FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0044362

Facility Name: Resurection Nursing & Rehab Center

Address: 1001 North Greenwood Avenue (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 692-5600 **Fax #** (847) 692-2305

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2009 to 06/30/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 10/29/2010 (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) 10/29/2010 (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Fax # (630) 530-7106

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	298	Skilled (SNF)	298	108,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	108,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,196	14,515	25,698	66,409	8
9	SNF/PED					9
10	ICF	19,213	4,813	557	24,583	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,409	19,328	26,255	90,992	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.66%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 298 and days of care provided 66,409

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] 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 Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	621,069		185,625	806,694		806,694		806,694			1
2	Food Purchase		663,970		663,970		663,970	(5,873)	658,097			2
3	Housekeeping	382,184	39,999	8,973	431,156		431,156		431,156			3
4	Laundry	170,251	79,154	3,903	253,308		253,308		253,308			4
5	Heat and Other Utilities			305,165	305,165		305,165		305,165			5
6	Maintenance	165,677	20,237	166,479	352,393		352,393		352,393			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,339,181	803,360	670,145	2,812,686		2,812,686	(5,873)	2,806,813			8
	B. Health Care and Programs											
9	Medical Director			25,200	25,200		25,200		25,200			9
10	Nursing and Medical Records	6,256,716	366,047	263,095	6,885,858		6,885,858	(30,879)	6,854,979			10
10a	Therapy	1,146,046	13,111	72,909	1,232,066		1,232,066		1,232,066			10a
11	Activities	180,743	4,386	13,748	198,877		198,877		198,877			11
12	Social Services	295,773	6,774	18,102	320,649		320,649		320,649			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,879,278	390,318	393,054	8,662,650		8,662,650	(30,879)	8,631,771			16
	C. General Administration											
17	Administrative			2,352,743	2,352,743		2,352,743	(957,222)	1,395,521			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			5,674	5,674		5,674		5,674			20
21	Clerical & General Office Expenses	558,522	37,956	(173,794)	422,684		422,684	340,654	763,338			21
22	Employee Benefits & Payroll Taxes			3,631,992	3,631,992		3,631,992	152,694	3,784,686			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			575	575		575		575			25
26	Insurance-Prop.Liab.Malpractice			(301,505)	(301,505)		(301,505)		(301,505)			26
27	Other (specify):*											27
28	**TOTAL General Administration**	558,522	37,956	5,515,685	6,112,163		6,112,163	(463,874)	5,648,289			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	9,776,981	1,231,634	6,578,884	17,587,499		17,587,499	(500,626)	17,086,873			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: Resurection Nursing & Rehab Center #0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			602,895	602,895		602,895	147,489	750,384			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,367	150,367		150,367	(62,629)	87,738			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			753,262	753,262		753,262	84,860	838,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,184,378		2,184,378		2,184,378		2,184,378			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		2,184,378	163,155	2,347,533		2,347,533		2,347,533			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,776,981	3,416,012	7,495,301	20,688,294		20,688,294	(415,766)	20,272,528			45

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	(5,873)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(30,879)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(40,016)	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 From Page 5A	428,392			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 351,624		$	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)	(767,390)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (767,390)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (415,766)		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

Resurection Nursing & Rehab Center

ID# 0044362

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Misc. Operating Revenue	(14,146)	21	2
3	Investment expenses - recorded as other income in WTB	87,738	32	3
4	Charity Care Revenue - Recorded as reduction			4
5	to expenses on working trial balance	354,800	21	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
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25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	428,392		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurection Nursing & Rehab Center **#** 0044362 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,873)	0	0	0	0	0	0	0	0	0	0	(5,873)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,873)	0	0	0	0	0	0	0	0	0	0	(5,873)	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	(30,879)	0	0	0	0	0	0	0	0	0	0	(30,879)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(30,879)	0	0	0	0	0	0	0	0	0	0	(30,879)	16
	C. General Administration													
17	Administrative	0	(957,222)	0	0	0	0	0	0	0	0	0	(957,222)	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	340,654	0	0	0	0	0	0	0	0	0	0	340,654	21
22	Employee Benefits & Payroll Taxes	0	152,694	0	0	0	0	0	0	0	0	0	152,694	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**	340,654	(804,528)	0	0	0	0	0	0	0	0	0	(463,874)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	303,902	(804,528)	0	0	0	0	0	0	0	0	0	(500,626)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurection Nursing & Rehab Center **#** 0044362 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	147,489	0	0	0	0	0	0	0	0	0	147,489	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	47,722	(110,351)	0	0	0	0	0	0	0	0	0	(62,629)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	47,722	37,138	0	0	0	0	0	0	0	0	0	84,860	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)**	351,624	(767,390)	0	0	0	0	0	0	0	0	0	(415,766)	45

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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
Resurection Health Care	100	See Attached Page 6A		See Attached Page 6A		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 2,352,743	Resurection Health Care	100.00%	$ 1,395,521	$ (957,222)	1
2	V	22	Employee Benefits		Resurection Health Care	100.00%	152,694	152,694	2
3	V	30	Depreciation		Resurection Health Care	100.00%	147,489	147,489	3
4	V	32	Interest	150,367	Resurection Health Care	100.00%	40,016	(110,351)	4
5	V								5
6	V								6
7	V								7
8	V	39	Intercompany Pharmacy	2,184,378	Resurection Health Care	100.00%	2,184,378		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 4,687,488			$ 3,920,098	$ * (767,390)	14

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

Resurrection Nursing & Rehab Center
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2010

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 Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Pages 7A & 7B								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS

	Office
Sandra Bruce *Ex Officio*	President & CEO Resurrection Health Care 7435 W. Talcott Avenue Suite 520 Chicago, IL 60631 Phone: 773-792-5555 Fax: 773-990-8601 SBruc01@reshealthcare.org
John Baird	Executive Vice President/CEO Holy Family Medical Center 100 N. River Road Des Plaines, IL 60016 Phone: 847-813-3161 Fax: 847-297-1863 John.Baird@reshealthcare.org
Connie March	President Provena Senior Services 19065 Hickory Creek Drive Suite 310 Mokena, IL 60448-8507 Phone: 708-478-7922 Fax: 708-478-5143 Connie.march@provena.org
Michael J. Nabolotny, M.D.	Resurrection Medical Center 7447 W. Talcott Avenue Suite 262 Chicago, IL 60631 Phone: 773-775-1900 Fax: 773-775-8034 Timc262@sbcglobal.net
Lawrence Pankau, M.D.	132 S. Prospect Park Ridge, IL 60068 Phone: 847-825-6631 Fax: 847-825-8684 Lawrence.Pankau@reshealthcare.org
Sr. Elizabeth Trem, CSFN	Executive Director Casa San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-562-4300 Fax: 708-492-0548 ETrem@reshealthcare.org
Sr. Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Medical Center 7435 W. Talcott Avenue Chicago, IL 60631 Phone: 773-774-8000 Fax: 773-990-7626 Sdonna@reshealthcare.org
John 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 Jwalton@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 Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Resurection 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative				$	$		$ 1,395,521	1
2	22	Employee Benefits							152,694	2
3	30	Depreciation							147,489	3
4	32	Interest							40,016	4
5										5
6										6
7	39	Intercompany Pharmacy							2,184,378	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,920,098	25

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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							Allocated From Home Office				40,016	10
11							Offset Interest Income				(40,016)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007		10
2008		11
2009	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurection Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044362

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald, Controller

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$	$
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 3+Ground

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: N/A 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	298			1976	$ 6,276,546	$		$	$	$ 6,276,546	4
5				1976	1,733,006					1,733,006	5
6				1976	4,035,308					4,035,308	6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Electrical Engineering			2007	2,959	198	15	198		693	11
12	Window Treatments			2007	67,000	8,376	8	8,376		29,316	12
13	Removal and Installation of Fresh Air Damper			2007	3,365	420	8	420		1,470	13
14	Removal and Installation of Exhaust Fan			2007	4,465	558	8	558		1,953	14
15	Install Plastic laminate wall & base cabinet w/plastic laminate cour			2007	4,590	458	10	458		1,603	15
16	Direct Sale Card Access System			2007	3,995	500	8	500		1,750	16
17											17
18											18
19											19
20	Room Lighting for Wing			2007	13,244	1,324	10	1,324		3,310	20
21	Provide/Install Oak Cabinets, countertops & SS sink			2007	37,360	2,491	15	2,491		6,227	21
22	Move plumbing for break room sink relocation			2007	3,127	125	25	125		313	22
23	Furnish/Install Flagpole			2007	4,146	207	20	207		568	23
24	Furnish/Install Flagpole			2008	3,100	310	10	310		775	24
25	Supply/Install Interior Signage			2008	22,635	2,264	10	2,264		5,659	25
26	Ceiling tiles 2x2			2008	13,192	1,319	10	1,319		3,298	26
27	Carpeting			2008	6,042	604	10	604		1,510	27
28	Provide/Install Doors (frames, door, hardware, hinges & closures)			2008	17,436	872	20	872		2,180	28
29	remove/Install new flooring in employee lunch room			2008	9,444	944	10	944		2,360	29
30	Lith 2 MDR Mvolt Light Fixture			2008	6,475	648	10	648		1,620	30
31	Extend Analogue MW line and 11C Cabinet			2008	2,830	283	10	283		707	31
32	R&M Reclass -			2007	2,746		10	275	275	687	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 Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	INSTALLED NEW SMOKE DAMPER ON MAIN BUILDING A	2008	3,790	379	10	379		569	38
39	80" V-RISER BED W/ HEAD AND FOOT BOARDS	2008	2,552	213	12	213		319	39
40	CODE ALERT MODEL 7O WANDERER SYSTEM	2008	7,424	742	10	742		1,114	40
41	80"V-RISER BED	2008	12,370	1,031	12	1,031		1,546	41
42	3 FUNCTION BED 48 X 48	2008	6,050	504	12	504		756	42
43	EST. INSTALL COST OF CODE ALERT MODEL 70 WANDER	2008	2,625	263	10	263		394	43
44	LIFE SAFETY PLAN OF CORRECTIONS	2008	55,000	3,667	15	3,667		5,500	44
45	MISC. REPAIRS TO 1996 FORD PICK-UP	2008	3,823	1,274	3	1,274		1,912	45
46	MITSUBISHI 18,000 BTU MINI-SPLIT A/C UNIT	2008	7,663	766	10	766		1,149	46
47	15 SECOND DELAYED EGRESS DOOR HARDWARE FOR MI	2008	6,977	1,395	5	1,395		2,093	47
48									48
49									49
50	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	1,344	3	1,344		2,016	50
51	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	41,460	4,146	10	4,146		6,219	51
52	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	123,826	12,383	10	12,383		18,574	52
53	FIRE ALARM UPGRADES	2009	6,000	2,000	3	2,000		3,000	53
54	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	174,027	17,403	10	17,403		26,104	54
55	RUN ELEVATORS ON INSPECTION FOR ELECTRICIANS	2009	1,586	529	3	529		793	55
56	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	37,159	3,716	10	3,716		5,574	56
57	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	32,593	3,259	10	3,259		4,889	57
58	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE AL	2009	35,010	3,501	10	3,501		5,252	58
59	PROVIDE ELECTRICAL SERVICES FOR RNRC	2009	16,250	1,625	10	1,625		2,438	59
60	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RN	2009	1,250	125	10	125		188	60
61	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RN	2009	2,541	254	10	254		381	61
62	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE	2009	85,250	8,525	10	8,525		12,788	62
63	INSTALLATION CHARGE-15 SEC DELAYED EGRESS DOOR	2009	238	48	5	48		71	63
64	L & M TO EXCAVATE & REPAIR WATER MAIN BREAK	2009	5,000	250	20	250		375	64
65	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RN	2009	2,531	253	10	253		380	65
66	REMOVE OLD EJECTOR PUMP & REPLACE W/ NEW 3" SU	2009	6,888	459	15	459		689	66
67	Survey if facilities for electrical equipment	2009	4,000	1,333	3	1,333		2,000	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,960,925	$ 93,288		$ 93,562	$ 275	$ 12,217,938	70

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,960,925	$ 93,288		$ 93,562	$ 275	$ 12,217,938	1
2									2
3	Lower Level Firestopping	2009	12,803	427	15	427		427	3
4	Emergency Power Upgrades	2009	2,016	67	10	67		67	4
5	CMS Response 2009	2009	6,028	301	10	301		301	5
6	ComEd Smart Ideas Program - Lighting Retrofit	2009	14,296	715	10	715		715	6
7	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,744	87	10	87		87	7
8	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,244	62	10	62		62	8
9	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,608	80	10	80		80	9
10	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,090	55	10	55		55	10
11									11
12	Installation of Tankless Hot Water System for Kitchen + La	2010	32,000	1,600	10	1,600		1,600	12
13	Installation of 4 Tankless Hot Water Units with Return Pipir	2010	38,500	1,925	10	1,925		1,925	13
14									14
15	Home Office Allocation			(15,527)		(15,527)			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	TOTAL (lines 1 thru 33)		$ 13,072,255	$ 83,080		$ 83,355	$ 275	$ 12,223,258	34

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 3,348,002	$ 487,897	$ 487,897	$	25-Mar	$ 1,602,767	71
72	Current Year Purchases	111,330	5,319	5,319		10-15	5,319	72
73	Fully Depreciated Assets							73
74	Home Office Allocation		163,016	163,016				74
75	TOTALS	$ 3,459,332	$ 656,232	$ 656,232	$		$ 1,608,086	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	Ford Truck	2002	$ 26,878	$	$	$	5	$ 26,878	76
77	Residence	Ford Starcraft	2007	53,983	10,797	10,797	0	5	37,787	77
78										78
79										79
80	TOTALS			$ 80,861	$ 10,797	$ 10,797	$ 0		$ 64,665	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 17,192,741	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 750,109	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 750,384	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 275	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,896,009	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	Chapel-various02002	$ 18,534	$	$ 18,534	86
87	Sinks for Beauty shop -2002	8,659	433	3,900	87
88	Prov Serv Asst Living - 2002	897	90	720	88
89	Prov Serv Asst Living - 2003	478	32	256	89
90					90
91	TOTALS	$ 28,568	$ 555	$ 23,410	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.

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 32,150 Description: Please Refer to 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			N/A		18
19					19
20					20
21	TOTAL		$	$	21

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

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

Provider Number: 0044362

FYE: 6/30/2010

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Equipment	Amount
Copiers	14,041
CUTLERY SHARPENING & CUTTING EDGE SERVICE	2,106
Food Service Equipment	15,867
Other Misc.	136
Total Equipment Lease Exp	32,150

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		5856	hrs	$ 203,048	654	$ 39,341	$	6,510	$ 242,389	1
2	Licensed Speech and Language Development Therapist		2174	hrs	75,665				2,174	75,665	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		11391	hrs	485,424	16	962		11,407	486,386	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				2,184,378		2,184,378	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				$ 764,137	670	$ 40,303	$ 2,184,378	20,091	$ 2,988,818	14

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 735,693	$ 735,693	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,414,990))	1,717,218	1,717,218	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,957	5,957	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): interest receivable	268,661	268,661	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,727,529	$ 2,727,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	40,212,799	40,212,799	12
13	Land	580,293	580,293	13
14	Buildings, at Historical Cost	10,228,352	10,228,352	14
15	Leasehold Improvements, at Historical Cost	46,073	46,073	15
16	Equipment, at Historical Cost	6,338,023	6,338,023	16
17	Accumulated Depreciation (book methods)	(13,896,009)	(13,896,009)	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)**	$ 43,509,531	$ 43,509,531	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 46,237,060	$ 46,237,060	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,908	$ 115,908	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,012	27,012	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to RMC	(491,502)	(491,502)	36
37	Payable to Stroke Fund	388	388	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (348,194)	$ (348,194)	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)**	$ (348,194)	$ (348,194)	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 46,585,254	$ 46,585,254	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 46,237,060	$ 46,237,060	48

***(See instructions.)**

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 44,046,636	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 44,046,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,538,618	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,538,618	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)**	$ 46,585,254	24 *

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 29,336,449	1
2	Discounts and Allowances for all Levels	(6,958,311)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 22,378,138	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		13
14	Non-Patient Meals	5,873	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	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,873	23
	D. Non-Operating Revenue		
24	Contributions	135	24
25	Interest and Other Investment Income***	1,645,201	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,645,336	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue - Please Refer to Page 19A	67,201	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 67,201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 24,096,548	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,812,686	31
32	Health Care	8,662,650	32
33	General Administration	6,112,163	33
	B. Capital Expense		
34	Ownership	753,262	34
	C. Ancillary Expense		
35	Special Cost Centers	2,184,378	35
36	Provider Participation Fee	163,155	36
	D. Other Expenses (specify):		
37	Provision for Bad Debts	869,636	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,557,930	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,538,618	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,538,618	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 6/30/2010
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	4,218	Not an income
Admin - Other Revenue	14,146	Offset on Page 5A
Medical Supply Revenue	30,879	Patient Revenue- not subject to offset
Laundry _ Private Patient Revenue	17,958	Pvt Pt. Not subject to offset
Total - Other Revenue	67,201	

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

Interest Income		1,732,939	
Less: Investment Fees		(87,738)	
Net Interest Income		1,645,201	
Interest Expenses	150,367		Page 6
Adjusted to Home office allowable int. exp		40,016	Page 5
Interest income offset - limited to interest exp		40,016	

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,056	2,080	$ 93,198	$ 44.81	1
2	Assistant Director of Nursing	1,880	2,080	81,777	39.32	2
3	Registered Nurses	87,643	98,936	3,443,469	34.81	3
4	Licensed Practical Nurses	4,941	5,576	132,251	23.72	4
5	CNAs & Orderlies	147,015	162,762	2,194,950	13.49	5
6	CNA Trainees					6
7	Licensed Therapist	22,872	25,456	887,903	34.88	7
8	Rehab/Therapy Aides	16,030	17,950	370,496	20.64	8
9	Activity Director	1,879	2,047	58,290	28.48	9
10	Activity Assistants	9,922	10,836	116,271	10.73	10
11	Social Service Workers	7,011	8,044	159,272	19.80	11
12	Dietician	3,315	3,455	73,180	21.18	12
13	Food Service Supervisor	3,233	3,625	89,241	24.62	13
14	Head Cook	7,164	8,212	113,831	13.86	14
15	Cook Helpers/Assistants	29,801	33,035	343,187	10.39	15
16	Dishwashers					16
17	Maintenance Workers	7,132	8,032	165,640	20.62	17
18	Housekeepers	25,465	29,293	359,397	12.27	18
19	Laundry	16,488	19,496	210,370	10.79	19
20	Administrator	1,960	2,048	113,661	55.50	20
21	Assistant Administrator	2,056	2,120	43,022	20.29	21
22	Other Administrative	15,460	17,018	298,877	17.56	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)	7,729	8,505	302,212	35.53	32
33	Other(specify) Religious	5,120	5,504	126,486	22.98	33
34	TOTAL (lines 1 - 33)	426,172	476,110	$ 9,776,981 *	$ 20.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Farlee, James	Administrator		$ 113,661
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,661

B. Administrative - Other

Description	Amount
Management Fees	$ 2,352,743
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,352,743
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
N/A		$
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	$ 46,446
Unemployment Compensation Insurance	55,282
FICA Taxes	696,761
Employee Health Insurance	1,864,846
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Ins	18,208
Employee Group Disability	61,876
Employee Retirement Plan	837,512
Employee Assistance and Other Benefits	51,061
Home Office Allocation	152,694
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,784,686

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Allscript	1,456
Life Service Network Subscription	4,218
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,674

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

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

Facility Name & ID Number Resurection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Service Network $4,218**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **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. $ **20,886** 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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **5,873**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequare Records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG, LLP**

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

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