

			FOR BHF USE			

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0044354</u></p> <p>Facility Name: <u>Resurrection Life Center</u></p> <p>Address: <u>7370 West Talcott Avenue</u> <u>Chicago</u> <u>60631</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 594-7400</u> Fax # <u>(773) 594-7402</u></p> <p>HFS ID Number: <u>362235165002</u></p> <p>Date of Initial License for Current Owners: <u>02/02/1998</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2006</u> to <u>06/30/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____		(Title) _____		(Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

0044354 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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 05/29/07

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	102	34,470	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	35	11,402	3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	25	10,624	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	162	56,496	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	14,812	12,979	6,184	33,975	8
9	SNF/PED					9
10	ICF	8,270	3,310		11,580	10
11	ICF/DD					11
12	SC			10,499	10,499	12
13	DD 16 OR LESS					13
14	TOTALS	23,082	16,289	16,683	56,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.22%

D. How many bed-hold days during this year were paid by the Department? 10 (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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location
Date started 03/26/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/26/98 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 93 and days of care provided 6,184

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Resurrection Life Center
 Provider # 0044354
 FYE: 06/30/07
 BED DAYS AVAILABLE

Schedule 2A

	CERTIFIED SECTION	NON CERT. SECTION	SHELTERED CARE	TOTAL HOUSE
07/01/06 - 02/03/07				
NUMBER OF BEDS	93	34	32	159
DAYS IN REPORTING PERIOD	218	218	218	218
TOTAL BEDS FOR PERIOD #1	20,274	7,412	6,976	34,662
02/03/07 - 05/28/07				
NUMBER OF BEDS	95	35	32	162
DAYS IN REPORTING PERIOD	114	114	114	114
TOTAL BEDS FOR PERIOD #2	10,830	3,990	3,648	18,468
05/29/07 - 06/30/07				
NUMBER OF BEDS	102	35	25	162
DAYS IN REPORTING PERIOD	33	33	33	33
TOTAL BEDS FOR PERIOD #1	3,366	1,155	825	5,346
TOTAL BED DAYS AVAILABLE	34,470	11,402	10,624	56,496

STATE OF ILLINOIS

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	382,976	34,691		417,667		417,667		417,667		1
2	Food Purchase		364,780		364,780		364,780	(5,403)	359,377		2
3	Housekeeping	240,366	23,814	469	264,649		264,649		264,649		3
4	Laundry	45,053	275,694		320,747		320,747		320,747		4
5	Heat and Other Utilities			229,007	229,007		229,007		229,007		5
6	Maintenance	68,555	2,295	105,072	175,922		175,922		175,922		6
7	Other (specify):*										7
8	TOTAL General Services	736,950	701,274	334,548	1,772,772		1,772,772	(5,403)	1,767,369		8
9	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	3,081,761	137,117	66,043	3,284,921		3,284,921		3,284,921		10
10a	Therapy	101,940	4,747	60,258	166,945		166,945		166,945		10a
11	Activities	201,175	8,102	5,706	214,983		214,983		214,983		11
12	Social Services	98,182	147		98,329		98,329		98,329		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,483,058	150,113	141,007	3,774,178		3,774,178		3,774,178		16
17	C. General Administration										
17	Administrative	86,033		765,364	851,397		851,397	(765,364)	86,033		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotion			9,399	9,399		9,399		9,399		20
21	Clerical & General Office Expense	193,426	19,957	22,115	235,498		235,498	512,422	747,920		21
22	Employee Benefits & Payroll Tax			1,536,410	1,536,410		1,536,410	188,077	1,724,487		22
23	Inservice Training & Education										23
24	Travel and Semina			2,756	2,756		2,756		2,756		24
25	Other Admin. Staff Transportatior			612	612		612		612		25
26	Insurance-Prop.Liab.Malpractice			200,960	200,960		200,960		200,960		26
27	Other (specify):*										27
28	TOTAL General Administration	279,459	19,957	2,537,616	2,837,032		2,837,032	(64,865)	2,772,167		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,499,467	871,344	3,013,171	8,383,982		8,383,982	(70,268)	8,313,714		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Resurrection Life Center

#0044354

Report Period Beginning: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			727,820	727,820		727,820	67,303	795,123			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:			17,338	17,338		17,338		17,338			35
36	Other (specify): ³											36
37	TOTAL Ownership			745,158	745,158		745,158	67,303	812,461			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		970,303		970,303		970,303		970,303			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			70,460	70,460		70,460		70,460			42
43	Other (specify): ³ Non-allowable Cos											43
44	TOTAL Special Cost Centers		970,303	70,460	1,040,763		1,040,763		1,040,763			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,499,467	1,841,647	3,828,789	10,169,903		10,169,903	(2,965)	10,166,938			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(5,403)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,231)	30		9
10	Interest and Other Investment Income	(10,197)	32		10
11	Discounts, Allowances, Rebates & Refund				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 Transaction				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 Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(110)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,941)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	14,976		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 14,976		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,965)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Resurrection Life Center

ID# 0044354

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Offset office supplies income	\$ (110)	21
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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32			32
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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	(110)	49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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	(5,403)	0	0	0	0	0	0	0	0	0	0	(5,403)	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	(5,403)	0	0	0	0	0	0	0	0	0	0	(5,403)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(765,364)	0	0	0	0	0	0	0	0	0	(765,364)	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	(110)	512,532	0	0	0	0	0	0	0	0	0	512,422	21
22	Employee Benefits & Payroll Taxes	0	188,077	0	0	0	0	0	0	0	0	0	188,077	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	(110)	(64,755)	0	(64,865)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,513)	(64,755)	0	(70,268)	29								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See attached		See attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Clerical & data processing	\$	Resurrection Health Care	100.00%	\$ 512,532	\$ 512,532	1
2	V	22 Employee benefits		Resurrection Health Care	100.00%	188,077	188,077	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	69,534	69,534	3
4	V	32 Interest Expense		Resurrection Health Care	100.00%	10,197	10,197	4
5	V							5
6	V	17 Intercompany expense	765,364	Resurrection Health Care	100.00%		(765,364)	6
7	V	39 Intercompany pharmac	970,303	Resurrection Health Care	100.00%	970,303		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,735,667			\$ 1,750,643	\$ * 14,976	14

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached page 7A								\$		1
2											2
3											3
4	Sister Elizabeth Trembczynsk	Director	Board of Directors	0.00	93,368	1	2.00	N/A	N/A	N/A	4
5											5
6	Sister Elizabeth Trembczynski was the administrator for Holy Family Nursing and Rehabilitation Center, a related entity, from July 1, 20										6
7	through April 30, 2007.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2006 Ending: 6/30/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Resurrection Health Care/Medical Center
 Street Address 7435 W. Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

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

1 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	21 Clerical & data processing				\$	\$		512,532	1
2	22 Employee benefits							188,077	2
3	30 Depreciation							69,534	3
4	32 Interest Expense							10,197	4
5									5
6	39 Intercompany Pharmaci							970,303	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				\$	\$		1,750,643	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center# 0044354

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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
						Original	Balance				
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									
A. Directly Facility Related											
Long-Term											
1	N/A					\$	\$			\$	1
2											2
3											3
4											4
5											5
Working Capital											
6	N/A										6
7											7
8											8
9	TOTAL Facility Related					\$	\$			\$	9
B. Non-Facility Related*											
10	N/A										10
11								Home Office Allocation			10,197
12								Interest Income Offset			(10,197)
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. \$ None Line # N/A

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurrection Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044354

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	N/A _____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Resurrection Life Center

0044354 Report Period Beginning:

07/01/2006 Ending: 06/30/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,000 B. General Construction Type: Exterior Brick/Concrete Frame Steel Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et

List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>281,860</u>	<u>1996</u>	<u>\$ 3,600,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>281,860</u>		<u>\$ 3,600,000</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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

1	2	3	4	5	6	7	8	9		
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159		1998	\$ 11,711,085	\$ 626,575	Various	\$ 626,575	\$	\$ 5,927,378	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Window for chapel		1998	16,500	1,650	10	1,650		14,025	9
10	Interior sign system		1998	1,898	190	10	190		1,615	10
11	Modify nurse call system		1998	4,692	313	15	313		2,660	11
12	Install water softener		1998	2,325	233	10	233		1,980	12
13	Exterior directional illuminated sign		1999	15,825	1,583	10	1,583		13,453	13
14	Exterior main illuminated sign		1999	12,265	1,227	10	1,227		10,429	14
15	Five foot fence and gate		1999	7,974	532	15	532		4,521	15
16	Spacesaver medical records system		1999	12,661	1,266	10	1,266		10,761	16
17	Electrical work-kitchen door holders		1999	900	60	15	60		510	17
18	Replacement flooring shower and tub rooms		1999	8,037	536	15	536		4,566	18
19	Electric water heater		1999	2,570	257	10	257		2,185	19
20	Work on second floor		2000	3,144	157	20	157		1,256	20
21	Digital access control system		2000	3,252	163	20	163		1,304	21
22	Electrical work - kitchen door holders		2000	2,165	108	20	108		864	22
23	Architect fees		2000	3,145	105	30	105		840	23
24	Site lighting		2000	7,686	256	30	256		2,048	24
25	Site lighting		2000	14,947	498	30	498		3,984	25
26	Electrical work - Chapel		2000	1,354	45	30	45		360	26
27	Front entrance canopy		2000	60,000	2,000	30	2,000		16,000	27
28	Laundry plumbing and piping		2000	16,600	553	30	553		4,424	28
29	Construction work		2000	10,110	337	30	337		2,696	29
30	Flooring		2000	600	40	15	40		300	30
31	Flooring		2000	625	42	15	42		315	31
32	Raceway for signs		2000	1,504	75	20	75		563	32
33	Rubrail		2000	903	45	20	45		338	33
34	Rubrail		2000	875	44	20	44		330	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Assets reclassified from equipment to improvements								37
38	Message waiting line cards	1998	2,919		5			2,919	38
39	Closed circuit monitoring system	1998	17,882		5			17,882	39
40	Security system equipment	1998	9,790	653	15	653		6,202	40
41	Message waiting line	1998	16,200		5			16,200	41
42	Custom work counter	1998	1,657	110	15	110		1,046	42
43	Sharpen prep sink	1998	2,392	159	15	159		1,512	43
44	Walk-in refrigerator freezer	1998	40,774	4,077	10	4,077		38,733	44
45	Custom wall panel	1998	7,272	727	10	727		6,907	45
46	Three compartment sink	1998	3,248	217	15	217		2,060	46
47	Fire protection system	1998	3,887	389	10	389		3,694	47
48	Wall guards	1999	2,596		5			2,596	48
49									49
50	Electrical installatior	2001	3,681	184	20	184		1,288	50
51	Parking lot light fixtures	2001	421	21	20	21		147	51
52	Exit signs	2001	1,510	76	20	76		532	52
53	Nurse call box	2001	1,796	90	20	90		630	53
54	Time recorder system R&M	2001	5,363		20	268	268	1,876	54
55	Time recorder svstem R&M	2001	1,204		20	60	60	420	55
56	Water line R&M	2001	522		20	26	26	182	56
57	Chiller fuses R&M	2001	1,546		20	77	77	462	57
58	Disposal R&M	2001	571		20	29	29	174	58
59	Hot water tank R&M	2001	1,048		20	52	52	312	59
60	Cobbles R&M	2001	2,794		20	140	140	840	60
61	Door alarms R&M	2001	705		20	35	35	210	61
62	Exhaust R&M	2001	1,175		20	59	59	354	62
63	Disposal R&M	2001	1,412		20	70	70	421	63
64	Nurse call master	2001	1,595	80	20	80		480	64
65	Drywall/soffit	2001	2,874	144	20	144		864	65
66	Information system modul	2001	18,330	914	20	914		5,490	66
67	Information system modul	2001	1,050	53	20	53		318	67
68	Concrete sections	2002	2,923	146	20	146		876	68
69	Floor	2001	2,410	121	20	121		726	69
70	TOTAL (lines 4 thru 69)		\$ 12,085,189	\$ 647,051		\$ 647,867	\$ 816	\$ 6,146,058	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 12,085,189	\$ 647,051		\$ 647,867	\$ 816	\$ 6,146,058		1
2	Code alarm system	2003 3,109	311	10	311		1,088		2
3	Boiler repairs	2003 5,230	523	10	523		1,831		3
4	VCT sanitary sewer	2003 19,635	1,309	15	1,309		4,582		4
5	Sewer line in corridor	2005 1,944	194	10	194		582		5
6									6
7	Install Plants, Trees, Mulch, Soil & Sod	2006 10,309	1,031	10	1,031		1,546		7
8	Wire Nurse Call System	2006 2,600		10	260	260	390		8
9	Remove & Replace 5 wall temperature transmitter	2006 4,000	400	10	400		600		9
10	Hot Water Main Repair	2006 5,246	525	10	525		787		10
11	Walk in Cooler Evaporator Coi	2006 1,550	221	7	221		332		11
12									12
13	Replace broken sprinkler systems, controller upgrad	2006 7,090	355	10	355		355		13
14	Paint Main Entrance	2006 28,865	1,443	10	1,443		1,443		14
15	Renovation of 3 Nurses Lounges	2006 144,840	3,621	20	3,621		3,621		15
16	A/E fees, General Requirements, Demolition, Doors &								16
17	Hardware, Carpentry, Drywall, Acoustic Ceiling, Floorin								17
18	Painting, Plumbing, Fire Protection, HVAC, Electrical &								18
19	Contractor's fees.								19
20	Inspect, lubricate & test 28 smoke dampers	2006 19,250	642	15	642		642		20
21	Painting	2007 21,720	1,551	7	1,551		1,551		21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Allocated from Home Office				69,534	69,534			31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 12,360,577	\$ 659,177		\$ 729,787	\$ 70,610	\$ 6,165,408		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number: Resurrection Life Center

0044354

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 1,030,739	\$ 66,714	\$ 63,407	\$ (3,307)	8-15	\$ 780,120	71
72	Current Year Purchases	38,544	1,929	1,929		7-15	1,929	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,069,283	\$ 68,643	\$ 65,336	\$ (3,307)		\$ 782,049	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,029,860	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 727,820	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 795,123	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,303	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,947,457	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 1

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 17,338 Description: Copiers - \$8,550; Medical Eqpt. - \$2,182; Specialty Beds - \$6,190; Dietary Eqpt. - \$416
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (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

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
					Units	Cost						
1	Licensed Occupational Therapist	10A (1,2,3)	74	hrs	\$ 2,545	878	\$ 52,663	\$ 142	952	\$ 55,350	1	
2	Licensed Speech and Language Development Therapist	10A (1,2,3)	68	hrs	2,110	59	3,541	95	127	5,746	2	
3	Licensed Recreational Therapist			hrs							3	
4	Licensed Physical Therapist	10A (1,2,3)	2352	hrs	82,229	68	4,054	4,510	2,420	90,793	4	
5	Physician Care			visits							5	
6	Dental Care			visits							6	
7	Work Related Program			hrs							7	
8	Habilitation			hrs							8	
9	Pharmacy	39(2)		# of prescripts				970,303		970,303	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10	
11	Academic Education			hrs							11	
12	Exceptional Care Program										12	
13	Other (specify):										13	
14	TOTAL				\$ 86,884	1,005	\$ 60,258	\$ 975,050	3,499	\$ 1,122,192	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 256,888	\$ 256,888	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 433,331)	1,576,522	1,576,522	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,038	8,038	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	522	522	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,841,970	\$ 1,841,970	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	61,427	61,427	12
13	Land	3,600,000	3,600,000	13
14	Buildings, at Historical Cost	11,794,555	11,711,085	14
15	Leasehold Improvements, at Historical Cost	219,120	649,492	15
16	Equipment, at Historical Cost	1,411,864	1,069,283	16
17	Accumulated Depreciation (book methods)	(6,959,572)	(6,947,457)	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)	\$ 10,127,394	\$ 10,143,830	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,969,364	\$ 11,985,800	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 62,437	\$ 62,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Due to Related Parties	46,184	46,184	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 108,621	\$ 108,621	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)	\$ 108,621	\$ 108,621	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,860,743	\$ 11,877,179	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,969,364	\$ 11,985,800	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,797,160	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(68,061)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,729,099	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,131,644	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,131,644	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)	\$ 11,860,743	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,654,636	1
2	Discounts and Allowances for all Level	(3,491,032)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,163,604	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	431,688	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 431,688	8
C. Other Operating Revenue			
9	Payments for Educator		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	5,403	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,130,455	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	138,235	21
22	Laundry	56,105	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,330,198	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	375,307	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 375,307	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	750	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 750	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,301,547	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,772,772	31
32	Health Care	3,774,178	32
33	General Administrator	2,837,032	33
B. Capital Expense			
34	Ownership	745,158	34
C. Ancillary Expense			
35	Special Cost Centers	970,303	35
36	Provider Participation Fee	70,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,169,903	40
41	Income before Income Taxes (line 30 minus line 40)**	1,131,644	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,131,644	43

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

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

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

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

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,080	\$ 83,773	\$ 40.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,716	43,014	1,391,158	32.34	3
4	Licensed Practical Nurses	8,032	9,478	207,348	21.88	4
5	CNAs & Orderlies	93,902	104,099	1,300,399	12.49	5
6	CNA Trainees					6
7	Licensed Therapist	2,238	2,494	86,884	34.84	7
8	Rehab/Therapy Aides	1,201	1,293	15,056	11.64	8
9	Activity Director	1,768	2,088	42,013	20.12	9
10	Activity Assistants	6,871	8,017	83,815	10.45	10
11	Social Service Worker	3,628	4,200	98,182	23.38	11
12	Dietician	1,591	1,822	36,326	19.94	12
13	Food Service Supervisor	2,359	2,570	52,962	20.61	13
14	Head Cook	5,931	6,838	94,439	13.81	14
15	Cook Helpers/Assistants	18,728	21,380	199,249	9.32	15
16	Dishwashers					16
17	Maintenance Worker	3,116	3,648	68,555	18.79	17
18	Housekeepers	19,493	22,487	240,366	10.69	18
19	Laundry	3,615	4,201	45,053	10.72	19
20	Administrator	1,840	2,064	86,033	41.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,304	11,492	193,426	16.83	24
25	Vocational Instructor					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: See Sch 20A	3,040	3,474	99,083	28.52	32
33	Other(specify) See Sch 20A	2,846	3,284	75,347	22.94	33
34	TOTAL (lines 1 - 33)	229,171	260,023	\$ 4,499,467 *	\$ 17.30	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	9,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,000		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	92	\$ 3,986	10(3)	50
51	Licensed Practical Nurses	72	3,179	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	164	\$ 7,165		53

SEE ACCOUNTANTS' COMPILATION REPORT

Resurrection Life Center
Provider # 0044354
07/01/06 - 06/30/07
Staffing & Salary Costs

Schedule 20A

Other Health Care Wages - Line 32:

	Hours <u>Worked</u>	Hours <u>Paid</u>	Salary or <u>Wages</u>	Ave. Hrly. <u>Wages</u>
MDS Care Plan Coordinator	3,016	3,418	98,374	28.78
Pharmacy Technician	24	48	617	12.85
Resident Assistant		8	92	11.50
TOTAL	3,040	3,474	99,083	28.52

Other Wages - Line 33:

	Hours <u>Worked</u>	Hours <u>Paid</u>	Salary or <u>Wages</u>	Ave. Hrly. <u>Wages</u>
Chaplain	2,620	3,024	66,556	22.01
Group Coordinator Spiritual Services	226	260	8,791	33.81
	2,846	3,284	75,347	22.94

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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 Services Network - \$5,167
- (3) Did the nursing home make political contributions or payments to a political 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 expenses and the location of this expense on Sch. V. 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. 70,460
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 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 if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 5,403
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation N/A
- 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 program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain Audit is not yet completed.
- (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

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

Resurrection Life Center

12:04 PM 12/27/2007

ITEM	Value 1		Value 2		RESULTS	COMPARE CEL	SUB-	LINE	COL.	SUB-	LINE	COL.	
	Cond.		Cond.	Difference			SCHED.	NO.	NO.		WITH CELL	SCHED.	NO.
Adjustment Detail	-2,965	equal to	-2,965	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	795,123	equal to	795,123	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	17,338	equal to	17,338	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	86,884	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	151,889	equal to	166,945	-15,056	FAILED	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	975,050	equal to	975,050	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	1,772,772	equal to	1,772,772	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,774,178	equal to	3,774,178	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,837,032	equal to	2,837,032	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	745,158	equal to	745,158	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	970,303	equal to	970,303	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	70,460	equal to	70,460	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,982,678	equal to	3,081,761	-99,083	FAILED	Pg20 K11..K15+	A.	1-5.24.25.27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	86,884	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	125,828	equal to	201,175	-75,347	FAILED	Pg20 K19+K20	A.	9-10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	98,182	equal to	98,182	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	382,976	equal to	382,976	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	68,555	equal to	68,555	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	240,366	equal to	240,366	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	45,053	equal to	45,053	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	86,033	equal to	86,033	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	193,426	equal to	193,426	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,499,467	equal to	4,499,467	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,000	< or = to	9,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	7,165	< or = to	66,043	-58,878	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	5,706	-5,706	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched. - Admin. Salar.	86,033	equal to	86,033	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched. - Admin. Other	765,364	equal to	765,364	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched. - Prof. Serv.	0	equal to	0	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched. - Benefit/Taxes	1,724,487	equal to	1,724,487	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched. - Sched of dues...	9,399	equal to	9,399	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched. - Sched. of trav	2,756	equal to	2,756	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	70,460	equal to	70,460	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	188,077	-188,077	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,184	equal to	6,184	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	14,976	equal to	14,976	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	3,600,000	equal to	3,600,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	12,360,577	equal to	12,360,577	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,069,283	equal to	1,069,283	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,947,457	equal to	6,947,457	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	11,860,743	equal to	11,860,743	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	1,131,644	equal to	1,131,644	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	11,969,364	equal to	11,969,364	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	382,976	34,691	0	417,667	0	417,667	0	417,667
2. Food Purchase	0	364,780	0	364,780	0	364,780	-5,403	359,377
3. Housekeeping	240,366	23,814	469	264,649	0	264,649	0	264,649
4. Laundry	45,053	275,694	0	320,747	0	320,747	0	320,747
5. Heat and Other Utilities	0	0	229,007	229,007	0	229,007	0	229,007
6. Maintenance	68,555	2,295	105,072	175,922	0	175,922	0	175,922
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	736,950	701,274	334,548	1,772,772	0	1,772,772	-5,403	1,767,369
9. Medical Director	0	0	9,000	9,000	0	9,000	0	9,000
10. Nursing & Medical Records	3,081,761	137,117	66,043	3,284,921	0	3,284,921	0	3,284,921
10a. Therapy	101,940	4,747	60,258	166,945	0	166,945	0	166,945
11. Activities	201,175	8,102	5,706	214,983	0	214,983	0	214,983
12. Social Services	98,182	147	0	98,329	0	98,329	0	98,329
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,483,058	150,113	141,007	3,774,178	0	3,774,178	0	3,774,178
17. Administrative	86,033	0	765,364	851,397	0	851,397	-765,364	86,033
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	0	0	0	0	0	0
20. Fees, Subscriptions & Promotion	0	0	9,399	9,399	0	9,399	0	9,399
21. Clerical & General Office	193,426	19,957	22,115	235,498	0	235,498	512,422	747,920
22. Employee Benefits & Payroll	0	0	1,536,410	1,536,410	0	1,536,410	188,077	1,724,487
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	2,756	2,756	0	2,756	0	2,756
25. Other Admin. Staff Trans	0	0	612	612	0	612	0	612
26. Insurance-Prop.Liab.Malpractice	0	0	200,960	200,960	0	200,960	0	200,960
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	279,459	19,957	2,537,616	2,837,032	0	2,837,032	-64,865	2,772,167
29. Total General Administrative	4,499,467	871,344	3,013,171	8,383,982	0	8,383,982	-70,268	8,313,714
30. Depreciation	0	0	727,820	727,820	0	727,820	67,303	795,123
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	17,338	17,338	0	17,338	0	17,338
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	745,158	745,158	0	745,158	67,303	812,461
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	970,303	0	970,303	0	970,303	0	970,303
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	70,460	70,460	0	70,460	0	70,460
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	970,303	70,460	1,040,763	0	1,040,763	0	1,040,763
45. Grand Total	4,499,467	1,841,647	3,828,789	10,169,903	0	10,169,903	-2,965	10,166,938

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	256,888	256,888
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,576,522	1,576,522
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	8,038	8,038
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	522	522
10. Total current assets	1,841,970	1,841,970
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	61,427	61,427
13. Land	3,600,000	3,600,000
14. Buildings, at Historical Cost	11,794,555	11,711,085
15. Leasehold Improvements, Historical Cost	219,120	649,492
16. Equipment, at Historical Cost	1,411,864	1,069,283
17. Accumulated Depreciation (book methods)	-6,959,572	-6,947,457
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	10,127,394	10,143,830
25. Total Assets	11,969,364	11,985,800
CURRENT LIABILITIES		
26. Accounts Payable	62,437	62,437
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	46,184	46,184
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	108,621	108,621
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	0
46. Total Liabilities	108,621	108,621
47. Total Equity	11,860,743	11,877,179
48. Total Liabilities and Equity	11,969,364	11,985,800

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	12,654,636
2. Discounts and Allowances for all Levels	-3,491,032
Subtotal - Inpatient Care	9,163,604
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	431,688
7. Oxygen	0
Subtotal - Ancillary Revenue	431,688
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	5,403
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	1,130,455
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	138,235
22. Laundry	56,105
Subtotal - Other Operating Revenue	1,330,198
24. Contributions	0
25. Interest and Other Investments Income	375,307
Subtotal - Non-Operating Revenue	375,307
27. Other Revenue (specify):	750
28. Other Revenue (specify):	0
Subtotal - Other Revenue	750
30. Total Revenue	11,301,547
31. General Services	1,772,772
32. Health Care	3,774,178
33. General Administration	2,837,032
34. Ownership	745,158
35. Special Cost Centers	970,303
35. Provider Participation Fee	70,460
37. Other	0
40. Total Expenses	10,169,903
41. Income Before Income Taxes	1,131,644
42. Income Taxes	0
43. Net Income or Loss for the Year	1,131,644

Resurrection Life Center
 IDPA Comparative Data - Per Resident Day Cost
 Year Ending

Enter your HSA # in next column =====
 Census (Pulls from Page 2) 56,054

Cost Report Line	Description	2006 Average Median Cost Per Day		
		Your Facility	State	HSA
1	Dietary	7.45	-	#N/A
2	Food Purchase	6.41	-	#N/A
3	Housekeeping	4.72	-	#N/A
4	Laundry	5.72	-	#N/A
5	Heat & Other Utilities	4.09	-	#N/A
6	Maintenance	3.14	-	#N/A
8	Total General Services	31.53	-	#N/A
10	Nursing & Medical Records	58.60	-	#N/A
10A	Therapy	2.98	-	#N/A
11	Activities	3.84	-	#N/A
12	Social Services	1.75	-	#N/A
16	Total Health Care & Programs	67.33	-	#N/A
17	Administration	1.53	-	#N/A
19	Professional Services	-	-	#N/A
21	Clerical & Gen. Office Expense	13.34	-	#N/A
22	Employee Benefits & PR Taxes	30.76	-	#N/A
24	Travel & Seminar	0.05	-	#N/A
26	Insurance-Property, Liability & Malpractice	3.59	-	#N/A
28	Total General Administrative	49.46	-	#N/A
29	Total Operating Expenses	148.32	-	#N/A
30	Depreciation	14.18	-	#N/A
32	Interest	-	-	#N/A
33	Real Estate Taxes	-	-	#N/A
37	Total Ownership	14.49	-	#N/A
	Total Operating and Ownership Cost	162.81	-	#N/A

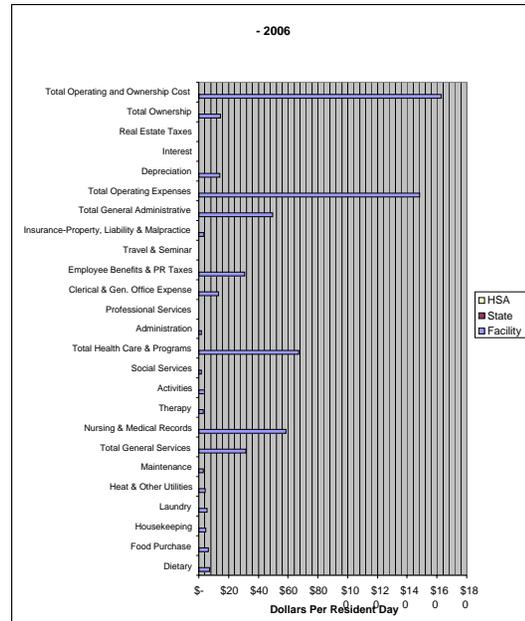
Notes:
 Your Facility data is from page 3, column 8 of your 2007 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the State and your HSA is taken from the most recent data available from the Illinois Department of Health Care and Family Services and corresponds with the respective cost report data after final adjustments.

IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2005 Cost Reports
 2005 (Run August 15, 2006)

UN-INFLATED

Cost Report Line	Description	State-Wide	HSA											10th %	90th %	
			1	2	3	4	5	6	7	8	9	10	11			
1	Dietary															
2	Food Purchase															
3	Housekeeping															
4	Laundry															
5	Heat & Other Utilities															
6	Maintenance															
8	TOTAL GENERAL SERVICES															
10	Nursing & Medical Records															
10A	Therapy															
11	Activities															
12	Social Services															
16	TOTAL HEALTH CARE & PROGRAMS															
17	Administration															
19	Professional Services															
21	Clerical & Gen. Office Expense															
22	Employee Benefits & PR Taxes															
24	Travel & Seminar															
26	Insurance-Property, liability & Malpractice															
28	TOTAL GENERAL ADMINISTRATIVE															
29	TOTAL OPERATING EXPENSES															
30	Depreciation															
32	Interest															
33	Real Estate Taxes															
37	TOTAL OWNERSHIP															
	TOTAL OPERATING & OWNERSHIP COST															



Interrelated LR Cost
HSA Comparative Data - Per Resident Day Cost
Year Ending

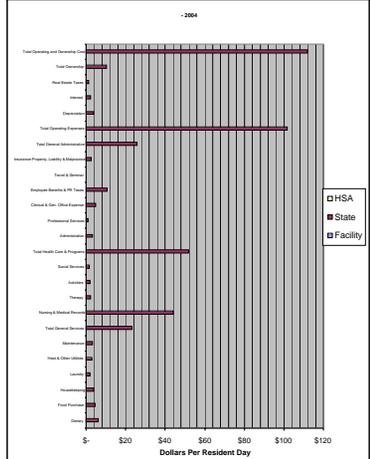
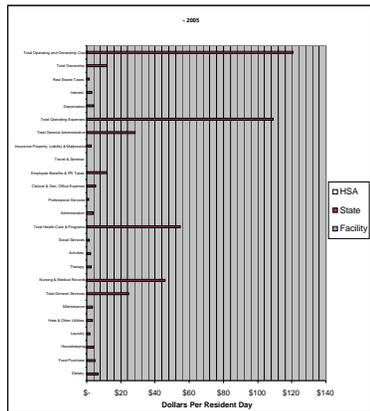
Enter your HSA # in row column
 Column (P)H from Page 2

2005

Cost Report Line	Description	2007			2006 Median			2006			2005			2005 Median			
		Per State Year Facility	Cost Per Day	Rate	HSA	Per State Year Facility	Cost Per Day	Rate	HSA	Per State Year Facility	Cost Per Day	Rate	HSA	Per State Year Facility	Cost Per Day	Rate	HSA
1	Dietary	7,015,642	6.52	ANA	PFALL17	6.52	ANA	HEV07	6.23	ANA							
2	Food Purchase	4,411,244	4.48	ANA	PFALL17	4.48	ANA	HEV07	4.53	ANA							
3	Housekeeping	4,724,223	4.62	ANA	PFALL17	4.62	ANA	HEV07	3.77	ANA							
4	Laundry	5,723,073	1.96	ANA	PFALL17	1.96	ANA	HEV07	1.86	ANA							
5	House of Home Utilities	4,088,712	3.31	ANA	PFALL17	3.31	ANA	HEV07	3.62	ANA							
6	Maintenance	3,194,179	3.51	ANA	PFALL17	3.51	ANA	HEV07	3.21	ANA							
8	Total General Services	31,527,977	24.43	ANA	PFALL17	24.43	ANA	HEV07	23.12	ANA							
10	Nursing & Medical Supplies	58,462,794	49.97	ANA	PFALL17	49.97	ANA	HEV07	44.65	ANA							
10A	Therapy	3,979,288	2.45	ANA	PFALL17	2.45	ANA	HEV07	2.16	ANA							
11	Activities	3,829,288	2.96	ANA	PFALL17	2.96	ANA	HEV07	1.95	ANA							
12	Social Services	1,741,835	1.58	ANA	PFALL17	1.58	ANA	HEV07	1.48	ANA							
16	Total Health Care & Programs	67,219,199	54.45	ANA	PFALL17	54.45	ANA	HEV07	51.90	ANA							
17	Administration	1,548,256	3.90	ANA	PFALL17	3.90	ANA	HEV07	3.24	ANA							
19	Professional Services	0	1.61	ANA	PFALL17	1.61	ANA	HEV07	0.87	ANA							
21	Chemical & Gas, Office Equipment	13,542,268	5.65	ANA	PFALL17	5.65	ANA	HEV07	4.89	ANA							
22	Employee Benefits & HR Taxes	30,764,745	11.77	ANA	PFALL17	11.77	ANA	HEV07	10.66	ANA							
24	Travel & Seminar	0.000169	0.00	ANA	PFALL17	0.00	ANA	HEV07	0.00	ANA							
26	Insurance (Property, Liability & Malpractice)	5,081,144	2.49	ANA	PFALL17	2.49	ANA	HEV07	2.67	ANA							
28	Total General Administration	49,492,263	26.30	ANA	PFALL17	26.30	ANA	HEV07	25.82	ANA							
29	Total Operating Expenses	148,116,616	109.93	ANA	PFALL17	109.93	ANA	HEV07	100.50	ANA							
30	Depreciation	14,184,497	5.95	ANA	PFALL17	5.95	ANA	HEV07	1.78	ANA							
32	Interest	0	2.87	ANA	PFALL17	2.87	ANA	HEV07	2.22	ANA							
33	Rent State Taxes	0	1.51	ANA	PFALL17	1.51	ANA	HEV07	1.48	ANA							
37	Total Ownership	14,184,497	11.78	ANA	PFALL17	11.78	ANA	HEV07	10.42	ANA							
	Total Operating and Ownership Cost	162,301	121.68	ANA	PFALL17	121.68	ANA	HEV07	112.04	ANA							

Your facility data is from page 3, column K of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2006, 2007 LR Data Cost Facility, for the State and your HSA is taken from data available from the Illinois Department of Health Care and Family Services and corresponds with the respective cost report data after final adjustments.



IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2006 Cost Reports
 2006

UN-INFLATED

Cost Report Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

State-Wide	HSA											
	1	2	3	4	5	6	7	8	9	10	11	
[Empty Data Table]												

10th % 90th %

2006 Costs

2006 Census

Cost Report Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

2006 - Average Wage Data Table

Total staff hours including contract nursing per diem
 Nursing hours including contract nurses per diem
 RN
 LPN
 CNA
 DON
 ADON

State-Wide	HSA										
	1	2	3	4	5	6	7	8	9	10	11
[Empty Data Table]											

2006 - Staffing and Occupancy Data

Average Occupancy
 Medicaid Utilization
 Medicare Utilization

State-Wide	HSA										
	1	2	3	4	5	6	7	8	9	10	11
[Empty Data Table]											

IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2004 Cost Reports
 2004 (Run June 1, 2004)

UN-INFLATED

Cost Report	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.23	7.09	6.81	5.63	6.81	5.56	6.37	6.37	6.37	6.12	7.09	5.94	4.27	10.11
2	Food Purchase	4.53	4.79	4.73	4.56	4.73	4.33	4.48	4.48	4.48	4.40	4.79	4.27	3.48	6.23
3	Housekeeping	3.77	3.68	3.76	3.10	3.76	3.37	4.12	4.12	4.12	3.93	3.68	3.66	2.59	5.78
4	Laundry	1.86	2.27	1.99	1.79	1.99	1.97	1.64	1.64	1.64	1.62	2.27	2.16	1.00	3.16
5	Heat & Other Utilities	3.02	3.13	3.07	3.04	3.07	2.71	3.06	3.06	3.06	2.87	3.13	2.86	2.10	4.39
6	Maintenance	3.21	3.63	3.33	3.22	3.33	2.45	3.35	3.35	3.35	3.25	3.63	2.88	2.02	5.28
8	TOTAL GENERAL SERVICES	23.12	25.66	23.97	21.71	23.97	21.28	23.50	23.50	23.50	23.47	25.66	21.76	18.27	32.52
10	Nursing & Medical Records	44.05	43.48	45.03	40.84	45.03	35.79	47.50	47.50	47.50	47.81	43.48	44.17	28.00	68.18
10A	Therapy	2.16	2.01	3.55	4.52	3.55	2.05	1.47	1.47	1.47	2.21	2.01	3.40	-	12.21
11	Activities	1.95	2.28	1.95	1.58	1.95	1.34	2.21	2.21	2.21	2.16	2.28	1.54	1.07	3.52
12	Social Services	1.48	1.44	1.63	1.10	1.63	1.27	1.64	1.64	1.64	1.34	1.44	1.37	0.62	3.10
16	TOTAL HEALTH CARE & PROGRAMS	51.90	52.55	53.10	49.97	53.10	43.69	53.78	53.78	53.78	56.90	52.55	53.31	33.59	81.45
17	Administration	3.24	3.47	3.24	3.08	3.24	3.65	3.19	3.19	3.19	3.24	3.47	2.99	1.75	8.15
19	Professional Services	0.97	1.19	0.70	0.68	0.70	0.77	1.09	1.09	1.09	1.34	1.19	0.70	0.05	2.58
21	Clerical & Gen. Office Expense	4.89	4.21	5.22	4.23	5.22	4.03	5.31	5.31	5.31	5.13	4.21	4.41	2.35	10.74
22	Employee Benefits & PR Taxes	10.66	10.98	12.14	9.56	12.14	8.62	11.17	11.17	11.17	11.21	10.98	9.81	6.89	20.31
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.15	0.08	0.08	0.08	0.04	0.12	0.09	-	0.34
26	Insurance-Property, liability & Malpractice	2.67	2.38	2.53	2.36	2.53	2.33	3.03	3.03	3.03	2.47	2.38	2.16	0.85	4.36
28	TOTAL GENERAL ADMINISTRATIVE	25.82	26.66	27.48	23.91	27.48	22.08	26.27	26.27	26.27	27.23	26.66	22.86	17.40	40.90
29	TOTAL OPERATING EXPENSES	101.59	104.24	105.69	96.02	105.69	89.62	103.51	103.51	103.51	106.84	104.24	100.77	71.40	151.58
30	Depreciation	3.74	3.67	3.95	3.52	3.95	2.64	4.23	4.23	4.23	3.72	3.67	3.20	1.00	8.58
32	Interest	2.22	2.43	1.42	1.72	1.42	0.55	3.91	3.91	3.91	2.22	2.43	0.94	-	10.11
33	Real Estate Taxes	1.40	1.04	1.00	0.84	1.00	0.87	3.21	3.21	3.21	1.30	1.04	1.14	-	5.54
37	TOTAL OWNERSHIP	10.42	8.95	9.03	7.51	9.03	6.11	14.54	14.54	14.54	10.03	8.95	9.17	3.61	22.83
	TOTAL OPERATING & OWNERSHIP COST	112.01	113.19	114.72	103.53	114.72	95.73	118.05	118.05	118.05	116.87	113.19	109.94	75.01	174.41

Cost Report	Description	2004 Costs	2004 Census
1	Dietary	3.48	6.23
2	Food Purchase	2.59	5.78
3	Housekeeping	1.00	3.16
4	Laundry	2.10	4.39
5	Heat & Other Utilities	2.02	5.28
6	Maintenance	28.00	68.18
8	TOTAL GENERAL SERVICES	18.27	32.52
10	Nursing & Medical Records	44.17	68.18
10A	Therapy	-	12.21
11	Activities	1.07	3.52
12	Social Services	0.62	3.10
16	TOTAL HEALTH CARE & PROGRAMS	33.59	81.45
17	Administration	1.75	8.15
19	Professional Services	0.05	2.58
21	Clerical & Gen. Office Expense	2.35	10.74
22	Employee Benefits & PR Taxes	6.89	20.31
24	Travel & Seminar	-	0.34
26	Insurance-Property, liability & Malpractice	0.85	4.36
28	TOTAL GENERAL ADMINISTRATIVE	17.40	40.90
29	TOTAL OPERATING EXPENSES	71.40	151.58
30	Depreciation	1.00	8.58
32	Interest	-	10.11
33	Real Estate Taxes	-	5.54
37	TOTAL OWNERSHIP	3.61	22.83
	TOTAL OPERATING & OWNERSHIP COST	75.01	174.41

Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.10	2.80	2.80	2.80	3.10	3.20	3.10
RN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	20.42
LPN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.09	17.13
CNA	10.02	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	10.13	9.84
DON	28.97	27.38	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.77

2003 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	10.30%	7.70%	8.90%