



Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	298	Skilled (SNF)	298	109,068	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	109,068	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,187	16,956	24,735	67,878	8
9	SNF/PED					9
10	ICF	18,822	7,490	50	26,362	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,009	24,446	24,785	94,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.40%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/80

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/80 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 78 and days of care provided 22,033

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: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number Resurrection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	640,272	73,953	8,179	722,404		722,404		722,404		1
2	Food Purchase		689,239		689,239		689,239	(6,552)	682,687		2
3	Housekeeping	322,838	68,058		390,896		390,896		390,896		3
4	Laundry	237,420	89,018		326,438		326,438		326,438		4
5	Heat and Other Utilities			444,211	444,211		444,211		444,211		5
6	Maintenance	183,495	3,251	235,762	422,508		422,508	(2,746)	419,762		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,384,025	923,519	688,152	2,995,696		2,995,696	(9,298)	2,986,398		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,673	24,673		24,673		24,673		9
10	Nursing and Medical Records	6,528,475	437,014	156,855	7,122,344		7,122,344		7,122,344		10
10a	Therapy	923,995	8,937	331,255	1,264,187		1,264,187		1,264,187		10a
11	Activities	334,777	8,657	4,103	347,537		347,537		347,537		11
12	Social Services	179,484	1,093	2,141	182,718		182,718		182,718		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	7,966,731	455,701	519,027	8,941,459		8,941,459		8,941,459		16
	<b>C. General Administration</b>										
17	Administrative	126,838		1,423,032	1,549,870		1,549,870	(1,423,032)	126,838		17
18	Directors Fees										18
19	Professional Services			23,667	23,667		23,667	(22,600)	1,067		19
20	Dues, Fees, Subscriptions & Promotions			6,563	6,563		6,563		6,563		20
21	Clerical & General Office Expenses	352,739	79,446	217,048	649,233		649,233	1,336,761	1,985,994		21
22	Employee Benefits & Payroll Taxes			3,162,377	3,162,377		3,162,377	431,300	3,593,677		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,189	5,189		5,189		5,189		24
25	Other Admin. Staff Transportation			939	939		939		939		25
26	Insurance-Prop.Liab.Malpractice			684,060	684,060		684,060		684,060		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	479,577	79,446	5,522,875	6,081,898		6,081,898	322,429	6,404,327		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	9,830,333	1,458,666	6,730,054	18,019,053		18,019,053	313,131	18,332,184		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 Nursing & Rehab Center

#0044362

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			564,092	564,092		564,092	(80,651)	483,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,924	77,924		77,924	(77,924)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,054	28,054		28,054		28,054			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			670,070	670,070		670,070	(158,575)	511,495			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,488,495		2,488,495		2,488,495		2,488,495			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,602	163,602		163,602		163,602			42
43	Other (specify):* <b>Non-allowable cost</b>			13,912	13,912		13,912	(13,912)				43
44	<b>TOTAL Special Cost Centers</b>		2,488,495	177,514	2,666,009		2,666,009	(13,912)	2,652,097			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	9,830,333	3,947,161	7,577,638	21,355,132		21,355,132	140,644	21,495,776			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 Programs				3
4	Non-Patient Meals	(6,552)	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				8
9	Non-Straightline Depreciation	(241,367)	30		9
10	Interest and Other Investment Income	(107,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(44,132)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (399,471)		\$	30

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)	540,115		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 540,115		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 140,644		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 Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Resurrection Nursing & Rehab Center

ID# 0044362

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow non-allowable marketing expense	\$ (13,912)	43	1
2	Offset office supply revenue	(4,874)	21	2
3	Reclass R&M	(2,746)	6	3
4	Disallow non-allowable penalties & fines	(22,600)	19	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(44,132)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,552)	0	0	0	0	0	0	0	0	0	0	(6,552)	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	(2,746)	0	0	0	0	0	0	0	0	0	0	(2,746)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,298)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,298)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(1,423,032)	0	0	0	0	0	0	0	0	0	(1,423,032)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,600)	0	0	0	0	0	0	0	0	0	0	(22,600)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,874)	1,341,635	0	0	0	0	0	0	0	0	0	1,336,761	21
22	Employee Benefits & Payroll Taxes	0	431,300	0	0	0	0	0	0	0	0	0	431,300	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(27,474)</b>	<b>349,903</b>	<b>0</b>	<b>322,429</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(36,772)</b>	<b>349,903</b>	<b>0</b>	<b>313,131</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/2007 Ending:06/30/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(241,367)	160,716	0	0	0	0	0	0	0	0	0	(80,651)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(107,420)	29,496	0	0	0	0	0	0	0	0	0	(77,924)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(348,787)</b>	<b>190,212</b>	<b>0</b>	<b>(158,575)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,912)	0	0	0	0	0	0	0	0	0	0	(13,912)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(13,912)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,912)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(399,471)</b>	<b>540,115</b>	<b>0</b>	<b>140,644</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	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%	\$ 1,341,635	\$ 1,341,635	1
2	V	22 Employee benefits		Resurrection Health Care	100.00%	431,300	431,300	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	160,716	160,716	3
4	V	32 Interest Expense		Resurrection Health Care	100.00%	29,496	29,496	4
5	V							5
6	V	17 Intercompany expense	1,423,032	Resurrection Health Care	100.00%		(1,423,032)	6
7	V	39 Intercompany pharmacy	2,488,495	Resurrection Health Care	100.00%	2,488,495		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,911,527			\$ 4,451,642	\$ * 540,115	14

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

Facility Name & ID Number Resurrection Nursing & Rehab Center # 0044362 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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										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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

Report Period Beginning: 07/01/2007

Ending: 6/30/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & data processing			\$	\$		\$ 1,341,635	1
2	22	Employee benefits						431,300	2
3	30	Depreciation						160,716	3
4	32	Interest Expense						29,496	4
5									5
6	39	Intercompany Pharmacy						2,488,495	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 4,451,642	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Resurrection Nursing & Rehab Center

# 0044362

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	N/A						\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6	N/A																	
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10	N/A																	
11												77,924						
12												29,496						
13												(107,420)						
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				\$						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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.)

\$           N/A           **2**

3. Under or (over) accrual (line 2 minus line 1).

\$                      **3**

4. Real Estate Tax accrual used for 2008 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:	2003	<u>                    </u>	<b>8</b>
	2004	<u>                    </u>	<b>9</b>
	2005	<u>                    </u>	<b>10</b>
	2006	<u>                    </u>	<b>11</b>
	2007	<u>          N/A          </u>	<b>12</b>

**This facility is a not-for-profit entity and does not pay real estate tax.**

		<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<u>                    </u>	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<u>                    </u>	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<u>                    </u>	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<u>                    </u>	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Resurrection Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044362

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 2007 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 2007.

(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. <u>This facility is a not-for-profit entity and does not pay real estate tax.</u>		\$ _____	\$ _____
2. _____	<u>N/A</u>	\$ _____	\$ _____
3. _____		\$ _____	\$ _____
4. _____		\$ _____	\$ _____
5. _____		\$ _____	\$ _____
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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        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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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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 &amp;</u>	<u>126,500</u>	<u>1983</u>	<u>\$ 580,293</u>	<u>1</u>
2	<u>Parking area</u>				<u>2</u>
3	<b>TOTALS</b>	<b>126,500</b>		<b>\$ 580,293</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	298		1976	\$ 6,276,546	\$	30	\$ (104,639)	\$ (104,639)	\$ 6,276,546	4
5			1976	1,733,006					1,733,006	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1981	3,549		20			3,549	9
10	Various		1983	35,281		20			35,281	10
11	Various		1985	3,892		20			3,892	11
12	Various		1986	14,629		20			14,629	12
13	Various		1987	41,215		20			41,215	13
14	Various		1988	40,512		20			40,512	14
15	Various		1989	190,627		20	9,538	9,538	190,627	15
16	Various		1990	171,816		20	8,591	8,591	163,229	16
17	Various		1991	60,020		20	3,001	3,001	54,018	17
18	Various		1992	107,965		20	5,398	5,398	91,766	18
19	Various		1993	105,120		20	5,256	5,256	84,096	19
20	Various		1994	259,632		20	12,982	12,982	194,730	20
21	Various		1995	630,342		20	31,517	31,517	441,238	21
22	Various		1996	105,335		20	5,267	5,267	84,100	22
23	Various		1997	1,130,243		20	56,512	56,512	862,563	23
24	Various		1998	68,801		20	3,440	3,440	45,633	24
25	Various		1999	228,020		20	11,401	11,401	114,666	25
26	Various		2000	37,589		20	1,879	1,879	17,832	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

SEE ACCOUNTANTS' COMPILATION REPORT

## 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	POWER SMOKE DAMPER	2001	\$ 1,850	\$	20	\$ 93	\$ 93	\$ 744	37
38	ELECTRICAL-REWIRING	2001	27,267		20	1,363	1,363	10,906	38
39	NEW PVI FOR BOILER	2001	16,985		20	849	849	6,794	39
40	GAS VENT LINE FOR BOILER	2001	1,374		20	69	69	552	40
41	REPLACE COMPRESSOR FOR FREEZER	2001	1,061		20	53	53	424	41
42	INSTALL BACK FLOW DEVICE FOR TUB	2001	985		20	49	49	394	42
43	BOILER SYSTEM REPAIR	2001	886		20	44	44	354	43
44	CODE ALERT SYSTEM / INSTALLATION	2001	3,000		20	150	150	1,200	44
45	CODE ALERT BANDS	2001	1,263		20	61	61	496	45
46	LANDSCAPE UPGRADE	2001	3,525		20	176	176	1,410	46
47	WALLPAPERING	2001	930		20	47	47	376	47
48	SHOWER BASES REPAIR	2001	16,283		20	814	814	6,514	48
49	TUBING IN CHILLER R&M	2001	2,681		20	134	134	1,072	49
50	DEFROST CLOCK IN COOLER R&M	2001	1,532		20	77	77	616	50
51	ALARM SYSTEM R&M	2001	579		20	29	29	232	51
52	PIPE REPAIR R&M	2001	650		20	33	33	231	52
53	REPLACE TILE R&M	2002	535		20	27	27	189	53
54	BOILER REPAIR R&M	2002	2,394		20	120	120	840	54
55	Water pipe	2002	1,300		20	65	65	455	55
56	Hot water tank	2002	17,950		20	898	898	6,286	56
57	Groundcover	2002	2,850		20	143	143	1,001	57
58	Window treatment	2002	1,209		20	60	60	420	58
59	Freezer door	2002	6,900		20	345	345	2,415	59
60	Mixing valve	2002	5,480		20	274	274	1,918	60
61	Flooring & carpeting	2002	29,982		20	1,499	1,499	10,493	61
62	Boiler	2002	17,218		20	861	861	6,027	62
63	Hot water pumping	2002	3,740		20	187	187	1,309	63
64	Disposal replacement	2002	3,251		20	163	163	1,141	64
65	SEWAGE EJECTOR & PUMP	2002	4,454		20	223	223	1,226	65
66	SIGNS REPLACEMENT	2002	2,703		20	135	135	743	66
67	SIDEWALKS	2002	12,901		20	645	645	3,548	67
68	WATER PRESSURE CONTROL	2002	2,852		20	143	143	786	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,440,710	\$		\$ 59,972	\$ 59,972	\$ 10,564,240	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 11,440,710	\$		\$ 59,972	\$ 59,972	\$ 10,564,240	1
2	AUTOMATIC DOORS KEYPAD	2002	722		20	36	36	198	2
3	REPLACE TILES	2002	694		20	35	35	192	3
4	3 GALLON SYSTEM MICRO SW	2003	2,946		20	147	147	809	4
5	STEAMER MAINT.	2003	1,886		20	94	94	517	5
6	WATER SOFTENER	2003	1,042		20	52	52	286	6
7	REPL EMERG GENERATOR	2003	12,800		20	640	640	3,520	7
8	REPL EMERG GENERATOR	2003	52,200		20	2,610	2,610	14,355	8
9	VALVE IN BOILER ROOM	2003	2,518		20	126	126	693	9
10	GRAB BARS FOR 3RD FLOOR	2003	1,148		20	57	57	314	10
11	CEILING REPAIR	2003	6,735		20	337	337	1,853	11
12	INSTALL COUNTER TOPS	2003	24,000		20	1,200	1,200	6,600	12
13	KRONOS TIME KEEPER	2003	24,765		20	1,238	1,238	6,809	13
14	LIGHTING DESIGN - PT ROOMS	2003	975		20	49	49	269	14
15	REPL EMERG GENERATOR	2003	54,750		20	2,738	2,738	15,059	15
16	POWER BRUSH CHILLER	2003	675		20	34	34	187	16
17									17
18	Disposer In-Sinkerator sinkmount	2003	1,672	167	10	167		752	18
19	Wall carpet for 1,2,3 FL. Nurse Stations	2003	9,783	1,956	5	1,956		8,802	19
20	Serv Work - install disposal	2003	431	44	10	44		198	20
21	Furnish & install half door - 2nd FL	2003	650	44	15	44		198	21
22	Furnish & install dutch door - 3rd FL	2003	900	60	15	60		270	22
23	Repair hot water line under floor	2003	1,745	116	15	116		522	23
24	Final pmt for 2nd & 3rd FL nurses stations	2003	16,735	1,116	15	1,116		5,022	24
25	Evaporator coil & capillary assembly	2003	1,453	290	5	290		1,305	25
26	Repairs on 10 lb. washer	2003	2,850	570	5	570		2,565	26
27	5 hp motor, 7.5 hp motor sleeve kits & hardware	2004	4,109	822	5	822		3,699	27
28	Base 3/4 water valve and install labor charge	2004	1,300	86	15	86		387	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,670,194	\$ 5,271		\$ 74,636	\$ 69,365	\$ 10,639,621	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 11,670,194	\$ 5,271		\$ 74,636	\$ 69,365	\$ 10,639,621	1
2	Seal coating, restriping, pot holes	2005	5,580	698	8	698		2,443	2
3	Diamond Tread plate floor, install/cutting	2005	2,200	220	10	220		770	3
4	Generator	2005	9,227	1,154	8	1,154		4,039	4
5	Automatic Doors	2005	7,072	168	7	168		588	5
6	Skilled wing renovation	2005	1,877	20	15	20		70	6
7	Flooring on elevator	2005	4,480	74	10	74		259	7
8	Skilled wing renovation	2005	995	16	10	16		56	8
9	Water Booster	2005	2,509	52	8	52		182	9
10	Makeup air system-west hallway	2005	13,122	274	8	274		959	10
11									11
12	Replace concrete sidewalk and curb section	2006	3,650	243	15	243		608	12
13	Remove & Resurface pavement	2006	29,745	1,487	20	1,487		3,718	13
14	Analog line card - 16 port	2006	2,250	450	5	450		1,125	14
15	New boiler controls	2006	12,140	1,214	10	1,214		3,035	15
16	3 exterior doors & frames	2006	5,196	260	20	260		650	16
17	Electric strike and camera in vestibule	2006	2,770	396	7	396		990	17
18	44" Packer compactor replacement	2006	18,873	1,887	10	1,887		4,717	18
19	Oxygen Concentrators	2006	36,570	3,657	10	3,657		9,142	19
20	Rebuild 3" self prime ejector pump & reinstall	2006	3,477	348	10	348		870	20
21	Replace 2 3/4 meters & 11 1/2 meters piping	2006	2,400	300	8	300		750	21
22									22
23	Tile restoration in Kitchen and Dish Room	2006	15,904	1,988	8	1,988		2,982	23
24	Electrical Engineering	2007	2,959	198	15	198		297	24
25	Window Treatments	2007	67,000	8,376	8	8,376		12,564	25
26	Removal and Installation of Fresh Air Damper	2007	3,365	420	8	420		630	26
27	Removal and Installation of Exhaust Fan	2007	4,465	558	8	558		837	27
28	Install Plastic laminate wall & base cabinet w/plastic laminate cou	2007	4,590	458	10	458		687	28
29	Direct Sale Card Access System	2007	3,995	500	8	500		750	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,936,605	\$ 30,687		\$ 100,052	\$ 69,365	\$ 10,693,339	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 11,936,605	\$ 30,687		\$ 100,052	\$ 69,365	\$ 10,693,339	1
2	Room Lighting for Wing	2007	13,244	662	10	662		662	2
3	Provide/Install Oak Cabinets, countertops & SS sink	2007	37,360	1,245	15	1,245		1,245	3
4	Move plumbing for break room sink relocation	2007	3,127	63	25	63		63	4
5	Furnish/Install Flagpole	2007	4,146	154	20	154		154	5
6	Furnish/Install Flagpole	2008	3,100	155	10	155		155	6
7	Supply/Install Interior Signage	2008	22,635	1,131	10	1,131		1,131	7
8	Ceiling tiles 2x2	2008	13,192	660	10	660		660	8
9	Carpeting	2008	6,042	302	10	302		302	9
10	Provide/Install Doors (frames, door, hardware, hinges & closures)	2008	17,436	436	20	436		436	10
11	remove/Install new flooring in employee lunch room	2008	9,444	472	10	472		472	11
12	Lith 2 MDR Mvolt Light Fixture	2008	6,475	324	10	324		324	12
13	Extend Analogue MW line and 11C Cabinet	2008	2,830	141	10	141		141	13
14	R&M Reclass -	2007	2,746		10	137	137	137	14
15									15
16									16
17									17
18									18
19									19
20									20
21	Home Office Allocation					160,716	160,716		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	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,078,382	\$ 36,432		\$ 266,650	\$ 230,218	\$ 10,699,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,557,223	\$ 513,008	\$ 202,139	\$ (310,869)	3-25	\$ 1,570,122	71
72	Current Year Purchases	66,602	2,827	2,827		10-25	2,827	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,623,825	\$ 515,835	\$ 204,966	\$ (310,869)		\$ 1,572,949	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	Ford Truck	2002	\$ 26,878	\$ 1,029	\$ 1,029	\$	5	\$ 6,174	76
77	Resident Use	Ford Starcraft	2007	53,983	10,796	10,796		5	16,194	77
78										78
79										79
80	TOTALS			\$ 80,861	\$ 11,825	\$ 11,825	\$		\$ 22,368	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)	\$ 15,363,361	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 564,092	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 483,441	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (80,651)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,294,538	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Chapel - Various - 2002	\$ 18,534	\$	\$ 18,534	86
87	Sinks for beauty shop 2002	8,659	433	3,034	87
88	Prov Serv Asst Living - 2002	897	90	540	88
89	Prov Serv Asst Living - 2003	478	32	192	89
90					90
91	TOTALS	\$ 28,568	\$ 555	\$ 22,300	91

G. Construction-in-Progress

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

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

\*\* This must agree with Schedule V line 30, column 8.

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

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 N/A  
by the length of the lease N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 28,054 Description: Security Consoles & Carts - \$13,021; Dietary Eqpt. - \$15,033

(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

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. /2009 \$ \_\_\_\_\_

13. /2010 \$ \_\_\_\_\_

14. /2011 \$ \_\_\_\_\_

\* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10(1,2,3)	1747 hrs	\$ 81,900	3,569	\$ 232,794	\$ 3,575	5,316	\$ 318,269	1
2	Licensed Speech and Language Development Therapist	10(1,2,3)	994 hrs	47,563	65	5,320	447	1,059	53,330	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10(1,2,3)	7921 hrs	361,036	1,639	93,141	4,915	9,560	459,092	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 prescrpts				2,488,495		2,488,495	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 490,499	5,273	\$ 331,255	\$ 2,497,432	15,935	\$ 3,319,186	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,586,804	\$ 1,586,804	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,326,080 )	2,307,201	2,307,201	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,714	3,714	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest Receivable</u>	292,004	292,004	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,189,723	\$ 4,189,723	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	37,298,127	37,298,127	12
13	Land	580,293	580,293	13
14	Buildings, at Historical Cost	10,228,352	8,093,228	14
15	Leasehold Improvements, at Historical Cost	306,463	3,985,154	15
16	Equipment, at Historical Cost	5,502,516	2,704,686	16
17	Accumulated Depreciation (book methods)	(12,971,642)	(12,294,538)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 40,944,109	\$ 40,366,950	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 45,133,832	\$ 44,556,673	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 233,940	\$ 233,940	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Parties</u>	565,247	565,247	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 799,187	\$ 799,187	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 799,187	\$ 799,187	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 44,334,645	\$ 43,757,486	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 45,133,832	\$ 44,556,673	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>41,869,472</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior Period Adjustment</b>	<b>1,614,216</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>43,483,688</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>850,957</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>850,957</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>44,334,645</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 21,769,378	1
2	Discounts and Allowances for all Levels	(7,975,674)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,793,704	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,274,089	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,274,089	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,552	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,926,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	98,957	21
22	Laundry	19,730	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,052,108	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	2,077,764	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,077,764	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	8,424	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,424	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 22,206,089	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,995,696	31
32	Health Care	8,941,459	32
33	General Administration	6,081,898	33
	<b>B. Capital Expense</b>		
34	Ownership	670,070	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	2,502,407	35
36	Provider Participation Fee	163,602	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 21,355,132	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	850,957	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 850,957	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.

Resurrection Nursing & Rehabilitation Center  
Provider #0044362  
7/1/2007 - 6/30/2008

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

**NOTE:** Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

XVII - Income Statement: Line 28 - Other Revenue

	<u>Amount</u>
Other Revenue	4,874
Other	1,509
Vending Commission	<u>2,041</u>
	<u><u>8,424</u></u>

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

**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	1,216	1,392	\$ 59,505	\$ 42.75	1
2	Assistant Director of Nursing	1,760	2,080	83,999	40.38	2
3	Registered Nurses	85,018	96,758	3,275,758	33.86	3
4	Licensed Practical Nurses	5,428	6,330	152,264	24.05	4
5	CNAs & Orderlies	169,785	192,552	2,505,690	13.01	5
6	CNA Trainees					6
7	Licensed Therapist	10,662	12,583	490,499	38.98	7
8	Rehab/Therapy Aides	20,003	23,064	433,495	18.80	8
9	Activity Director	1,628	1,720	45,530	26.47	9
10	Activity Assistants	9,753	11,021	114,270	10.37	10
11	Social Service Workers	8,627	9,606	179,484	18.68	11
12	Dietician	3,739	4,193	77,142	18.40	12
13	Food Service Supervisor	3,102	3,669	84,990	23.16	13
14	Head Cook	7,358	8,727	123,933	14.20	14
15	Cook Helpers/Assistants	32,415	36,081	354,207	9.82	15
16	Dishwashers					16
17	Maintenance Workers	7,794	8,612	183,495	21.31	17
18	Housekeepers	26,099	28,765	322,838	11.22	18
19	Laundry	19,492	21,768	237,420	10.91	19
20	Administrator	1,840	2,120	126,838	59.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,688	19,046	352,739	18.52	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	5,459	6,592	140,198	21.27	31
32	Other Health C: See Sch 20A	8,102	9,407	311,062	33.07	32
33	Other(specify) See Sch 20A	6,530	7,133	174,977	24.53	33
34	TOTAL (lines 1 - 33)	452,498	513,219	\$ 9,830,333 *	\$ 19.15	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	24,673	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)		\$ 24,673		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Resurrection Nursing & Rehabilitation Center  
 Provider # 0044362  
 07/01/07 - 06/30/08  
 Staffing & Salary Costs

Schedule 20A

**Other Health Care Wages - Line 32:**

	<b>Hours <u>Worked</u></b>	<b>Hours <u>Paid</u></b>	<b>Salary or <u>Wages</u></b>	<b>Ave. Hrly. <u>Wages</u></b>
MDS Care Plan Coordinator	6,630	7,485	236,774	31.63
MDS Manager	1,472	1,922	74,288	38.65
TOTAL	8,102	9,407	311,062	33.07

**Other Wages - Line 33:**

	<b>Hours <u>Worked</u></b>	<b>Hours <u>Paid</u></b>	<b>Salary or <u>Wages</u></b>	<b>Ave. Hrly. <u>Wages</u></b>
Chaplain	6,318	6,882	166,159	24.14
Group Coordinator Spiritual Services	212	251	8,818	35.13
	6,530	7,133	174,977	24.53



**Resurrection Nursing & Rehabilitation Center**  
**Provider # 0044362**  
**07/01/07 - 06/30/08**  
**Staffing & Salary Costs**

**Schedule 21A**

XIX - Support Schedules - Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Total (agrees to Schedule V, Line 19, Col. 3)		23,667
Less: Disallowed Legal Fees		<u>(22,600)</u>
Total (agrees to Schedule V, Line 19, Col. 8)		<u><u>1,067</u></u>

**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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Nursing & Rehab Center# 0044362Report Period Beginning: 07/01/2007Ending: 06/30/2008**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 - \$3,963
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 17.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,496 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 163,602  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,552
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG 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