	SNF/PED					9
10	ICF	30,409	8,097	1,382	39,888	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,548	10,371	9,141	56,060	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.19%

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 102 and days of care provided 16,172

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Holy Family Nursing & Rehab # 0048652 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

**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
	<b>A. General Services</b>										
1	Dietary	453,777	30,957	13,858	498,592		498,592		498,592		1
2	Food Purchase		333,120		333,120		333,120	(184)	332,936		2
3	Housekeeping	265,959	44,888	5,915	316,762		316,762		316,762		3
4	Laundry	172,155	54,934		227,089		227,089		227,089		4
5	Heat and Other Utilities			368,069	368,069		368,069		368,069		5
6	Maintenance	130,538	1,965	288,224	420,727		420,727		420,727		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,022,429	465,864	676,066	2,164,359		2,164,359	(184)	2,164,175		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	3,779,472	283,587	316,081	4,379,140		4,379,140	76	4,379,216		10
10a	Therapy	475,024	434	419,020	894,478		894,478		894,478		10a
11	Activities	175,853	2,853	2,863	181,569		181,569		181,569		11
12	Social Services	132,913	30	3,050	135,993		135,993	(30)	135,963		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,563,262	286,904	762,014	5,612,180		5,612,180	46	5,612,226		16
	<b>C. General Administration</b>										
17	Administrative			766,992	766,992		766,992	124,527	891,519		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			18,339	18,339		18,339		18,339		20
21	Clerical & General Office Expenses	376,353	9,461	(191,779)	194,035		194,035	242,318	436,353		21
22	Employee Benefits & Payroll Taxes			2,146,165	2,146,165		2,146,165	380,974	2,527,139		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			499	499		499		499		25
26	Insurance-Prop.Liab.Malpractice			438,786	438,786		438,786		438,786		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	376,353	9,461	3,179,002	3,564,816		3,564,816	747,819	4,312,635		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,962,044	762,229	4,617,082	11,341,355		11,341,355	747,681	12,089,036		29

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

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

Facility Name & ID Number Holy Family Nursing & Rehab

#0048652

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			466,063	466,063		466,063	118,678	584,741			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											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			466,063	466,063		466,063	118,678	584,741			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,423,033	1,423,033		1,423,033		1,423,033			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,423	137,423		137,423		137,423			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			1,560,456	1,560,456		1,560,456		1,560,456			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,962,044	762,229	6,643,601	13,367,874		13,367,874	866,359	14,234,233			45

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



Holy Family Nursing & Rehab

ID# 0048652

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Chargeable supplies - Other Revenue Negative	\$ 76	10	1
2	Spiritual - Other collection	(30)	12	2
3				3
4	Patient Revenue related to Charity Patients			4
5	recorded as negative expense on the trial balance.			5
6	It is corrected now	281,600	21	6
7				7
8	Other Revenue	(39,282)	21	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	<b>Total</b>	242,364		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

## 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	(184)	0	0	0	0	0	0	0	0	0	0	(184)	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	<b>TOTAL General Services</b>	<b>(184)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(184)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	76	0	0	0	0	0	0	0	0	0	0	76	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	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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	<b>TOTAL Health Care and Programs</b>	<b>46</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>46</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	124,527	0	0	0	0	0	0	0	0	0	124,527	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	242,318	0	0	0	0	0	0	0	0	0	0	242,318	21
22	Employee Benefits & Payroll Taxes	0	380,974	0	0	0	0	0	0	0	0	0	380,974	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	<b>TOTAL General Administration</b>	<b>242,318</b>	<b>505,501</b>	<b>0</b>	<b>747,819</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>242,180</b>	<b>505,501</b>	<b>0</b>	<b>747,681</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Nursing & Rehab

# 0048652

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(366)	119,044	0	0	0	0	0	0	0	0	0	118,678	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,110)	25,110	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	<b>TOTAL Ownership</b>	<b>(25,476)</b>	<b>144,154</b>	<b>0</b>	<b>118,678</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>216,704</b>	<b>649,655</b>	<b>0</b>	<b>866,359</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$		1
2	V	17 Administrative	766,992	Resurrection Health Care	100.00%	891,519	124,527	2
3	V	22 Employee Benefits		Resurrection Health Care	100.00%	380,974	380,974	3
4	V	30 Depreciation		Resurrection Health Care	100.00%	119,044	119,044	4
5	V	32 Interest		Resurrection Health Care	100.00%	25,110	25,110	5
6	V							6
7	V	39 Intercompany Pharmacy	1,423,033	Resurrection Health Care	100.00%	1,423,033		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,190,025			\$ 2,839,680	\$ * 649,655	14

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

Resurrection Health Care  
 Schedule for Form 990  
 Page 5, Part VI, Line 80b  
 Related Organizations  
 Twelve Months Ending June 30, 2009

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

Facility Name & ID Number Holy Family Nursing & Rehab # 0048652 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	Please Refer to Attached Pages 7A and 7B								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

**RESURRECTION SENIOR SERVICES  
BOARD OF DIRECTORS  
OCTOBER 1, 2008**

Name	Office
Mr. Joseph F. Toomey	President and CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5555; Fax 773-990-8601 Email: DEJesus-ortiz@reshealthcare.org
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5153; Fax - 773-990-7626 Email: srdmarie@reshealthcare.org
Mr. John R. Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 ; Fax: 847-813-3876 Email: Jwalton@reshealthcare.org
Michael Rosenberg, M.D.	Director, Emergency Medicine Resurrection Medical Center 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5219; Fax 773-594-7980 Email: Morsenberg@reshealthcare.org  Director, Emergency Medicine Our Lady of the Resurrection Medical Center 5645 W. Addison Chicago, IL 60634 Phone: 773-794-7602; Fax 773-794-7664 Email: Morsenberg@reshealthcare.org
Sister Elizabeth Trembczynski, CSFN	Administrator Case San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-561-4300; Fax - 708-562-5677 Email: Etrem@reshealthcare.org

RESURRECTION SENIOR SERVICES  
OFFICERS  
OCTOBER 1, 2008

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

Facility Name & ID Number Holy Family Nursing & Rehab

# 0048652

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

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

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

Name of Related Organization

Resurrection Health Care

Street Address

7435 W Talcott

City / State / Zip Code

Chicago, IL 60631

Phone Number

( 773) 774-8000

Fax Number

( 773) 594-7488

1	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					\$	\$		\$	1
2									2
3	17	Administrative						891,519	3
4	22	Employee Benefits						380,974	4
5	30	Depreciation						119,044	5
6	32	Interest						25,110	6
7									7
8	39	Intercompany Pharmacy						1,423,033	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				\$	\$		\$ 2,839,680	25

Facility Name & ID Number

Holy Family Nursing & Rehab

# 0048652

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	N/A						\$	\$				\$						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6	N/A																	
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
<b>B. Non-Facility Related*</b>																		
10	N/A																	
11																		
12	Interest								Home Office Allocation			25,110						
13									Interest Income Offset			(25,110)						
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

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

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

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





Facility Name & ID Number Holy Family Nursing & Rehab

# 0048652

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**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	<b>TOTALS</b>			<b>\$ 1,725,277</b>	<b>3</b>

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**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	\$		\$	\$	\$ 5,610,288	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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		1,652	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		108,246	19
20	Building Improvements		1984		161,928		various			161,928	20
21	Building Improvements		1985		140,002		various			140,002	21
22	Building Improvements		1986		74,495	793	15	793		74,495	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		15			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

Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

# 0048652

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## 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		6,441	40
41	Building Improvement #26-5	1995	6,358	424	15	424		5,936	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		11,622	44
45	Building Improvements:Upgrade East elevator	1996	35,024	1,751	20	1,751		22,764	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		274,340	48
49	Building Improvements:Tiling of shower room	1996	1,355	68	20	68		884	49
50	Building Improvements:Cabinets and shower doors	1996	15,698	785	20	785		10,205	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		81,949	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		3,445	58
59	Carpeting Room 215	1997	650		5			650	59
60	Air Handler of West Building	1997	1,450		10			1,450	60
61	Painting,wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		25,421	61
62	Painting,wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		56,706	62
63	Painting,wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		56,067	63
64	30 Ton Chiller	1998	17,670	1,178	15	1,178		13,578	64
65	Fire Dampers in bath rooms	1998	7,135	476	15	476		5,236	65
66	Repair water main from Department 300	1998	3,887		10			3,887	66
67	Gutter replacement of East Building	1999	6,400	640	10	640		6,400	67
68	Painting,wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		41,860	68
69	Replacement of Tran Compressor	1999	7,063	471	15	471		4,707	69
70	TOTAL (lines 4 thru 69)		\$ 8,083,317	\$ 53,721		\$ 53,721	\$	\$ 7,889,777	70

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

Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 8,083,317	\$ 53,721		\$ 53,721	\$	\$ 7,889,777	1
2	Call system upgrade 1 West	1999	33,238	3,322	10	3,322		33,238	2
3	Call system upgrade 3 West	1999	17,274	1,728	10	1,728		17,274	3
4	Painting,wallcovering,floor replacement of 4 West station	1999	2,082	139	15	139		1,387	4
5	Painting,wallcovering,floor replacement of Physical Therapy	1999	8,665	578	15	578		5,780	5
6	Construction of Parking Lot	2000	227,278	11,364	20	11,364		102,276	6
7	Landscaping	2000	7,208	721	10	721		6,488	7
8	Replace East elevator hydrolift	2000	33,472	2,231	15	2,231		20,081	8
9	Repair decking	2000	7,000	467	15	467		4,202	9
10	Door replacement	2000	3,035	304	10	304		2,736	10
11	Construction of Parking Lot	2001	15,451	813	19	813		6,505	11
12	2380 Building remodeling	2001	6,985	699	10	699		5,243	12
13	Freight elevator gate	2001	1,300	87	15	87		695	13
14	Door replacement	2001	3,378	282	12	282		2,256	14
15	Gas Steamer - connection with Booster	2001	7,507	500	15	500		4,000	15
16	Water Main Repair	2002	8,109	405	20	405		2,936	16
17	Building, Reception and office improvements	2002	199,513	13,301	15	13,301		96,432	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		6,851	19
20	Telephone cables	2002	16,900	1,690	10	1,690		12,253	20
21	Topographic Mapping of entire facility	2002	8,316	554	15	554		4,017	21
22									22
23	7 new signs	2002	7,744	774	10	774		5,031	23
24	1 new sign	2003	5,487	549	10	549		3,568	24
25	Norstar digital trunk cartridge, DTI/PRI assy.	2003	5,425		5	(543)	(543)	5,425	25
26	Programming - Direct TV	2003	15,000		5			15,000	26
27	Electrical equipment and labor	2002	24,029	1,602	15	1,602		10,413	27
28	Exterior & interior renov-From 3/30/02 to 4/26/02	2002	10,381	692	15	692		4,498	28
29	Install bumper/crash	2002	15,049	1,505	10	1,505		9,782	29
30	New circuit in basement	2002	6,155	410	15	410		2,665	30
31	Kronos clock - replace jack,install jack cord	2002	265	18	15	18		117	31
32	New door locks	2002	8,575	572	15	572		3,718	32
33	Overhead paging system	2002	2,500	250	10	250		1,625	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,803,521	\$ 100,223		\$ 99,680	\$ (543)	\$ 8,289,707	34

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

Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

# 0048652

Report Period Beginning:

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## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 8,803,521	\$ 100,223		\$ 99,680	\$ (543)	\$ 8,289,707	1
2	Accounting Dept relocating to Des Plaines	2002	1,613	108	15	108		702	2
3	Disconnect furn. Re-wire at Holy Family-Des Pl.	2002	2,995	300	10	300		1,950	3
4	Wrought iron pipe rail	2003	1,820	91	20	91		592	4
5	Install raceways for voice data lines	2003	770	77	10	77		501	5
6	Basement office - data and voice cabling	2003	2,755	184	15	184		1,196	6
7	Redesign and constructions-1st fl. Office space	2002	127,916	3,280	39	3,280		21,320	7
8	Architect fees for exterior & interior renovation	2003	14,810	987	15	987		6,416	8
9	Sign	2003	10,000	1,000	10	1,000		6,500	9
10									10
11	Repair catch basin on North parking lot	2003	850	86	10	86		473	11
12	Install new 6" storm line from bldg to new inl	2003	8,614	862	10	862		4,741	12
13	Parking Patch project # 50950-04	2004	1,523	102	15	102		561	13
14	Data Cable for Res Info/Rooms 120 & 135	2004	1,041	105	5	105		1,041	14
15	Building renovation	2004	4,333	216	20	216		1,188	15
16	Res-info-ancillary bldg dev.	2004	1,444	206	7	206		1,133	16
17	HF/Res info-remove/relocate 2 voice & data	2004	450	64	7	64		352	17
18	Work performed - 2nd floor, room 203	2004	1,191	120	10	120		660	18
19	Landscaping design	2004	2,709	108	25	108		594	19
20	Exterior & interior renovation - SD	2004	25,855	1,724	15	1,724		9,482	20
21									21
22	Crackseal, sealcoat, restripe parking lots	2005	6,040	604	10	604		2,718	22
23	Landscaping improvements	2005	1,700	340	5	340		1,530	23
24	Lighting retrofit project	2005	32,463	2,164	15	2,164		9,738	24
25	Interior finishes renovation	2005	9,600	640	15	640		2,880	25
26	Cable wiring	2005	28,297	1,886	15	1,886		8,487	26
27	Siding, dormers, columns entrance ceiling	2005	24,875	2,488	10	2,488		11,196	27
28	Two new pumps in mechanical room	2005	8,445	564	15	564		2,538	28
29	Boiler maintenance	2005	15,795	1,580	10	1,580		7,110	29
30	Fire alarm panel replacement	2005	6,950	464	15	464		2,088	30
31	One Drop ceiling - 2nd floor of nursing home	2005	1,058	70	15	70		315	31
32	Shower trolley 1900mm electric universal shower	2005	8,303	554	15	554		2,493	32
33	Wiring across from room 218	2005	2,547	170	15	170		765	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,160,283	\$ 121,367		\$ 120,824	\$ (543)	\$ 8,400,967	34

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

Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

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## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 9,160,283	\$ 121,367		\$ 120,824	\$ (543)	\$ 8,400,967	1
2	5 ton condensing unit for laundry area	2005	1,977	198	10	198		891	2
3	Roof work	2005	2,500	250	10	250		1,125	3
4	Materials for winter repairs	2005	7,365	736	10	736		3,312	4
5	Burner tray & burners on Rheem hot water boiler	2005	3,485	349	10	349		1,570	5
6	Casing, relief valve replacement	2005	3,142	448	7	448		2,016	6
7	Wiring room 215	2005	1,519	152	10	152		684	7
8	Wiring standard locations	2005	3,121	312	10	312		1,404	8
9									9
10	Engineering Services for new Driveway & Front Entrance	2005	11,347	756	15	756		2,646	10
11	Landscape Architectural Services	2006	5,517	276	20	276		966	11
12	Sign renovation and Installation	2006	21,214	2,121	10	2,121		7,424	12
13	Retaining Wall landscape work	2006	10,357	1,036	10	1,036		3,626	13
14	Underground irrigation system	2006	12,350	1,235	10	1,235		4,323	14
15	Exterior landscape work & clean up	2006	4,824	689	7	689		2,412	15
16	Magnabox DBNPA Biocide	2006	3,861	386	10	386		1,351	16
17	Main Entrance Studies & Construction	2005	1,421	284	5	284		994	17
18	Lobby, Reception - Finish & Furniture upgrade	2006	30,721	1,536	20	1,536		5,377	18
19	Renovation of Residential Floors	2006	104,781	5,239	20	5,239		18,337	19
20	Asbestos Removal	2006	191,375	9,569	20	9,569		33,356	20
21	Exterior entry renovation	2006	48,443	2,422	20	2,422		8,035	21
22	1st & 3rd floor mobilization, fees & materials	2006	70,000	3,500	20	3,500		12,250	22
23	Evacuation Plan Professional Services	2006	2,585	258	10	258		903	23
24	Asbestos Removal	2006	45,300	2,265	20	2,265		7,927	24
25	2nd Floor Dialysis Room Construction	2006	45,681	4,568	10	4,568		15,988	25
26	Internally installed ductwork to existing wall	2006	1,958	131	15	131		458	26
27	6" Waste Line in Basement	2006	6,560	328	20	328		1,148	27
28	Wanderguards	2006	16,504	1,100	15	1,100		3,850	28
29	Dryer Vent Upgrade	2006	9,817	982	10	982		3,437	29
30	TWP Elevator Doors & Installation	2006	1,960	131	15	131		458	30
31	Rooms 107R & 109R Cable Installation	2006	1,234	123	10	123		431	31
32	Trane Chiller Maintenance and Upgrade	2006	2,953	295	10	295		1,033	32
33	Building Ramps to Basement, E. Bldg, S. exit, W. Caretaker	2006	20,450	1,022	20	1,022		3,577	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,854,605	\$ 164,064		\$ 163,521	\$ (543)	\$ 8,552,276	34

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

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## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 9,854,605	\$ 164,064		\$ 163,521	\$ (543)	\$ 8,552,276	1
2	Thermostats, Reciever/Controllers	2006	14,645	976	15	976		3,416	2
3	100Amp, 3 phase, 4 wire, Subfeed from EM Switchboard	2006	29,793	1,986	15	1,986		6,951	3
4	Repair frozen coil in air handler	2006	1,623	203	8	203		710	4
5	Monitor assembly w/bearings/labor/service call	2006	1,960	245	8	245		858	5
6	Medical Gas Evaluation	2006	2,000	200	10	200		700	6
7	Circuit Boards 16 Port Analog Card	2006	375	38	10	38		133	7
8	Kitchen Doors & Frame	2006	3,944	263	15	263		920	8
9	Fire Sprinkler Valve Replacement	2006	3,548	355	10	355		1,242	9
10	New Raypak Boiler	2006	3,657	244	15	244		854	10
11	5 - 20 Amp Circuits	2006	3,781	252	15	252		882	11
12	Replace Water Feeder, Clean burner	2006	5,438	544	10	544		1,904	12
13	Pharmacy Office Expansion	2006	2,463	164	15	164		589	13
14	ARJO Lifts	2006	2,204	315	7	315		1,102	14
15	Floor area & room sign	2006	4,847	242	20	242		855	15
16	Brick Ledge	2006	8,000	400	20	400		1,400	16
17	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	1,193,401	59,670	20	59,670		208,847	17
18									18
19	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	45,952	2,298	20	2,298		8,043	19
20	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	76,176	3,809	20	3,809		13,331	20
21	Concrete work	2006	3,150	158	20	158		553	21
22	Carpentry, drywall, electrical, ceilings, floors, doors, paint	2006	1,728	173	10	173		605	22
23	Exterior landscape work & clean up	2006	4,500	450	10	450		1,575	23
24	Main Entrance Studies & Construction	2006	58,938	2,947	20	2,947		10,314	24
25	2nd Floor Dialysis Room Construction	2006	7,111	356	20	356		1,246	25
26									26
27	Roof Repairs	2006	5,330	533	10	533		1,332	27
28	Exterior Restoration & Tuckpointing of Brick	2006	4,975	332	15	332		830	28
29	1st Floor Renovation - Professional Services & Insulation	2007	2,367	270	7-10	270		675	29
30	Resurface Terrace	2007	38,736	4,842	8	4,842		12,105	30
31	Electrical Engineering for HFNRC	2007	2,500	167	15	167		417	31
32	Furnish & Install New Door & Apply Weatherstripping	2007	7,434	496	15	496		1,240	32
33	Replace Main Entrance Drive	2007	43,579	2,905	15	2,905		7,263	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,438,760	\$ 249,897		\$ 249,354	\$ (543)	\$ 8,843,168	34

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

Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

# 0048652

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

## 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	<b>Totals from Page 12E, Carried Forward</b>		\$ 11,438,760	\$ 249,897		\$ 249,354	\$ (543)	\$ 8,843,168	1
2	Replace Nurses Call Station on 3rd Floor	2006	38,700	4,838	8	4,838		12,095	2
3	Remove, Rebuild, Re-Install Pump	2006	7,106	711	10	711		1,777	3
4	Replace Chiller Tubes	2006	4,824	965	5	965		2,412	4
5	Remove & Install 3 Travelling Cables	2007	8,270	1,034	8	1,034		2,585	5
6	Purchase & Installation of 50 ARMM in Switchroom & 100 from 1	2006	15,352	1,919	8	1,919		4,798	6
7	Replace 2 Upright ejector pumps w/ new Submersible Pump	2006	14,354	1,794	8	1,794		4,485	7
8	Repair Generator - spark plug, current transformer, seal & o-ring	2006	5,799	1,160	5	1,160		2,900	8
9	Purchase & Installation of 2 Friedrich A/C's	2007	16,735	2,092	8	2,092		5,230	9
10	Auditorium Smoke Walls	2007	6,177	412	15	412		1,030	10
11	Purchase & Installation of 50 Doors in various locations	2007	8,713	871	10	871		2,178	11
12	Installation of New Freezer & Water Cooled System	2006	16,294	1,629	10	1,629		4,073	12
13	Salvajor 100 IHP Food Waste Disposer	2006	3,203	320	10	320		800	13
14									14
15	Replace Hot Water Heater	2007	7,199	480	15	480		720	15
16	Repair/Replace Pump & Check Valve	2007	3,072	307	10	307		461	16
17	Nurse Call System	2007	47,900	4,790	10	4,790		7,185	17
18	Install Circuit Panel for Dialysis System	2007	4,367	546	8	546		819	18
19	Major Landscaping Improvements	2008	17,254	3,451	5	3,451		5,176	19
20	Replace Hot Water Heater	2008	7,222	481	15	481		797	20
21	Fabricate & Install grading, ladder & platforms for North Patio	2008	7,958	531	15	531		796	21
22	Boiler Repair	2008	8,300	415	20	415		622	22
23	Repair water damage in elevators	2008	2,764	138	20	138		207	23
24	Replace shower valves	2008	12,470	1,781	7	1,781		2,672	24
25	Carpeting	2008	2,658	532	5	532		798	25
26	Emergency generator & auto switch	2008	3,707	741	5	741		1,112	26
27	Remove & Install new tubs	2008	9,136	914	10	914		1,371	27
28	R&M Reclass - Install new float & ball	2008	5,306		15	177	177	354	28
29									29
30	Allocated from Home Office	2009				80,969	80,969		30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,723,600	\$ 282,749		\$ 363,352	\$ 80,603	\$ 8,910,621	34

\*\*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:

07/01/2008

Ending:

06/30/2009

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	\$ 2,750,941	\$ 133,903	\$ 133,903	\$	5-15	\$ 1,720,975	71
72	Current Year Purchases	963,214	49,411	49,411			49,411	72
73	Fully Depreciated Assets	825,058					825,058	73
74	Allocation from Home Office			38,075	38,075			74
75	TOTALS	\$ 4,539,213	\$ 183,314	\$ 221,389	\$ 38,075		\$ 2,595,444	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	1992 Ford F-250	1992	\$ 18,860	\$	\$	\$	5	\$ 18,860	76
77	Facility	1998 Saturn Wagon	1997	10,891				5	10,891	77
78	Resident	Dodge Caravan SS	1998	38,811				4	38,811	78
79	Facility	Dodge 10 Passenger Van	1999	30,027				4	30,027	79
80	TOTALS			\$ 98,589	\$	\$	\$		\$ 98,589	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)	\$ 18,086,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 466,063	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 584,741	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 118,678	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,604,654	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <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. N/A

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

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

**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: \$ 170,590 Description: See Attached Page 14A for the details

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. 2010 \$ \_\_\_\_\_

13. 2011 \$ \_\_\_\_\_

14. 2012 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Provider Number: 0026286

FYE: 30-Jun-09

Attachment to Schedule XII, Line 16- Equipment Rental Cost

<u>Equipment</u>	<u>Amount</u>
Copiers	6,575
Medical Equipment	44,835
Postage Services	3,118
Special Beds	50,805
Therapeutic Equipment	65,257
	<hr/>
Total Equipment Lease Exp	<u><u>170,590</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>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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.

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		68 hrs	\$ 3,485	2,018	\$ 131,688		2,086	\$ 135,173	1
2	Licensed Speech and Language Development Therapist		41 hrs	1,672	1,142	74,978		1,183	76,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		3177 hrs	138,712	782	48,549	434	3,959	187,695	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				1,423,033		1,423,033	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$ 143,869	3,942	\$ 255,215	\$ 1,423,467	7,228	\$ 1,822,551	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **06/30/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,417,532	\$ 1,417,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>891,506</u> )	1,247,920	1,247,920	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,578	10,578	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,676,030	\$ 2,676,030	10
	<b>B. Long-Term Assets</b>			
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	14,345,663	5,610,288	14
15	Leasehold Improvements, at Historical Cost	534,834	6,113,312	15
16	Equipment, at Historical Cost	1,537,389	4,637,802	16
17	Accumulated Depreciation (book methods)	(11,609,431)	(11,604,654)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,483,882	\$ 6,482,025	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,159,912	\$ 9,158,055	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 213,626	\$ 213,626	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
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Due to Related Org</u>	21,825,475	21,823,618	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 22,039,101	\$ 22,037,244	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 22,039,101	\$ 22,037,244	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (12,879,189)	\$ (12,879,189)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,159,912	\$ 9,158,055	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(11,162,732)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>111,326</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(11,051,406)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,827,783)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,827,783)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(12,879,189)</b>	<b>24</b> *

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

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 16,194,322	1
2	Discounts and Allowances for all Levels	(5,707,290)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,487,032	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
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	184	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 184	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	264,683	24
25	Interest and Other Investment Income***	472,706	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 737,389	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Admin - Other Rev</u>	315,486	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 315,486	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,540,091	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,164,359	31
32	Health Care	5,612,180	32
33	General Administration	3,564,816	33
	<b>B. Capital Expense</b>		
34	Ownership	466,063	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,560,456	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,367,874	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,827,783)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,827,783)	43

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

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

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

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

Holy Family Nursing and Rehab Center  
Medicaid Provider Number: 0026286  
FYE 6/30/2009  
Attachment to Line 28, Schedule XVII - Other Revenue

Page 19 A

Spiritual - Chapel Collection	30	Offset on Page 5A
Admin - Other Revenue	40,954	Offset on Page 5A
Medical Supply Revenue	(76)	Expense. Add back on Page 5A
Laundry _ Private Patient Revenue	7,565	Pvt Pt. Not subject to offset
Rental Income	267,013	Not subject to offset
Total - Other Revenue	<u>315,486</u>	

Attachment to Line 25, Schedule XVII - Interest Income

Interest Income	472,706
Interest Expense thru home office cost report	25,110
Interest income offset (limited to interest exp)	<u>25,110</u>

Facility Name & ID Number Holy Family Nursing & Rehab

# 0048652

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

**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	1,624	2,079	\$ 94,363	\$ 45.39	1
2	Assistant Director of Nursing	1,600	1,798	59,777	33.25	2
3	Registered Nurses	50,933	58,992	1,954,359	33.13	3
4	Licensed Practical Nurses	3,984	4,724	114,770	24.30	4
5	CNAs & Orderlies	93,482	109,843	1,476,021	13.44	5
6	CNA Trainees					6
7	Licensed Therapist	13,110	14,592	431,653	29.58	7
8	Rehab/Therapy Aides	2,282	2,496	35,390	14.18	8
9	Activity Director	1,864	2,128	44,999	21.15	9
10	Activity Assistants	4,923	5,889	75,178	12.77	10
11	Social Service Workers	3,087	3,304	60,000	18.16	11
12	Dietician	1,852	2,080	47,258	22.72	12
13	Food Service Supervisor	5,989	6,656	129,684	19.48	13
14	Head Cook	4,047	4,522	61,393	13.58	14
15	Cook Helpers/Assistants	19,010	20,656	213,970	10.36	15
16	Dishwashers					16
17	Maintenance Workers	5,347	6,005	130,411	21.72	17
18	Housekeepers	20,617	23,259	266,845	11.47	18
19	Laundry	13,284	14,857	171,742	11.56	19
20	Administrator	1,832	2,130	118,322	55.55	20
21	Assistant Administrator					21
22	Other Administrative	12,180	13,492	209,459	15.52	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: MDS Care	3,957	4,381	145,186	33.14	32
33	Other(specify) <u>Spiritual Svc</u>	6,109	6,410	121,264	18.92	33
34	TOTAL (lines 1 - 33)	271,113	310,293	\$ 5,962,044 *	\$ 19.21	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	21,000	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)		\$ 21,000		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	55	\$ 3,161	10(3)	50
51	Licensed Practical Nurses	59	2,471	10(3)	51
52	Certified Nurse Assistants/Aides	10	249	10(3)	52
53	TOTAL (lines 50 - 52)	124	\$ 5,881		53





Facility Name &amp; ID Number Holy Family Nursing &amp; Rehab

# 0048652

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN \$2,432; ICLTC \$13,674
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A  
What was the average life used for new equipment added during this period? 15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,709 Line 4 Col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 137,423  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees