

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0044362</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Resurrection Nursing and Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2010</u> to <u>06/30/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1001 North Greenwood</u> <u>Park Ridge</u> <u>60068</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(847) 692-5600</u> Fax # <u>(847) 692-2305</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td><u>10/28/2011</u></td></tr><tr><td>(Type or Print Name) <u>Nicola Byrne</u></td><td>(Date)</td></tr><tr><td>(Title) <u>Vice President, Finance</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Raj Shah</u> <u>Senior Reimbursement Consultant</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u></td><td></td></tr><tr><td>(Telephone) <u>(630) 530-7100 Ext 107</u> Fax # <u>(630) 530-7106</u></td><td></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	<u>10/28/2011</u>	(Type or Print Name) <u>Nicola Byrne</u>	(Date)	(Title) <u>Vice President, Finance</u>		(Signed) _____	(Date)	Paid Preparer	(Print Name and Title) <u>Raj Shah</u> <u>Senior Reimbursement Consultant</u>		(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u>		(Telephone) <u>(630) 530-7100 Ext 107</u> Fax # <u>(630) 530-7106</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																													
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Date of Initial License for Current Owners: <u>05/01/1980</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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IRS Exemption Code <u>501C(3)</u>																																																	
In the event there are further questions about this report, please contact:																																																	
Name: <u>Raj Shah</u> Telephone Number: <u>(630) 530-7100 Ext 107</u>																																																	
Email Address: _____																																																	

#	0044362	Report Period Beginning:	07/01/2010	Ending:	06/30/2011
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

Yes

YES ☒ NO ☐

YES ☐ NO ☒

Date started 02/01/1980

YES ☒ Date 02/01/1980 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified	298	and days of care provided	64,660
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IV. ACCOUNTING BASIS

ACCRUAL	X
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CASH*	
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CASH* ☐

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

Tax Year: 06/30/2011 **Fiscal Year:** 06/30/2011

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

	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	28,485	11,060	25,115	64,660	8
9	SNF/PED					9
10	ICF	19,115	5,622	524	25,261	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,600	16,682	25,639	89,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.67%

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	642,354		192,987	835,341		835,341		835,341			1
2	Food Purchase		650,941		650,941		650,941	(7,941)	643,000			2
3	Housekeeping	376,957	40,136	12,722	429,815		429,815		429,815			3
4	Laundry	172,469	86,696	10,303	269,468		269,468	(17,744)	251,724			4
5	Heat and Other Utilities			389,468	389,468		389,468		389,468			5
6	Maintenance	178,452	23,192	154,424	356,068		356,068		356,068			6
7	Other (specify):*											7
8	TOTAL General Services	1,370,232	800,965	759,904	2,931,101		2,931,101	(25,685)	2,905,416			8
	B. Health Care and Programs											
9	Medical Director			25,200	25,200		25,200		25,200			9
10	Nursing and Medical Records	6,456,324	305,299	418,890	7,180,513		7,180,513	(7,659)	7,172,854			10
10a	Therapy	1,209,668	7,897	82,280	1,299,845		1,299,845		1,299,845			10a
11	Activities	197,112	3,898	8,133	209,143		209,143	(287)	208,856			11
12	Social Services	296,818	6,805	12,915	316,538		316,538		316,538			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	8,159,922	323,899	547,418	9,031,239		9,031,239	(7,946)	9,023,293			16
	C. General Administration											
17	Administrative			2,030,418	2,030,418		2,030,418		2,030,418			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			3,621	3,621		3,621		3,621			20
21	Clerical & General Office Expenses	785,691	40,867	(151,098)	675,460		675,460	351,679	1,027,139			21
22	Employee Benefits & Payroll Taxes			3,247,557	3,247,557		3,247,557		3,247,557			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,190	2,190		2,190		2,190			25
26	Insurance-Prop.Liab.Malpractice			426,924	426,924		426,924		426,924			26
27	Other (specify):*											27
28	TOTAL General Administration	785,691	40,867	5,559,612	6,386,170		6,386,170	351,679	6,737,849			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	10,315,845	1,165,731	6,866,934	18,348,510		18,348,510	318,048	18,666,558			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			904,672	904,672		904,672		904,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			216,778	216,778		216,778	(216,778)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Investment Fees							92,997	92,997			36
37	TOTAL Ownership			1,121,450	1,121,450		1,121,450	(123,781)	997,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,129,159		2,129,159		2,129,159		2,129,159			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,155	163,155		163,155		163,155			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,129,159	163,155	2,292,314		2,292,314		2,292,314			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,315,845	3,294,890	8,151,539	21,762,274		21,762,274	194,267	21,956,541			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,941)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(7,659)	10		7
8	Laundry for Non-Patients	(17,744)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(216,778)	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 Page 5A	444,389			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 194,267		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 194,267		37

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

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

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

Report Period Beginning:

Ending:

ID#0044362

07/01/2010

06/30/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Other Adm. Revenue	\$ (4,993)	21	1
2	Activity - Other Revenue	(287)	11	2
3	Charity Op Revenue-Recorded as Negative Exp	358,400	21	3
4	Marketing Exp	(1,728)	21	4
5	Investment fees	92,997	36	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
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19				19
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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	444,389		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Nursing and Rehab Center# 0044362

Report Period Beginning:

07/01/2010

Ending:

06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	(7,941)	0	0	0	0	0	0	0	0	0	0	(7,941)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(17,744)	0	0	0	0	0	0	0	0	0	0	(17,744)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(25,685)	0	0	0	0	0	0	0	0	0	0	(25,685)	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	(7,659)	0	0	0	0	0	0	0	0	0	0	(7,659)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(287)	0	0	0	0	0	0	0	0	0	0	(287)	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	(7,946)	0	0	0	0	0	0	0	0	0	0	(7,946)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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	351,679	0	0	0	0	0	0	0	0	0	0	351,679	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	351,679	0	0	0	0	0	0	0	0	0	0	351,679	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	318,048	0	0	0	0	0	0	0	0	0	0	318,048	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(216,778)	0	0	0	0	0	0	0	0	0	0	(216,778)	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):*	92,997	0	0	0	0	0	0	0	0	0	0	92,997	36
37	TOTAL Ownership	(123,781)	0	0	0	0	0	0	0	0	0	0	(123,781)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	194,267	0	0	0	0	0	0	0	0	0	0	194,267	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Resurrection Health Care</u>	<u>100</u>	<u>See Attached Page 6A</u>		<u>See Attached Page 6A</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	17	<u>Administrative</u>	\$ <u>2,030,418</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	\$ <u>2,030,418</u>	\$	1
2	V								2
3	V	30	<u>Depreciation</u>	<u>309,220</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>309,220</u>		3
4	V	32	<u>Interest</u>	<u>216,778</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>216,778</u>		4
5	V	39	<u>Intercompany Pharmacy</u>	<u>2,129,159</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>2,129,159</u>		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ <u>4,685,575</u>			\$ <u>4,685,575</u>	\$ *	14

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

Related Organizations	Fed Tax ID No	Tax Status
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Medical Center	36-2439318	Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Ambulatory Services	36-4286236	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care Corporation	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Ministries of New York	14-1720818	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES (continued)

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

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

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

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

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

Attachment to Schedule VII - Related Parties	PAGE 7A
RESURRECTION HEALTH CARE CORPORATION	
BOARD OF DIRECTORS	
October, 2010	
	<u>OFFICE</u>
Mr. Thomas D. Settles	1424 West Old Bay Road
Chairperson	Johnsburg, IL 60051
	847/925-1300 (FAX 847/214-6012)
	tsettles@pcec.net
Ms. Sandra Bruce, FACHE	President & CEO
	Resurrection Health Care
	7435 West Talcott Avenue
	Chicago, IL 60631
	773-792-5555 (FAX 773-990-8601)
	Email: sbruc01@reshealthcare.org
Janis Atkinson, M.D.	Saint Francis Hospital
	355 Ridge Avenue
	Evanston, IL 60201
	Cell: (847) 502-5800
	Home: (847) 256-0932
	FAX: (847) 316-2943
	E-Mail: jatkinson@reshealthcare.org
Mr. Kenneth Bauwens	Co-President
	Jamerson & Bauwens Electric Co.
	3055 MacArthur Boulevard
	Northbrook, Illinois 60062
	847/291-2000 (FAX 847/291-2008)
	kbauwens@jbelectric.com
Haven Cockerham	President & CEO
	Cockerham & Associates LLC
	10130 Mallard Creek Road
	Suite 300
	Charlotte, NC 28262
	704-944-5520 (Charlotte Office- Audra Miller)
	312-253-4037 (Chicago office)
	Email: Haven@cockerhamassociates.com
	Email assistant: audra@cockerhamassociates.com
Michael D. Connelly	President & CEO
	Catholic Healthcare Partners
	615 Elsinore Place
	Cincinnati, OH 45202
	513/639-2809 (FAX 513/639-2804)
	Email: mdconnelly@health-partners.org
	Assistant's email: cmross@health-partners.org
Anthony DeFurio	Vice President and CFO
	University of Colorado Hospital
	P.O. Box 6510, Mail Stop F417
	Aurora, CO 80045-6510
	720/848-7816 (FAX 720-848-5542)
	Email: Anthony.defurio@uch.edu
	Via FedEx:
	University of Colorado Hospital
	Leprino Building, 10 th floor
	12401 E. 17 th Avenue, #1043
	Aurora, CO 80045
Sister Loretta Theresa Felici, C.S.F.N.	4001 Grant Avenue
	Philadelphia, PA 19114-2999
	215/268-1035
	Email: ltfelici@aol.com
Stephen Klasko, M.D.	17717 Gulf Blvd.
	#701
	Redington Shores, FL 33708
	813-760-5642 –cell (FAX 813-974-4207)
	Email: sklasko2@gmail.com
Sister Patricia Ann Koschalke, C.S.F.N.	Chairperson
	Sponsorship Board
	Holy Family Medical Center
	150 North River Road, Ste. 210
	847/813-3451 (FAX: 847/813-3482)
	Email: pkoschalke@reshealthcare.org
Susan McDonough	Vice President, Strategy & System Development
	Covenant Health Systems, Inc.

RESURRECTION HEALTH CARE CORPORATION	
BOARD OF DIRECTORS	
October, 2010	
	OFFICE
	100 Ames Pond Drive, Suite 102
	Tewksbury, MA 01876
	978/654-6363 (FAX: 978/851-0828)
	Susan_mcdonough@covenanths.org
	Linda_donaghue@covenanths.org (assistant)
Victor Orler	121 west 9th street
	Hinsdale, IL 60521
	630/654-0615 (FAX 630/654-2030)
	Email: Vic@Orler.Net
Jeffrey M. Silver, M.D.	7447 West Talcott Avenue
	Suite 512
	Chicago, IL 60631
	847/788-1553 (FAX 773-577-8187)
	DJSilver@msn.com
Mr. Chester Stewart	703 N. East Avenue
	Oak Park, IL 60302
	708/383-7167
	Email: clstewy@aol.com
James Winikates	619 Keystone Avenue
	River Forest, IL 60305-1613
	708-771-9371 (voice and fax)
	Email: jwinikates@comcast.net
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO
	Resurrection Medical Center
	7435 West Talcott Avenue
	Chicago, Illinois 60631
	773/792-5153 (FAX 773/792-9926)
	Email: sdonna@reshealthcare.org

OFFICERS
EFFECTIVE AS OF SEPTEMBER 30, 2010

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

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Resurrection Health Care
Street Address 100 North River Road
City / State / Zip Code Des Plaines, IL 60016
Phone Number (847) 813-3722
Fax Number (847) 813-3785

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative				\$	\$		2,030,418	1
2										2
3	30	Depreciation							309,220	3
4	32	Interest							216,778	4
5	39	Intercompany Pharmacy							2,129,159	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		4,685,575	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10								Expected Allocation from H.O.			216,778	10	
11								Offset Interest Income			(216,778)	11	
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

B. Real Estate Taxes

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurrection Nursing and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044362

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

A. Square Feet: 99,460

B. General Construction Type: Exterior Brick & BlockFrame SteelNumber of Stories 3+Ground

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).

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:

3. Current Period Amortization:

N/A

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	126,500	1983	\$ 580,293	1
2	& Parking Area				2
3	TOTALS	126,500		\$ 580,293	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	298			1982	\$ 20,768	\$	20	\$		\$ 20,768	4
5				1983	6,333,842	209,100	19	209,100		5,915,601	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1984		1.736.552	-	16	-		#####	9
10	Various		1985		3.892	-	10	-		3.892	10
11	Various		1986		64.677	-	15	-		64.673	11
12	Various		1987		41.840	422	18	422		35.301	12
13	Various		1988		123.462	-	15	-		123.460	13
14	Various		1989		238.210	-	11	-		238.210	14
15	Various		1990		257.820	-	12	-		257.817	15
16	Various		1991		82.524	799	15	799		82.518	16
17	Various		1992		96.740	418	14	418		96.530	17
18	Various		1993		105.120	3.131	16	3.131		100.422	18
19	Various		1994		259.632	3.803	14	3.803		250.121	19
20	Various		1995		567.394	10.233	10	10.233		562.276	20
21	Various		1996		200.174	5.642	11	5.642		189.629	21
22	Various		1997		1.120.058	44.700	13	44.700		#####	22
23	Various		1998		80.880	3.719	12	3.719		75.301	23
24	Various		1999		2.005	134	15	134		1.537	24
25	Various		2000		324.909	21.082	13	21.082		251.057	25
26	Various		2001		1.344.769	88.699	10	88.699		949.984	26
27	Various		2002		75.146	6.071	12	6.071		56.161	27
28	Various		2003		283.076	11.136	9	11.136		255.444	28
29	Various		2004		11.852	853	10	853		10.508	29
30	Various		2005		58.311	6.690	10	6.690		43.484	30
31	Various		2006		214.383	15.063	15	15.063		83.719	31
32	Various		2007		65.275	5.619	13	5.619		21.802	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Resurrection Nursing and Rehab Center

0044362

Report Period Beginning:

07/01/2010 Ending: 06/30/2011

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HOT WATER LINE REPLACEMENT IN BOILER ROOM	2008	\$ 2,461	\$ 98	25	\$ 98		\$ 345	37
38	SUPPLY & INSTALL INTERIOR SIGNAGE PHASE 2	2008	7,545	755	10	755		2,641	38
39	SUPPLY & INSTALL INTERIOR SIGNAGE PHASE 1	2008	7,545	755	10	755		2,641	39
40	FURNISH/INSTALL FLAGPOLE LIGHT	2008	3,100	310	10	310		1,085	40
41	REMOVE OLD PHONES/INSTALL NEW HANDS FREE PHONES	2008	3,100	310	10	310		1,085	41
42	INSTALL NEW ELECTRIC PROJECTION SCREEN	2008	9,187	919	10	919		3,215	42
43	SUPPLY/INSTALL VARIOUS SIGNS THROUGHOUT BUILDING	2008	7,545	755	10	755		2,641	43
44	REMOVE/ INSTALL NEW ICE MACHINE	2008	5,500	550	10	550		1,925	44
45	VINYL SHEET 4x8 BURLAP, INPROBOUND ADHESIVE, CORNER G	2008	6,042	604	10	604		2,115	45
46	CEILING TILES ASTRO 2x2	2008	13,192	1,319	10	1,319		4,617	46
47	PROVIDE/INSTALL DOORS, FRAMES, HARDWARE, HINGES, CLO	2008	11,646	582	20	582		2,038	47
48	REMOVE/INSTALL NEW FLOORING IN EMPLOYEE LUNCHROOM	2008	9,444	944	10	944		3,305	48
49	REPLACED SPRINKLER HEADS IN KITCHEN	2008	2,400	240	10	240		840	49
50	PROVIDE/INSTALL DOORS, FRAMES, HARDWARE, HINGES, CLO	2008	5,790	290	20	290		1,013	50
51	EXT. ANALOGUE MW LINE AND 11C CABINET	2008	2,830	283	10	283		990	51
52	LITH 2 MDR MVOLT LIGHT FIXTURE	2008	6,475	648	10	648		2,266	52
53	INSTALLED NEW SMOKE DAMPER ON MAIN BUILDING AIR HAND	2008	3,790	379	10	379		948	53
54	CODE ALERT MODEL 70 WANDERER SYSTEM	2008	7,424	742	10	742		1,856	54
55	LITH 2 AVG.217 MDR MVOLT LIGHT FIXTURE	2008	6,475	648	10	648		1,619	55
56	80" V-RISER BED W/ HEAD AND FOOT BOARDS	2008	2,552	213	12	213		532	56
57	LIFE SAFETY PLAN OF CORRECTIONS	2008	55,000	3,667	15	3,667		9,167	57
58	EST. INSTALL COST OF CODE ALERT MODEL 70 WANDERER SY	2008	2,625	263	10	263		656	58
59	15 SECOND DELAYED EGRESS DOOR HARDWARE FOR MIDDLE	2008	6,977	1,395	5	1,395		3,488	59
60	MITSUBISHI 18,000 BTU MINI-SPLIT A/C UNIT	2008	7,663	766	10	766		1,916	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,909,621	\$ 454,748		\$ 454,748		\$ 12,515,762	70

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

Facility Name & ID Number Resurrection Nursing and Rehab Center

0044362

Report Period Beginning:

07/01/2010 Ending: 06/30/2011

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,909,621	\$ 454,748		\$ 454,748		\$ 12,515,762	1
2	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC	2009	2,541	254		254		635	2
3	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC	2009	1,250	125		125		313	3
4	PROVIDE ELECTRICAL SERVICES FOR RNRC	2009	16,250	1,625		1,625		4,063	4
5	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	35,010	3,501		3,501		8,753	5
6	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	32,593	3,259		3,259		8,148	6
7	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	37,159	3,716		3,716		9,290	7
8	RUN ELEVATORS ON INSPECTION FOR ELECTRICIANS	2009	1,586	529		529		1,321	8
9	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	174,027	17,403		17,403		43,507	9
10	FIRE ALARM UPGRADES	2009	6,000	2,000		2,000		5,000	10
11	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	123,826	12,383		12,383		30,957	11
12	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SY	2009	41,460	4,146		4,146		10,365	12
13	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	1,344		1,344		3,359	13
14	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD S	2009	85,250	8,525		8,525		21,313	14
15	L & M TO EXCAVATE & REPAIR WATER MAIN BREAK	2009	5,000	250		250		625	15
16	INSTALLATION CHARGE-15 SEC DELAYED EGRESS DOOR HARD	2009	238	48		48		119	16
17	REMOVE OLD EJECTOR PUMP & REPLACE W/ NEW 3" SUBMERS	2009	6,888	459		459		1,148	17
18	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC - FI	2009	2,531	253		253		633	18
19	Survey if facilities for electrical equipment	2009	4,000	1,333		1,333		3,333	19
20	ComEd Smart Ideas Program - Lighting Retrofit	2009	6,028	603		603		904	20
21	ComEd Smart Ideas Program - Lighting Retrofit	2009	14,296	1,430		1,430		2,144	21
22	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,744	174		174		262	22
23	Emergency Power Upgrades	2009	2,016	134		134		202	23
24	Lower Level Firestopping	2009	12,803	854		854		1,280	24
25	ComEd Smart Ideas Program - Lighting Retrofit	2009	408	41		41		121	25
26	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,244	124		124		187	26
27	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,090	109		109		164	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,528,891	\$ 519,369		\$ 519,369		\$ 12,673,906	34

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

Facility Name & ID Number Resurrection Nursing and Rehab Center

0044362

Report Period Beginning:

07/01/2010 Ending: 06/30/2011

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,528,891	\$ 519,369		\$ 519,369	\$	\$ 12,673,906	1
2	Installation of Tankless Hot Water System for Kitchen + Laundry	2010	32,000	3,200		3,200		4,800	2
3	Installation of 4 Tankless Hot Water Units with Return Piping	2010	38,500	3,850		3,850		5,775	3
4	INSTALL 8 NEW SPRINKLERS IN MAIN KITCHEN & BOILER ROOM	2010	2,800	56		56		56	4
5	INSTALLATION OF 4 FIRE DAMPERS	2010	15,957	824		824		824	5
6	L&M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2010	6,851	174		174		174	6
7	INSTALLATION OF NEW GAS VALVE REGULATORS ON ALL GAS	2010	11,508	607		607		607	7
8	REPLACE BROKEN CONCRETE AT FRONT ENTRANCE	2010	2,700	93		93		93	8
9	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2010	2,284	63		63		63	9
10									10
11	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2011	2,325	116		116		116	11
12	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES INSTALL	2011	10,866	217		217		217	12
13	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES INSTALL	2011	7,892	158		158		158	13
14	1ST FLOOR RENOVATION - SPECIALTY SNF - INITIAL DESIGN ST	2011	5,000	125		125		125	14
15	REPLACEMENT OF 4 SMOKE DAMPERS	2011	3,559	119		119		119	15
16	WIFI SYSTEM FOR RESIDENTS & VISITORS	2011	16,000	800		800		800	16
17									17
18	Corporate Depreciation Allocation	2011		309,220		309,220			18
19									19
20	Reconciliation to financial statements	2011		(378)		(378)			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	TOTAL (lines 1 thru 33)		\$ 14,687,133	\$ 838,614		\$ 838,614	\$	\$ 12,687,833	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,181,635	\$53,800	\$53,800	\$	12	\$1,977,720	71
72	Current Year Purchases	27,065	1,461	1,461		10	1,461	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,208,700	\$55,261	\$55,261	\$		\$1,979,181	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Residence	1993 Oldsmobile	1993	\$18,286	\$	\$	\$	4	\$18,286
77	Residence	1997 Buick Centura	1997	18,343				4	18,343
78	Residence	2007 Ford Starcraft	2007	53,983	10,797	10,797		5	48,585
79									
80	TOTALS			\$90,612	\$10,797	\$10,797	\$		\$85,214

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$17,566,738	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$904,672	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$904,672	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$14,752,228	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Accrued Fixed Assets	\$21,195
93		
94		
95		\$21,195

* 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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
- N/A
- N/A

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 36,172
- Description: Please Refer to Page 14A for the details
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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: 0044362

FYE: 6/30/2011

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

<u>Equipment</u>	<u>Amount</u>
Copiers	18,028
CUTLERY SHARPENING & CUTTING EDGE SERVICE	1,877
Food Service Equipment	15,592
Other - Ecolab	675
Total Equipment Lease Exp	<u><u>36,172</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	7461 hrs	\$ 276,580	728	\$ 47,340	\$	8,189	\$ 323,920	1
2	Licensed Speech and Language Development Therapist	10A	2234 hrs	79,055	27	1,769		2,261	80,824	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	12428 hrs	535,544	14	899		12,442	536,443	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				2,129,159		2,129,159	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 891,179	769	\$ 50,008	\$ 2,129,159	22,892	\$ 3,070,346	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.

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	\$ 452,141	\$ 452,141	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,155,884)	1,269,053	1,269,053	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,647	5,647	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>inerest,premier receivable</u>	326,042	326,042	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,052,883	\$ 2,052,883	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	42,264,761	42,264,761	12
13	Land	580,293	580,293	13
14	Buildings, at Historical Cost	13,065,027	13,065,027	14
15	Leasehold Improvements, at Historical Cost	35,207	35,207	15
16	Equipment, at Historical Cost	3,636,150	3,636,150	16
17	Accumulated Depreciation (book methods)	(14,480,595)	(14,480,595)	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)	\$ 45,100,843	\$ 45,100,843	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 47,153,726	\$ 47,153,726	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 96,177	\$ 96,177	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,315	25,315	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>Due to RMC</u>	(1,499,885)	(1,499,885)	36
37	<u>Medicare Settlement</u>	24,788	24,788	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (1,353,605)	\$ (1,353,605)	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)	\$ (1,353,605)	\$ (1,353,605)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 48,507,331	\$ 48,507,331	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 47,153,726	\$ 47,153,726	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 46,585,253	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 46,585,253	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,922,078	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)	\$ 1,922,078	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)	\$ 48,507,331	24 *

* 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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 30,354,920	1
2	Discounts and Allowances for all Levels	(8,691,607)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,663,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,659	13
14	Non-Patient Meals	7,941	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	17,745	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,345	23
	D. Non-Operating Revenue		
24	Contributions	475	24
25	Interest and Other Investment Income***	2,074,491	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,074,966	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please Refer to Attached Page 19A for the details	(87,273)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (87,273)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,684,352	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,931,101	31
32	Health Care	9,031,239	32
33	General Administration	6,386,170	33
	B. Capital Expense		
34	Ownership	1,121,450	34
	C. Ancillary Expense		
35	Special Cost Centers	2,129,159	35
36	Provider Participation Fee	163,155	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,762,274	40
41	Income before Income Taxes (line 30 minus line 40)**	1,922,078	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,922,078	43

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

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

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

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

Resurrection Nursing and Rehab Center
Medicaid Provider Number: 0044362
FYE 6/30/2011
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	444	Not an income
Admin - Other Revenue	4,993	Offset on Page 5A
Activity - Other Revenue	287	Offset on Page 5A
Investment Fees Exp	(92,997)	A-8 Add On on Page 5A
Total - Other Revenue	<u>(87,273)</u>	

Attachment to Line 25 , Schedule XVII - Interest and Other Investment Income

Interest Income	2,074,491	
Interest Expenses	216,778	Page 6
Interest income offset - limited to interest exp	<u>216,778</u>	

Facility Name & ID Number Resurrection Nursing and Rehab Center# 0044362Report Period Beginning: 07/01/2010Ending: 06/30/2011

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
2	Assistant Director of Nursing	1,720	1,952	79,242	40.60	2
3	Registered Nurses	92,142	102,244	3,740,564	36.58	3
4	Licensed Practical Nurses	4,308	4,715	117,715	24.97	4
5	CNAs & Orderlies	146,528	162,345	2,309,900	14.23	5
6	CNA Trainees					6
7	Licensed Therapist	25,664	28,715	1,032,379	35.95	7
8	Rehab/Therapy Aides	15,764	17,942	345,323	19.25	8
9	Activity Director	1,801	2,045	60,049	29.36	9
10	Activity Assistants	11,244	12,643	142,573	11.28	10
11	Social Service Workers	7,592	8,280	169,646	20.49	11
12	Dietician	3,097	3,441	70,712	20.55	12
13	Food Service Supervisor	3,200	3,672	93,836	25.55	13
14	Head Cook	7,264	8,372	120,099	14.35	14
15	Cook Helpers/Assistants	30,572	34,085	365,980	10.74	15
16	Dishwashers					16
17	Maintenance Workers	7,602	8,502	184,299	21.68	17
18	Housekeepers	23,539	26,697	340,820	12.77	18
19	Laundry	17,463	19,665	217,358	11.05	19
20	Administrator	1,944	2,080	137,406	66.06	20
21	Assistant Administrator	1,896	2,008	39,710	19.78	21
22	Other Administrative	16,242	17,908	336,050	18.77	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(specify)	7,246	7,716	293,387	38.02	32
33	Other(specify)	4,737	5,122	118,797	23.19	33
34	TOTAL (lines 1 - 33)	431,565	480,149	\$ 10,315,845 *	\$ 21.48	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	25,200	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)		\$ 25,200		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Facility Name & ID Number

Resurrection Nursing and Rehab Center

0044362

Report Period Beginning:

07/01/2010

Page 21

Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Farlee, James	Administrator	0	\$ 132,569
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,569

B. Administrative - Other

Description	Amount
Management Fees	\$ 2,030,418
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 2,030,418

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 185,838
Unemployment Compensation Insurance	35,942
FICA Taxes	727,814
Employee Health Insurance	1,345,581
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	20,198
Employee Group Disability	61,650
Employee Retirement Plan	831,836
Employee Assistance and Other Benefits	38,699
TOTAL (agree to Schedule V, line 22, col.8)	\$ 3,247,558

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

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	916
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Activity	75
All Script	2,338
Creative	60
ILRTA	195
Med-Pass	37
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,621

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A	N/A											
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

11.5 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

29,752

 Line

10(2)

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement? YES

X

 NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$

163,155

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$

None

Has any meal income been offset against related costs?

Yes

Indicate the amount. \$

7,941

(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. \$

0

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Adequate Records Have Been Maintained.

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

KPMG LLP

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes - in the electronic format in the enclosed CD

Attach invoices and a summary of services for all architect and appraisal fees

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