

Facility Name & ID Number Resurrection Life Center

0044354 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,125	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	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	14,176	13,396	8,677	36,249	8
9	SNF/PED					9
10	ICF	7,633	4,955	102	12,690	10
11	ICF/DD					11
12	SC			9,001	9,001	12
13	DD 16 OR LESS					13
14	TOTALS	21,809	18,351	17,780	57,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.99%

D. How many bed-hold days during this year were paid by the Department? 8 (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 03/26/1998

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/26/1998 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 102 and days of care provided 36,249

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: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	417,915	49,503	(21,833)	445,585		445,585		445,585		1
2	Food Purchase		364,287		364,287		364,287	(3,029)	361,258		2
3	Housekeeping	247,515	26,742	2,457	276,714		276,714		276,714		3
4	Laundry	52,172	281,988	972	335,132		335,132		335,132		4
5	Heat and Other Utilities			274,483	274,483		274,483		274,483		5
6	Maintenance	86,791	1,618	150,780	239,189		239,189		239,189		6
7	Other (specify):*										7
8	TOTAL General Services	804,393	724,138	406,859	1,935,390		1,935,390	(3,029)	1,932,361		8
	B. Health Care and Programs										
9	Medical Director			11,400	11,400		11,400		11,400		9
10	Nursing and Medical Records	3,179,283	145,407	112,690	3,437,380		3,437,380		3,437,380		10
10a	Therapy	248,751	3,579	45,833	298,163		298,163		298,163		10a
11	Activities	234,271	12,130	8,891	255,292		255,292		255,292		11
12	Social Services	105,689			105,689		105,689		105,689		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,767,994	161,116	178,814	4,107,924		4,107,924		4,107,924		16
	C. General Administration										
17	Administrative			809,407	809,407		809,407	(76,733)	732,674		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			12,614	12,614		12,614		12,614		20
21	Clerical & General Office Expenses	378,777	24,543	28,878	432,198		432,198	(24,686)	407,512		21
22	Employee Benefits & Payroll Taxes			1,802,487	1,802,487		1,802,487	336,779	2,139,266		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			16,365	16,365		16,365		16,365		25
26	Insurance-Prop.Liab.Malpractice			435,560	435,560		435,560		435,560		26
27	Other (specify):*										27
28	TOTAL General Administration	378,777	24,543	3,105,311	3,508,631		3,508,631	235,360	3,743,991		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,951,164	909,797	3,690,984	9,551,945		9,551,945	232,331	9,784,276		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Resurrection Life Center

#0044354

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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			610,384	610,384		610,384	100,863	711,247			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			610,384	610,384		610,384	100,863	711,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		909,547		909,547		909,547		909,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,008	75,008		75,008		75,008			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		909,547	75,008	984,555		984,555		984,555			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,951,164	1,819,344	4,376,376	11,146,884		11,146,884	333,194	11,480,078			45

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

VI. ADJUSTMENT DETAIL

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

		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	(3,029)	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	3,029	30		9
10	Interest and Other Investment Income	(24,475)	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 Page 5A	1,662	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,813)		\$	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)	359,331		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 359,331		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 336,518		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Resurrection Life Center

ID# 0044354

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Administration - Other Revenue	(24,686)	21	2
3	Investment Fees - Exp recorded as non-op.	3,839	32	3
4	Financial Audit Adj to Exp - Workers Comp.	11,078	22	4
5	Financial Audit Adj to Exp - Retirementt Plan	8,107	22	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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22				22
23				23
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25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Life Center# 0044354

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	(3,029)	0	0	0	0	0	0	0	0	0	0	(3,029)	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	(3,029)	0	0	0	0	0	0	0	0	0	0	(3,029)	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	(76,733)	0	0	0	0	0	0	0	0	0	(76,733)	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	(24,686)	0	0	0	0	0	0	0	0	0	0	(24,686)	21
22	Employee Benefits & Payroll Taxes	19,185	317,594	0	0	0	0	0	0	0	0	0	336,779	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	(5,501)	240,861	0	235,360	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,530)	240,861	0	232,331	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	3,029	97,834	0	0	0	0	0	0	0	0	0	100,863	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20,636)	20,636	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,607)	118,470	0	100,863	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(26,137)	359,331	0	333,194	45								

Facility Name & ID Number

Resurrection Life Center

0044354

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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 Healh Care	100	See Attached Page 6A		See Attached Page 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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	17 Administrative	\$ 809,407	Resurrection Healh Care	100.00%	\$ 732,674	\$ (76,733)	1
2	V	22 Employee Benefits		Resurrection Healh Care	100.00%	317,594	317,594	2
3	V	30 Depreciation		Resurrection Healh Care	100.00%	97,834	97,834	3
4	V	32 Interest Expenses		Resurrection Healh Care	100.00%	20,636	20,636	4
5	V							5
6	V	39 Intercompany Pharmacy	909,547	Resurrection Healh Care	100.00%	909,547		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,718,954			\$ 2,078,285	\$ * 359,331	14

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

Resurrection Health Care
 Schedule for Form 990
 Page 5, Part VI, Line 80b
 Related Organizations
 Twelve Months Ending June 30, 2009

Related Organizations	Fed Tax ID No	Tax Status
Family Medical Network	36-3961066	Non-Exempt
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Nursing & Rehab Center	36-3121158	Exempt
Holy Family Medical Center	36-2439318	Exempt
Key Opportunities Inc.	36-3499869	Non-Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Mount Loretto Nursing Home	14-1363014	Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Foundation	36-3466794	Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Rest Home	14-1348691	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt
Saint Mary of Nazareth PHO	36-4006358	Non-Exempt
Stamana, Inc.	36-3314912	Non-Exempt
Westlake Community Hospital	36-1649520	Exempt
West Suburban Health Providers	36-3980942	Non-Exempt
West Suburban Health Services	36-4286236	Exempt
West Suburban Medical Center	36-2182170	Exempt

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

VII. RELATED PARTIES (continued)

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

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

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

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

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

**RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS
OCTOBER 1, 2008**

Name	Office
Mr. Joseph F. Toomey	President and CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5555; Fax 773-990-8601 Email: DEJesus-ortiz@reshealthcare.org
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5153; Fax - 773-990-7626 Email: srdmarie@reshealthcare.org
Mr. John R. Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 ; Fax: 847-813-3876 Email: Jwalton@reshealthcare.org
Michael Rosenberg, M.D.	Director, Emergency Medicine Resurrection Medical Center 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5219; Fax 773-594-7980 Email: Morsenberg@reshealthcare.org Director, Emergency Medicine Our Lady of the Resurrection Medical Center 5645 W. Addison Chicago, IL 60634 Phone: 773-794-7602; Fax 773-794-7664 Email: Morsenberg@reshealthcare.org
Sister Elizabeth Trembczynski, CSFN	Administrator Case San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-561-4300; Fax - 708-562-5677 Email: Etrem@reshealthcare.org

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2008

Title	Name
President	Mr. Joseph F. Toomey
Group Vice President and EVP/CEO	Mr. John R. Walton
Secretary	Mr. Jeannie C. Frey
Treasurer	Mr. Tom Capobianco
Assistance Secretary	Mr. John R. Walton

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Resurrection Health Care

Street Address

7435 W. Talcott

City / State / Zip Code

Chicago, IL 60631

Phone Number

(773) 774-8000

Fax Number

(773) 594-7488

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.

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	17	Administrative			\$	\$		\$ 732,674	1
2	22	Employee Benefits						317,594	2
3	30	Depreciation						97,834	3
4	32	Interest Expenses						20,636	4
5									5
6	39	Intercompany Pharmacy						909,547	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 2,078,285	25

Facility Name & ID Number

Resurrection Life Center

0044354

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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			
	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													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$	\$				\$	15					

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

** 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

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 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:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	N/A	12
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

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

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: Resident Care, 281,860, 1996, \$3,600,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 281,860, (blank), \$3,600,000, 3.

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	159		1998	\$ 11,711,085	\$ 476,686	Various	\$ 476,686	\$	\$ 7,030,639	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Window for chapel		1998	16,500		10	825	825	16,500	9
10	Interior sign system		1998	1,898		10	93	93	1,898	10
11	Modify nurse call system		1998	4,692	313	15	313		3,286	11
12	Install water softener		1998	2,325		10	112	112	2,325	12
13	Exterior directional illuminated sign		1999	15,825	789	10	789		15,825	13
14	Exterior main illuminated sign		1999	12,265	609	10	609		12,265	14
15	Five foot fence and gate		1999	7,974	532	15	532		5,585	15
16	Spacesaver medical records system		1999	12,661	634	10	634		12,661	16
17	Electrical work-kitchen door holders		1999	900	60	15	60		630	17
18	Replacement flooring shower and tub rooms		1999	8,037	536	15	536		5,638	18
19	Electric water heater		1999	2,570	128	10	128		2,570	19
20	Work on second floor		2000	3,144	157	20	157		1,570	20
21	Digital access control system		2000	3,252	163	20	163		1,630	21
22	Electrical work - kitchen door holders		2000	2,165	108	20	108		1,080	22
23	Architect fees		2000	3,145	105	30	105		1,050	23
24	Site lighting		2000	7,686	256	30	256		2,560	24
25	Site lighting		2000	14,947	498	30	498		4,980	25
26	Electrical work - Chapel		2000	1,354	45	30	45		450	26
27	Front entrance canopy		2000	60,000	2,000	30	2,000		20,000	27
28	Laundry plumbing and piping		2000	16,600	553	30	553		5,530	28
29	Construction work		2000	10,110	337	30	337		3,370	29
30	Flooring		2000	600	40	15	40		380	30
31	Flooring		2000	625	42	15	42		399	31
32	Raceway for signs		2000	1,504	75	20	75		713	32
33	Rubrail		2000	903	45	20	45		428	33
34	Rubrail		2000	875	44	20	44		418	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

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		15	653	653	7,508	40
41	Message waiting line	1998	16,200		5			16,200	41
42	Custom work counter	1998	1,657	110	15	110		1,266	42
43	Sharpen prep sink	1998	2,392	159	15	159		1,830	43
44	Walk-in refrigerator freezer	1998	40,774		10			40,774	44
45	Custom wall panel	1998	7,272		10			7,272	45
46	Three compartment sink	1998	3,248	217	15	217		2,494	46
47	Fire protection system	1998	3,887		10			3,887	47
48	Wall guards	1999	2,596		5			2,596	48
49									49
50	Electrical installation	2001	3,681	184	20	184		1,656	50
51	Parking lot light fixtures	2001	421	21	20	21		189	51
52	Exit signs	2001	1,510	76	20	76		684	52
53	Nurse call box	2001	1,796	90	20	90		810	53
54	Time recorder system R&M	2001	5,363		20	268	268	2,412	54
55	Time recorder system R&M	2001	1,204		20	60	60	540	55
56	Water line R&M	2001	522		20	26	26	234	56
57	Chiller fuses R&M	2001	1,546		20	77	77	616	57
58	Disposal R&M	2001	571		20	29	29	232	58
59	Hot water tank R&M	2001	1,048		20	52	52	416	59
60	Cobbles R&M	2001	2,794		20	140	140	1,120	60
61	Door alarms R&M	2001	705		20	35	35	280	61
62	Exhaust R&M	2001	1,175		20	59	59	472	62
63	Disposal R&M	2001	1,412		20	70	70	561	63
64	Nurse call master	2001	1,595	80	20	80		640	64
65	Drywall/soffit	2001	2,874	144	20	144		1,152	65
66	Information system module	2001	18,330	914	20	914		7,318	66
67	Information system module	2001	1,050	53	20	53		424	67
68	Concrete sections	2002	2,923	146	20	146		1,168	68
69	Floor	2001	2,410	121	20	121		968	69
70	TOTAL (lines 4 thru 69)		\$ 12,085,189	\$ 487,069		\$ 489,568	\$ 2,499	\$ 7,280,899	70

**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	Totals from Page 12A, Carried Forward		\$ 12,085,189	\$ 487,069		\$ 489,568	\$ 2,499	\$ 7,280,899	1
2	Code alarm system	2003	3,109	311	10	311		1,710	2
3	Boiler repairs	2003	5,230	523	10	523		2,877	3
4	VCT sanitary sewer	2003	19,635	1,309	15	1,309		7,200	4
5	Sewer line in corridor	2005	1,944	194	10	194		970	5
6									6
7	Install Plants, Trees, Mulch, Soil & Sod	2006	10,309	1,031	10	1,031		3,608	7
8	Wire Nurse Call System	2006	2,600		10	260	260	910	8
9	Remove & Replace 5 wall temperature transmitters	2006	4,000	400	10	400		1,400	9
10	Hot Water Main Repair	2006	5,246	525	10	525		1,837	10
11	Walk in Cooler Evaporator Coil	2006	1,550	221	7	221		774	11
12									12
13	Replace broken sprinkler systems, controller upgrade	2006	7,090	709	10	709		1,773	13
14	Paint Main Entrance	2006	28,865	2,887	10	2,887		7,217	14
15	Renovation of 3 Nurses Lounges	2006	144,840	7,242	20	7,242		18,105	15
16	A/E fees, General Requirements, Demolition, Doors &								16
17	Hardware, Carpentry, Drywall, Acoustic Ceiling, Flooring								17
18	Painting, Plumbing, Fire Protection, HVAC, Electrical &								18
19	Contractor's fees.								19
20	Inspect, lubricate & test 28 smoke dampers	2006	19,250	1,284	15	1,284		3,210	20
21	Painting	2007	21,720	3,102	7	3,102		7,755	21
22									22
23	Code Alert Model 70 Wanderer & Flush Mount Accessory	2007	4,928	246	10	246		492	23
24	Install Additional Downspouts & repair roof	2007	6,775	339	10	339		678	24
25	Remove/Replace piping & valves on hot water line & in boiler room	2007	3,790	127	15	127		254	25
26	Exterior Painting - East side, Phase 3 of 4	2007	22,655	1,133	10	1,133		2,266	26
27	Paint/Install Wall Coverings	2007	24,255	2,425	5	2,425		4,850	27
28	Paint/Install Wall Coverings	2008	10,520	1,052	5	1,052		2,104	28
29	Install new passenger elevator	2008	4,601	115	20	115		230	29
30	Repipe/Rewire short in fire alarm	2008	3,380	85	20	85		170	30
31	Power wash & paint courtyard	2008	23,775	2,378	5	2,378		4,756	31
32	Conduit down wall & cut in gem for outlet in kitchen	2008	3,423	86	20	86		172	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,468,679	\$ 514,793		\$ 517,552	\$ 2,759	\$ 7,356,217	34

**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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,468,679	\$ 514,793		\$ 517,552	\$ 2,759	\$ 7,356,217	1
2	R&M Reclass - Install one chilled water air handler	2007	2,704			270	270	540	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14	Allocation From Home Office	2009				66,543	66,543		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	TOTAL (lines 1 thru 33)		\$ 12,471,383	\$ 514,793		\$ 584,365	\$ 69,572	\$ 7,356,757	34

**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:

07/01/2008

Ending:

06/30/2009

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	\$ 1,139,830	\$ 7,589	\$ 74,907	\$ 67,318	7-15	\$ 928,042	71
72	Current Year Purchases	186,856	20,684	20,684		3-20	20,684	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			31,291	31,291			74
75	TOTALS	\$ 1,326,686	\$ 28,273	\$ 126,882	\$ 98,609		\$ 948,726	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 Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,398,069	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 543,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 711,247	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 168,181	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,305,483	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	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.

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 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: \$ 13,724 Description: Copiers \$13,724

(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. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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>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			
		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 Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		1982	hrs	\$ 86,486	309	\$ 20,167	\$	2,291	\$ 106,653	1
2	Licensed Speech and Language Development Therapist		37	hrs	1,320	156	10,260		193	11,580	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		3164	hrs	129,664	34	2,081		3,198	131,745	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts				909,547		909,547	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				\$ 217,470	499	\$ 32,508	\$ 909,547	5,682	\$ 1,159,525	14

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

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(last day of reporting year)

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	\$ 323,932	\$ 323,932	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 252,267)	965,884	965,884	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,882	7,882	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,297,698	\$ 1,297,698	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,600,000	3,600,000	13
14	Buildings, at Historical Cost	11,795,956	11,711,085	14
15	Leasehold Improvements, at Historical Cost	219,120	760,298	15
16	Equipment, at Historical Cost	1,773,352	1,326,686	16
17	Accumulated Depreciation (book methods)	(8,241,002)	(8,305,483)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,507,381	5,507,381	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Due from Related Org.</u>	90,362	145,202	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,745,169	\$ 14,745,169	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,042,867	\$ 16,042,867	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 73,352	\$ 73,352	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120	120	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 73,472	\$ 73,472	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)	\$ 73,472	\$ 73,472	46
47	TOTAL EQUITY(page 18, line 24)	\$ 15,969,395	\$ 15,969,395	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,042,867	\$ 16,042,867	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,946,136	1
2	Restatements (describe):		2
3	Prior Period Adj	111,326	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,057,462	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,777,999	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)	\$ 1,777,999	17
	B. Transfers (Itemize):		
18	NET ASSET RELEASED FROM OPERATIONS	133,934	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 133,934	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 15,969,395	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,451,957	1
2	Discounts and Allowances for all Levels	(4,053,337)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,398,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,029	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,029	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	170,832	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 170,832	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue - Please Refer to Page 19A	371,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 371,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,944,068	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,935,390	31
32	Health Care	4,107,924	32
33	General Administration	3,508,631	33
	B. Capital Expense		
34	Ownership	610,384	34
	C. Ancillary Expense		
35	Special Cost Centers	909,547	35
36	Provider Participation Fee	75,008	36
	D. Other Expenses (specify):		
37	Financial Audit Adj to Expenses	19,185	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,166,069	40
41	Income before Income Taxes (line 30 minus line 40)**	1,777,999	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,777,999	43

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

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

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

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

Resurrection Life Center

Medicaid Provider Number: 0044354

FYE 6/30/2009

Attachment to Line 28, Schedule XVII - Other Revenue

Net Assets Released from restrictions	245,356	
Admin - Other Revenue	24,686	Offset on Page 5A
Medical Supply Revenue	70,519	Patient Revenue- not subject to offse
Laundry _ Private Patient Revenue	31,026	Pvt Pt. Not subject to offset
Total - Other Revenue	<u>371,587</u>	

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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	1,688	1,989	\$ 87,268	\$ 43.88	1
2	Assistant Director of Nursing	592	640	24,636	38.49	2
3	Registered Nurses	37,114	42,149	1,442,944	34.23	3
4	Licensed Practical Nurses	7,764	8,861	200,919	22.67	4
5	CNAs & Orderlies	91,571	102,214	1,362,281	13.33	5
6	CNA Trainees					6
7	Licensed Therapist	4,752	5,465	227,588	41.64	7
8	Rehab/Therapy Aides	1,769	1,972	23,716	12.03	8
9	Activity Director	1,772	2,088	44,129	21.13	9
10	Activity Assistants	6,659	7,421	83,364	11.23	10
11	Social Service Workers	3,744	4,200	105,152	25.04	11
12	Dietician	1,840	2,072	41,705	20.13	12
13	Food Service Supervisor	2,239	2,598	58,102	22.36	13
14	Head Cook	5,895	6,749	99,685	14.77	14
15	Cook Helpers/Assistants	19,329	21,637	219,952	10.17	15
16	Dishwashers					16
17	Maintenance Workers	3,351	3,806	86,743	22.79	17
18	Housekeepers	17,260	19,592	210,713	10.76	18
19	Laundry	5,415	6,334	90,153	14.23	19
20	Administrator	1,792	2,080	112,211	53.95	20
21	Assistant Administrator	1,732	2,032	45,869	22.57	21
22	Other Administrative	8,315	9,318	149,573	16.05	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	3,467	3,882	129,651	33.40	32
33	Other(specify)	4,900	5,249	104,810	19.97	33
34	TOTAL (lines 1 - 33)	232,960	262,348	\$ 4,951,164 *	\$ 18.87	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	11,400	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)		\$ 11,400		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	257	\$ 14,794	10(3)	50
51	Licensed Practical Nurses	186	7,813	10(3)	51
52	Certified Nurse Assistants/Aides	31	787	10(3)	52
53	TOTAL (lines 50 - 52)	474	\$ 23,394		53

Facility Name & ID Number Resurrection Life Center# 0044354Report Period Beginning: 07/01/2008Ending: 06/30/2009**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?
If YES, give association name and amount. LSN - \$2,281
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense 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. \$ 75,008
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,029
- (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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees