FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051490

Facility Name: Ballard Nursing Center

Address: 9300 Ballard Road (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847) 294-2300 **Fax #** (847) 299-4012

HFS ID Number:

Date of Initial License for Current Owners: 05/31/2011

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code 501(C)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 06/01/2011 to 06/30/2012 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) 10/30/2012 (Date)
(Type or Print Name) Michael Volante
(Title) System Director - Reimbursement

Paid Preparer

(Signed) 10/27/2012 (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 West Butterfiled Road, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Ext 107 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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	231	Skilled (SNF)	231	84,546	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	231	TOTALS	231	84,546	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	16,392	1,787	18,201	36,380	8
9	SNF/PED					9
10	ICF	10,928	1,295	440	12,663	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,320	3,082	18,641	49,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.01%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 01/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/31/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 231 and days of care provided 36,380

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: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	428,489	24,921	15,697	469,107		469,107		469,107			1
2	Food Purchase		245,928		245,928		245,928	835	246,763			2
3	Housekeeping	345,135	61,035	27,689	433,859		433,859		433,859			3
4	Laundry	131,872	50,296	4,913	187,081		187,081	(623)	186,458			4
5	Heat and Other Utilities			266,752	266,752		266,752		266,752			5
6	Maintenance	122,143	45,649	201,498	369,290		369,290		369,290			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,027,639	427,829	516,549	1,972,017		1,972,017	212	1,972,229			8
	B. Health Care and Programs											
9	Medical Director			176,850	176,850		176,850		176,850			9
10	Nursing and Medical Records	4,731,136	1,044,095	343,356	6,118,587		6,118,587	(365,447)	5,753,140			10
10a	Therapy	2,745,551	426,126	25,561	3,197,238		3,197,238		3,197,238			10a
11	Activities	164,472	7,003	476	171,951		171,951	(269)	171,682			11
12	Social Services	193,403	4,372	227	198,002		198,002		198,002			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,834,562	1,481,596	546,470	9,862,628		9,862,628	(365,716)	9,496,912			16
	C. General Administration											
17	Administrative			1,352,639	1,352,639		1,352,639	189,216	1,541,855			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			2,675	2,675		2,675		2,675			20
21	Clerical & General Office Expenses	1,255,669	127,291	(75,930)	1,307,030		1,307,030	(5,041)	1,301,989			21
22	Employee Benefits & Payroll Taxes			2,500,220	2,500,220		2,500,220		2,500,220			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			13,444	13,444		13,444		13,444			25
26	Insurance-Prop.Liab.Malpractice			116,679	116,679		116,679		116,679			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,255,669	127,291	3,909,727	5,292,687		5,292,687	184,175	5,476,862			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	10,117,870	2,036,716	4,972,746	17,127,332		17,127,332	(181,329)	16,946,003			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 Ballard Nursing Center #0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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			368,989	368,989		368,989		368,989			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,858	90,858		90,858		90,858			32
33	Real Estate Taxes			665,735	665,735		665,735	(665,735)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			428,028	428,028		428,028	828	428,856			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,553,610	1,553,610		1,553,610	(664,907)	888,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,389,204	828	1,390,032		1,390,032	364,619	1,754,651			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		287	354	641		641		641			41
42	Provider Participation Fee			401,164	401,164		401,164		401,164			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,389,491	402,346	1,791,837		1,791,837	364,619	2,156,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,117,870	3,426,207	6,928,702	20,472,779		20,472,779	(481,617)	19,991,162			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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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	835	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(623)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(481,829)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (481,617)		$	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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (481,617)		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

Ballard Nursing Center

ID# 0051490

Report Period Beginning: 06/01/2011

Ending: 06/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Exp	$ (269)	11	1
2	Admin - Other Rev	(8,100)	17	2
3	Charity Care CR from hosp:Reverse reduction of exp	194,400	21	3
4	Marketing Exp	(2,125)	21	4
5	Real Estate Taxes	(665,735)	33	5
6				6
7	Administrator's Salary	197,316	17	7
8	Administrator's Salary	(197,316)	21	8
9				9
10	Xray, Lab, dialysis,dental etc ancillary services	(365,447)	10	10
11	Xray, Lab, dialysis,dental etc ancillary services	365,447	39	11
12				12
13	Equipment Lease Exp - For Proper Grouping of Exp	(828)	39	13
14	Equipment Lease Exp - For Proper Grouping of Exp	828	35	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(481,829)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ballard Nursing Center **#** 0051490 **Report Period Beginning:** 06/01/2011 **Ending:** 06/30/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	835	0	0	0	0	0	0	0	0	0	0	835	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(623)	0	0	0	0	0	0	0	0	0	0	(623)	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**	212	0	0	0	0	0	0	0	0	0	0	212	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	(365,447)	0	0	0	0	0	0	0	0	0	0	(365,447)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(269)	0	0	0	0	0	0	0	0	0	0	(269)	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**	(365,716)	0	0	0	0	0	0	0	0	0	0	(365,716)	16
	C. General Administration													
17	Administrative	189,216	0	0	0	0	0	0	0	0	0	0	189,216	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	(5,041)	0	0	0	0	0	0	0	0	0	0	(5,041)	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**	184,175	0	0	0	0	0	0	0	0	0	0	184,175	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,329)	0	0	0	0	0	0	0	0	0	0	(181,329)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ballard Nursing Center **#** 0051490 **Report Period Beginning:** 06/01/2011 **Ending:** 06/30/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(665,735)	0	0	0	0	0	0	0	0	0	0	(665,735)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	828	0	0	0	0	0	0	0	0	0	0	828	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(664,907)	0	0	0	0	0	0	0	0	0	0	(664,907)	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	364,619	0	0	0	0	0	0	0	0	0	0	364,619	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**	364,619	0	0	0	0	0	0	0	0	0	0	364,619	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(481,617)	0	0	0	0	0	0	0	0	0	0	(481,617)	45

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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
Resurrection Health Care	100	See attached PG6-Supp		See attached PG6-Supp		

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 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	Adminstrative	$ 1,352,639	Resurrection Health Care	100	$ 1,352,639	$	1
2	V	30	Depreciation	102,572	Resurrection Health Care	100	102,572		2
3	V	32	Interest	90,858	Resurrection Health Care	100	90,858		3
4	V	39	Pharmacy	1,230,843	Resurrection Health Care	100	1,230,843		4
5	V								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			$ 2,776,912			$ 2,776,912	$ *	14

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

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Resurrection Health Care Corp. (RHCC)	100	Resurrection Senior Services	Chicago	Provena-Resurrectio	Chicago	Health Care	1
2					Resurrection Univers	Oak Park	Health Care	2
3					Holy Family Health C	Des Plaines	Health Care	3
4					Holy Family Medical	Des Plaines	Health Care	4
5					Mount Loretto Nursi	Amsterdam	Senior Living	5
6					Our Lady of the Resu	Chicago	Health Care	6
7					Provena Care & Hom	Mokena	Health Care	7
8					Provena Health	Frankfort	Health Care	8
9					Provena Home Healt	Mokena	Health Care	9
10					Provena Hospitals	Frankfort	Health Care	10
11					Provena Laverna Ter	Mokena	Health Care	11
12					Provena Self-Insuran	Frankfort	Insurance	12
13					Provena Senior Servi	Mokena	Health Care	13
14					Proviso Family Srvcs	Broadview	Health Care	14
15					Resurrection Ambula	Chicago	Health Care	15
16					Resurrection Develo	Des Plaines	Fundraising	16
17								17
18					Resurrection Health	Des Plaines	Health Care	18
19					Resurrection Home H	Morton Grove	Home Care	19
20					Resurrection Medica	Chicago	Health Care	20
21					Resurrection Medica	Chicago	Fundraising	21
22					Resurrection Ministr	Castleton	Parent Corp	22
23					Resurrection Nursing	Castleton	Senior Living	23
24								24
25					Resurrection Service	Chicago	Health Care	25
26					Saint Francis Hospita	Evanston	Health Care	26
27					Saint Francis Hospita	Evanston	Fundraising	27
28					Saints Mary and Eliza	Chicago	Health Care	28
29					St. Joseph Hospital	Chicago	Health Care	29
30								30

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	John Walton - Thru 10/31/11	BOD						1
2	Sr. Donna Marie Wolowicki thru 9/30/11	BOD						2
3	Nicola Byrne thru 12/16/11	BOD						3
4	Demetrios Kouzios thru 12/1/11	BOD						4
5	Connie March - effective 11/1/11	BOD						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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	N/A								$		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

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 6/30/2012

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: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 813-3719
Fax Number: (847) 813-3786

	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	Adminstrative				$	$		$ 1,352,639	1
2	30	Depreciation							102,572	2
3	32	Interest							90,858	3
4	39	Pharmacy							1,230,843	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,776,912	25

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Allocation From Home Office						$	$			$ 90,858	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 90,858	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 90,858	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ballard Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051490

CONTACT PERSON REGARDING THIS REPORT Michael Gordon, Business Unit CFO

TELEPHONE (708) 478-7911 FAX #: (708) 478-5387

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,917 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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. [ ] (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: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 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	Residence Care	52,917	2011	$ 2,480,000	1
2					2
3	TOTALS	52,917		$ 2,480,000	3

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	231		2011		$ 10,666,682	$ 237,424	5-35	$ 237,424	$	$ 237,424	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	EMERGENCY REPAIRS TO SIDEWALK & TRENCH			2011	14,500	725	10	725		725	9
10	INSTALLATION OF 1 DROP 3RD FLOOR - 2 FOR API CLOCKS LOWER LEV			2011	2,131	71	15	71		71	10
11	EMERGENCY REPAIRS TO PARKING LOT			2011	2,300	115	10	115		115	11
12	KITCHEN PIPING REPLACEMENT			2011	2,380	48	25	48		48	12
13	REPLACE SINKS			2011	3,810	95	20	95		95	13
14	ADDITIONAL COSTS TO COMPLETE 3RD MEDICAL GAS PROJECT			2011	35,300	1,177	15	1,177		1,177	14
15	SPRINKLER INSTALLATION PROJECT			2012	20,000	400	25	400		400	15
16	COMPLETE WALLS ABOVE CEILING IN PATIENT ROOM BATHROOMS			2012	18,800	627	15	627		627	16
17	NETWORK CABLE INSTALL 2 WEST & LOWER LEVEL / NETWORK CABLE			2012	7,859	262	15	262		262	17
18	REPAIRS TO FLASHINGS TO UPPER ROOF			2012	3,760	125	15	125		125	18
19	NETWORK CABLE INSTALL 2 WEST & LOWER LEVEL / NETWORK CABLE			2012	3,182	106	15	106		106	19
20											20
21	corporate allocation dep			2012		102,572		102,572			21
22											22
23	Reconcile to general ledger			2012		15,335		15,335			23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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	$	$	$	$		$	71
72	Current Year Purchases	107,417	9,907	9,907		5-15	9,907	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 107,417	$ 9,907	$ 9,907	$		$ 9,907	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 13,368,122	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 368,989	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 368,989	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 251,082	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 428,856 Description: See attached PG14A
    (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

* 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: 0023093

FYE: 6/30/2012

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment /Vendor	Amount
Food Equipment	245
Maintenance Equipment	1,311
Nursing Equipment	231,295
Admin. Equip including copier	48,702
Pharmacy Equip	828
Therapy Equipment	146,475
Total Equipment Lease Exp	428,856

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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.

   The CNAs that were hired were already trained.

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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	10(A)	visits		24	1,241		24	1,241	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				1,389,204		1,389,204	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			$	24	$ 1,241	$ 1,389,204	24	$ 1,390,445	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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (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	$ (224,549)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,998,304		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): bxbs settlement liability	(286,472)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,487,283	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,480,000		13
14	Buildings, at Historical Cost	10,666,682		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	221,440		16
17	Accumulated Depreciation (book methods)	(251,082)		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): Intangibles	2,354,665		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,471,705	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,958,988	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 184,712	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,056		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9		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	33,485,112		36
37	Accrued Exp	39,288		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 33,736,177	$	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)**	$ 33,736,177	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (11,777,189)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,958,988	$	48

***(See instructions.)**

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 231,524	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 231,524	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(12,008,713)	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)**	$ (12,008,713)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (11,777,189)	24	*

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

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 29,823,770	1
2	Discounts and Allowances for all Levels	(14,944,277)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,879,493	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	(835)	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	626	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (209)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	From Page 19A	(6,415,218)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (6,415,218)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,464,066	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,972,017	31
32	Health Care	9,862,628	32
33	General Administration	5,292,687	33
	B. Capital Expense		
34	Ownership	1,553,610	34
	C. Ancillary Expense		
35	Special Cost Centers	1,390,032	35
36	Provider Participation Fee	401,164	36
	D. Other Expenses (specify):		
37	Gift Shop	641	37
38	Real Estate Taxes		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,472,779	40
41	**Income before Income Taxes (line 30 minus line 40)****	(12,008,713)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (12,008,713)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,445,863	44
45	Private Pay - Net Inpatient Revenue	4,899,430	45
46	Medicare - Net Inpatient Revenue	4,534,200	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,879,493	49

* **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.**

Ballard Nursing Center
Medicaid Provider Number: 0023093
FYE 6/30/2012
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Admin - Other Revenue	8,100	Offset on Page 5A
Loss on disposal of assets	(6,423,318)	Gain/loss not recognized by the prograı
Total - Other Revenue	(6,415,218)	

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

Interest Income	-	
Interest Expenses	90,858	Page 4
Interest income offset - limited to interest ex	-	

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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	1,891	2,098	$ 117,809	$ 56.15	1
2	Assistant Director of Nursing	1,102	1,181	49,153	41.62	2
3	Registered Nurses	81,699	98,574	2,690,924	27.30	3
4	Licensed Practical Nurses	7,552	8,858	236,804	26.73	4
5	CNAs & Orderlies	104,275	119,288	1,653,892	13.86	5
6	CNA Trainees					6
7	Licensed Therapist	87,820	109,610	2,600,241	23.72	7
8	Rehab/Therapy Aides	7,096	8,540	279,047	32.68	8
9	Activity Director	1,825	2,342	57,903	24.72	9
10	Activity Assistants	7,553	9,238	115,129	12.46	10
11	Social Service Workers	6,524	8,136	157,631	19.37	11
12	Dietician	2,575	2,878	58,533	20.34	12
13	Food Service Supervisor	2,247	2,801	77,424	27.64	13
14	Head Cook	5,077	6,229	74,270	11.92	14
15	Cook Helpers/Assistants	20,206	22,900	231,246	10.10	15
16	Dishwashers					16
17	Maintenance Workers	7,852	8,905	120,929	13.58	17
18	Housekeepers	31,224	35,458	358,807	10.12	18
19	Laundry	6,252	7,624	104,797	13.75	19
20	Administrator	1,822	2,422	197,316	81.47	20
21	Assistant Administrator					21
22	Other Administrative	29,124	33,259	596,463	17.93	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 C: Clinical Aide	9,689	11,664	339,552	29.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	423,405	502,005	$ 10,117,870 *	$ 20.15	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				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)		$		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 Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ahlgren, Susan M	Administrator		$ 197,316
(Refer to PG 5A for Reclass)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 197,316

B. Administrative - Other

Description	Amount
Management Fees	$ 1,352,639
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,352,639
(Attach a copy of any management service agreement)	

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	$ 77,634
Unemployment Compensation Insurance	18,090
FICA Taxes	719,168
Employee Health Insurance	1,195,108
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	408,318
Group Life Insurance	14,216
Group Disability Insurance	32,673
Tuition Reimbursement	26,453
Employee Assistance	8,560
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,500,220

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Des Plaines Chamber of Commerce	2,675
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,675

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Ballard Nursing Center # 0051490 Report Period Beginning: 06/01/2011 Ending: 06/30/2012

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?

(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? 5-15 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 17,223 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. $ 401,164
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adeqate Records Have Been Maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

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

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

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