



Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362 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	298	Skilled (SNF)	298	108,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	108,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,068	15,444	21,210	61,722	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	18,017	6,822	1,007	25,846	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,085	22,266	22,217	87,568	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.51%

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 02/01/1980

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 02/01/1980 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 298 and days of care provided 61,722

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 Nursing & Rehab Center # 0044362 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
	<b>A. General Services</b>										
1	Dietary	638,107	101,440	44,963	784,510		784,510		784,510		1
2	Food Purchase		671,708		671,708		671,708	(7,061)	664,647		2
3	Housekeeping	393,782	34,387	5,057	433,226		433,226		433,226		3
4	Laundry	175,022	81,823	2,096	258,941		258,941		258,941		4
5	Heat and Other Utilities			434,897	434,897		434,897		434,897		5
6	Maintenance	155,219	338	189,832	345,389		345,389		345,389		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,362,130	889,696	676,845	2,928,671		2,928,671	(7,061)	2,921,610		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			25,200	25,200		25,200		25,200		9
10	Nursing and Medical Records	6,294,969	459,085	218,655	6,972,709		6,972,709		6,972,709		10
10a	Therapy	932,138	7,113	330,916	1,270,167		1,270,167		1,270,167		10a
11	Activities	178,032	4,026	14,846	196,904		196,904		196,904		11
12	Social Services	329,352	3,072	3,263	335,687		335,687		335,687		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	7,734,491	473,296	592,880	8,800,667		8,800,667		8,800,667		16
	<b>C. General Administration</b>										
17	Administrative			1,491,887	1,491,887		1,491,887	(71,108)	1,420,779		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			17,905	17,905		17,905		17,905		20
21	Clerical & General Office Expenses	520,596	32,349	(141,273)	411,672		411,672	335,141	746,813		21
22	Employee Benefits & Payroll Taxes			3,424,490	3,424,490		3,424,490	652,781	4,077,271		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			376	376		376		376		25
26	Insurance-Prop.Liab.Malpractice			1,643,467	1,643,467		1,643,467		1,643,467		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	520,596	32,349	6,436,852	6,989,797		6,989,797	916,814	7,906,611		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	9,617,217	1,395,341	7,706,577	18,719,135		18,719,135	909,753	19,628,888		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 Nursing & Rehab Center

#0044362

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	
	<b>D. Ownership</b>											
30	Depreciation			581,862	581,862		581,862	43,585	625,447			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	<b>TOTAL Ownership</b>			581,862	581,862		581,862	43,585	625,447			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,073,504	2,073,504		2,073,504	4,120	2,077,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,155	163,155		163,155		163,155			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			2,236,659	2,236,659		2,236,659	4,120	2,240,779			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	9,617,217	1,395,341	10,525,098	21,537,656		21,537,656	957,458	22,495,114			45

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



Resurrection Nursing & Rehab Center

ID# 0044362

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Charity Patient Revnue - Recorded as negative	\$		1
2	expensse on Schedule V - Error is corrected thru			2
3	this adjustment	341,600	21	3
4				4
5	Admin - Other Rev	(6,459)	21	5
6				6
7	Financial Audit Adj - Emp Bene, Workers comp	22,103	22	7
8	Financial Audit Adj - Emp bene. Retirement plan	16,176	22	8
9	Financial Audit Adj - Pharmacy	4,120	39	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>	377,540		49

## STATE OF ILLINOIS

Summary A

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

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	(7,061)	0	0	0	0	0	0	0	0	0	0	(7,061)	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	<b>TOTAL General Services</b>	<b>(7,061)</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>(7,061)</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	(71,108)	0	0	0	0	0	0	0	0	0	(71,108)	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	335,141	0	0	0	0	0	0	0	0	0	0	335,141	21
22	Employee Benefits & Payroll Taxes	38,279	614,502	0	0	0	0	0	0	0	0	0	652,781	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>373,420</b>	<b>543,394</b>	<b>0</b>	<b>916,814</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>366,359</b>	<b>543,394</b>	<b>0</b>	<b>909,753</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

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	(146,132)	189,717	0	0	0	0	0	0	0	0	0	43,585	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,016)	40,016	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	<b>TOTAL Ownership</b>	<b>(186,148)</b>	<b>229,733</b>	<b>0</b>	<b>43,585</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	4,120	0	0	0	0	0	0	0	0	0	0	4,120	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	<b>TOTAL Special Cost Centers</b>	<b>4,120</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>4,120</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>184,331</b>	<b>773,127</b>	<b>0</b>	<b>957,458</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 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	\$ 1,491,887	Resurrection Health Care	100.00%	\$ 1,420,779	\$ (71,108)	1
2	V	22 Employee Benefits		Resurrection Health Care	100.00%	614,502	614,502	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	189,717	189,717	3
4	V	32 Interest		Resurrection Health Care	100.00%	40,016	40,016	4
5	V							5
6	V	39 Intercompany Pharmacy	2,073,504	Resurrection Health Care	100.00%	2,073,504		6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,565,391			\$ 4,338,518	\$ * 773,127	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: 07/01/2008 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 and 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

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

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			\$	\$		1,420,779	1
2	22	Employee Benefits						614,502	2
3	30	Depreciation						189,717	3
4	32	Interest						40,016	4
5									5
6	39	Intercompany Pharmacy						2,073,504	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				\$	\$		4,338,518	25

Facility Name & ID Number

Resurrection Nursing & Rehab Center

# 0044362

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9						
<b>B. Non-Facility Related*</b>																		
10							Alloated from Home Office				40,016	10						
11							Offset Interest Income				(40,016)	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15						

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

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

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

**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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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
			<b>FOR BHF USE ONLY</b>
	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.**



X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Resident Care & Parking Area and a TOTALS row.

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	\$		\$	\$	\$ 6,276,546
5			1976	1,733,006					1,733,006
6									
7									
8									
<b>Improvement Type**</b>									
9	Various		1981	3,549		20			3,549
10	Various		1983	35,281		20			35,281
11	Various		1985	3,892		20			3,892
12	Various		1986	14,629		20			14,629
13	Various		1987	41,215		20			41,215
14	Various		1988	40,512		20			40,512
15	Various		1989	190,627		20			190,627
16	Various		1990	171,816		20	8,587	8,587	171,816
17	Various		1991	60,020		20	3,001	3,001	57,019
18	Various		1992	107,965		20	5,398	5,398	97,164
19	Various		1993	105,120		20	5,256	5,256	89,352
20	Various		1994	259,632		20	12,982	12,982	207,712
21	Various		1995	630,342		20	31,517	31,517	472,755
22	Various		1996	105,335		20	5,267	5,267	89,367
23	Various		1997	1,130,243		20	56,512	56,512	919,075
24	Various		1998	68,801		20	3,440	3,440	49,073
25	Various		1999	228,020		20	11,401	11,401	126,067
26	Various		2000	37,589		20	1,879	1,879	19,711
27									
28									
29									
30									
31									
32									
33									
34									
35									
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	POWER SMOKE DAMPER	2001	\$ 1,850	\$	20	\$ 93	\$ 93	\$ 837	37
38	ELECTRICAL-REWIRING	2001	27,267		20	1,363	1,363	12,269	38
39	NEW PVI FOR BOILER	2001	16,985		20	849	849	7,643	39
40	GAS VENT LINE FOR BOILER	2001	1,374		20	69	69	621	40
41	REPLACE COMPRESSOR FOR FREEZER	2001	1,061		20	53	53	477	41
42	INSTALL BACK FLOW DEVICE FOR TUB	2001	985		20	49	49	443	42
43	BOILER SYSTEM REPAIR	2001	886		20	44	44	398	43
44	CODE ALERT SYSTEM / INSTALLATION	2001	3,000		20	150	150	1,350	44
45	CODE ALERT BANDS	2001	1,263		20	61	61	557	45
46	LANDSCAPE UPGRADE	2001	3,525		20	176	176	1,586	46
47	WALLPAPERING	2001	930		20	47	47	423	47
48	SHOWER BASES REPAIR	2001	16,283		20	814	814	7,328	48
49	TUBING IN CHILLER R&M	2001	2,681		20	134	134	1,206	49
50	DEFROST CLOCK IN COOLER R&M	2001	1,532		20	77	77	693	50
51	ALARM SYSTEM R&M	2001	579		20	29	29	261	51
52	PIPE REPAIR R&M	2001	650		20	33	33	264	52
53	REPLACE TILE R&M	2002	535		20	27	27	216	53
54	BOILER REPAIR R&M	2002	2,394		20	120	120	960	54
55	Water pipe	2002	1,300		20	65	65	520	55
56	Hot water tank	2002	17,950		20	898	898	7,184	56
57	Groundcover	2002	2,850		20	143	143	1,144	57
58	Window treatment	2002	1,209		20	60	60	480	58
59	Freezer door	2002	6,900		20	345	345	2,760	59
60	Mixing valve	2002	5,480		20	274	274	2,192	60
61	Flooring & carpeting	2002	29,982		20	1,499	1,499	11,992	61
62	Boiler	2002	17,218		20	861	861	6,888	62
63	Hot water pumping	2002	3,740		20	187	187	1,496	63
64	Disposal replacement	2002	3,251		20	163	163	1,304	64
65	SEWAGE EJECTOR & PUMP	2002	4,454		20	223	223	1,449	65
66	SIGNS REPLACEMENT	2002	2,703		20	135	135	878	66
67	SIDEWALKS	2002	12,901		20	645	645	4,193	67
68	WATER PRESSURE CONTROL	2002	2,852		20	143	143	929	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,440,710	\$		\$ 155,069	\$ 155,069	\$ 10,719,309	70

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

Facility Name &amp; ID Number Resurrection Nursing &amp; Rehab Center

# 0044362

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

## 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	\$		\$ 155,069	\$ 155,069	\$ 10,719,309	1
2	AUTOMATIC DOORS KEYPAD	2002	722		20	36	36	234	2
3	REPLACE TILES	2002	694		20	35	35	227	3
4	3 GALLON SYSTEM MICRO SW	2003	2,946		20	147	147	956	4
5	STEAMER MAINT.	2003	1,886		20	94	94	611	5
6	WATER SOFTENER	2003	1,042		20	52	52	338	6
7	REPL EMERG GENERATOR	2003	12,800		20	640	640	4,160	7
8	REPL EMERG GENERATOR	2003	52,200		20	2,610	2,610	16,965	8
9	VALVE IN BOILER ROOM	2003	2,518		20	126	126	819	9
10	GRAB BARS FOR 3RD FLOOR	2003	1,148		20	57	57	371	10
11	CEILING REPAIR	2003	6,735		20	337	337	2,190	11
12	INSTALL COUNTER TOPS	2003	24,000		20	1,200	1,200	7,800	12
13	KRONOS TIME KEEPER	2003	24,765		20	1,238	1,238	8,047	13
14	LIGHTING DESIGN - PT ROOMS	2003	975		20	49	49	318	14
15	REPL EMERG GENERATOR	2003	54,750		20	2,738	2,738	17,797	15
16	POWER BRUSH CHILLER	2003	675		20	34	34	221	16
17									17
18	Disposer In-Sinkerator sinkmount	2003	1,672	167	10	167		919	18
19	Wall carpet for 1,2,3 FL. Nurse Stations	2003	9,783	1,956	5	1,956		10,758	19
20	Serv Work - install disposal	2003	431	44	10	44		242	20
21	Furnish & install half door - 2nd FL	2003	650	44	15	44		242	21
22	Furnish & install dutch door - 3rd FL	2003	900	60	15	60		330	22
23	Repair hot water line under floor	2003	1,745	116	15	116		638	23
24	Final pmt for 2nd & 3rd FL nurses stations	2003	16,735	1,116	15	1,116		6,138	24
25	Evaporator coil & capillary assembly	2003	1,453	290	5	290		1,595	25
26	Repairs on 10 lb. washer	2003	2,850	570	5	570		3,135	26
27	5 hp motor, 7.5 hp motor sleeve kits & hardware	2004	4,109	822	5	822		4,521	27
28	Base 3/4 water valve and install labor charge	2004	1,300	86	15	86		473	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,670,194	\$ 5,271		\$ 169,733	\$ 164,462	\$ 10,809,354	34

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

Facility Name &amp; ID Number Resurrection Nursing &amp; Rehab Center

# 0044362

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

## 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		\$ 169,733	\$ 164,462	\$ 10,809,354	1
2	Seal coating, restriping, pot holes	2005	5,580	698	8	698		3,141	2
3	Diamond Tread plate floor, install/cutting	2005	2,200	220	10	220		990	3
4	Generator	2005	9,227	1,154	8	1,154		5,193	4
5	Automatic Doors	2005	7,072	168	7	168		756	5
6	Skilled wing renovation	2005	1,877	20	15	20		90	6
7	Flooring on elevator	2005	4,480	74	10	74		333	7
8	Skilled wing renovation	2005	995	16	10	16		72	8
9	Water Booster	2005	2,509	52	8	52		234	9
10	Makeup air system-west hallway	2005	13,122	274	8	274		1,233	10
11									11
12	Replace concrete sidewalk and curb section	2006	3,650	243	15	243		851	12
13	Remove & Resurface pavement	2006	29,745	1,487	20	1,487		5,205	13
14	Analog line card - 16 port	2006	2,250	450	5	450		1,575	14
15	New boiler controls	2006	12,140	1,214	10	1,214		4,249	15
16	3 exterior doors & frames	2006	5,196	260	20	260		910	16
17	Electric strike and camera in vestibule	2006	2,770	396	7	396		1,386	17
18	44" Packer compactor replacement	2006	18,873	1,887	10	1,887		6,604	18
19	Oxygen Concentrators	2006	36,570	3,657	10	3,657		12,799	19
20	Rebuild 3" self prime ejector pump & reinstall	2006	3,477	348	10	348		1,218	20
21	Replace 2 3/4 meters & 11 1/2 meters piping	2006	2,400	300	8	300		1,050	21
22									22
23	Tile restoration in Kitchen and Dish Room	2006	15,904	1,988	8	1,988		4,970	23
24	Electrical Engineering	2007	2,959	198	15	198		495	24
25	Window Treatments	2007	67,000	8,376	8	8,376		20,940	25
26	Removal and Installation of Fresh Air Damper	2007	3,365	420	8	420		1,050	26
27	Removal and Installation of Exhaust Fan	2007	4,465	558	8	558		1,395	27
28	Install Plastic laminate wall & base cabinet w/plastic laminate cou	2007	4,590	458	10	458		1,145	28
29	Direct Sale Card Access System	2007	3,995	500	8	500		1,250	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,936,605	\$ 30,687		\$ 195,149	\$ 164,462	\$ 10,888,488	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	2	3	4	5	6	7	8	9	10
	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		\$ 195,149	\$ 164,462	\$ 10,888,488	1
2	Room Lighting for Wing	2007	13,244	1,324	10	1,324		1,986	2
3	Provide/Install Oak Cabinets, countertops & SS sink	2007	37,360	2,491	15	2,491		3,736	3
4	Move plumbing for break room sink relocation	2007	3,127	125	25	125		188	4
5	Furnish/Install Flagpole	2007	4,146	207	20	207		361	5
6	Furnish/Install Flagpole	2008	3,100	310	10	310		465	6
7	Supply/Install Interior Signage	2008	22,635	2,264	10	2,264		3,395	7
8	Ceiling tiles 2x2	2008	13,192	1,319	10	1,319		1,979	8
9	Carpeting	2008	6,042	604	10	604		906	9
10	Provide/Install Doors (frames, door, hardware, hinges & closures)	2008	17,436	872	20	872		1,308	10
11	remove/Install new flooring in employee lunch room	2008	9,444	944	10	944		1,416	11
12	Lith 2 MDR Mvolt Light Fixture	2008	6,475	648	10	648		972	12
13	Extend Analogue MW line and 11C Cabinet	2008	2,830	283	10	283		424	13
14	R&M Reclass -	2007	2,746		10	275	275	412	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,078,382	\$ 42,078		\$ 206,815	\$ 164,737	\$ 10,906,036	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	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12D, Carried Forward</b>	\$ 12,078,382	\$ 42,078		\$ 206,815	\$ 164,737	\$ 10,906,036		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	<b>Home Office Allocation</b>				129,038	129,038			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	\$ 42,078		\$ 335,853	\$ 293,775	\$ 10,906,036		34

\*\*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	\$ 2,623,825	\$ 489,833	\$ 178,964	\$ (310,869)	3-25	\$ 1,751,913	71
72	Current Year Purchases	724,177	38,126	38,126		10-25	38,126	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			60,679	60,679			74
75	TOTALS	\$ 3,348,002	\$ 527,959	\$ 277,769	\$ (250,190)		\$ 1,790,039	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	\$ 7,203	76
77	Residence	Ford Starcraft	2007	53,983	10,796	10,796		5	26,990	77
78										78
79										79
80	TOTALS			\$ 80,861	\$ 11,825	\$ 11,825	\$		\$ 34,193	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)	\$ 16,087,538	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 581,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 625,447	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,585	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,730,268	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Chapel-various02002	\$ 18,534	\$	\$ 18,534	86
87	Sinks for Beauty shop -2002	8,659	433	3,467	87
88	Prov Serv Asst Living - 2002	897	90	630	88
89	Prov Serv Asst Living - 2003	478	32	224	89
90					90
91	TOTALS	\$ 28,568	\$ 555	\$ 22,855	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:				\$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

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: \_\_\_\_\_ \*

**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: \$ 44,213 Description: Please Refer to Attached Page 14A for the details

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<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.

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		1838 hrs	\$ 78,042	2,544	\$ 166,004		4,382	\$ 244,046	1
2	Licensed Speech and Language Development Therapist		1283 hrs	47,401	336	22,062		1,619	69,463	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		10603 hrs	441,284	166	10,289		10,769	451,573	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				2,073,504		2,073,504	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>			\$ 566,727	3,046	\$ 198,355	\$ 2,073,504	16,770	\$ 2,838,586	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.

**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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 759,247	\$ 759,247	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>124,000</u> )	1,762,832	1,762,832	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,807	9,807	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,531,886	\$ 2,531,886	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	38,748,522	38,748,522	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	6,226,693	3,428,863	16
17	Accumulated Depreciation (book methods)	(13,553,503)	(12,730,268)	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>	\$ 42,536,820	\$ 42,105,792	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 45,068,706	\$ 44,637,678	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 147,520	\$ 147,520	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,387	28,387	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 RMC</u>	846,163	415,135	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,022,070	\$ 591,042	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>	\$ 1,022,070	\$ 591,042	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 44,046,636	\$ 44,046,636	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 45,068,706	\$ 44,637,678	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>44,334,645</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>435,849</b>	<b>3</b>
<b>4</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>44,770,494</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(723,858)</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>(723,858)</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>44,046,636</b>	<b>24</b> *

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

**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	\$ 27,474,566	1
2	Discounts and Allowances for all Levels	(7,516,793)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 19,957,773	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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	7,061	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,061	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	100	24
25	Interest and Other Investment Income***	841,128	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 841,228	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Other Rev - Please refer to Page 19A</u>	50,135	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 50,135	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 20,856,197	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	2,928,671	31
32	Health Care	8,800,667	32
33	General Administration	6,989,797	33
	<b>B. Capital Expense</b>		
34	Ownership	581,862	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	2,073,504	35
36	Provider Participation Fee	163,155	36
	<b>D. Other Expenses (specify):</b>		
37	<u>Finacial audit adj to exp</u>	42,399	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 21,580,055	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(723,858)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (723,858)	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.

Facility Name & ID Number Resurrection Nursing & Rehab Center

# 0044362

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	1,648	1,995	\$ 85,614	\$ 42.91	1
2	Assistant Director of Nursing	1,864	2,040	77,977	38.22	2
3	Registered Nurses	86,493	99,025	3,358,904	33.92	3
4	Licensed Practical Nurses	5,334	6,062	146,202	24.12	4
5	CNAs & Orderlies	153,196	176,991	2,280,297	12.88	5
6	CNA Trainees					6
7	Licensed Therapist	13,629	15,118	617,656	40.86	7
8	Rehab/Therapy Aides	17,884	20,356	388,933	19.11	8
9	Activity Director	1,882	2,024	56,009	27.67	9
10	Activity Assistants	9,799	10,940	116,800	10.68	10
11	Social Service Workers	8,170	9,316	175,947	18.89	11
12	Dietician	2,905	3,648	70,474	19.32	12
13	Food Service Supervisor	3,767	4,996	112,290	22.48	13
14	Head Cook	7,098	8,215	110,226	13.42	14
15	Cook Helpers/Assistants	33,589	37,832	387,991	10.26	15
16	Dishwashers					16
17	Maintenance Workers	6,733	7,559	156,388	20.69	17
18	Housekeepers	24,933	28,387	330,532	11.64	18
19	Laundry	16,633	19,030	200,907	10.56	19
20	Administrator	1,825	2,040	112,440	55.12	20
21	Assistant Administrator					21
22	Other Administrative	18,937	22,299	416,215	18.67	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MD Care plan	6,827	7,782	266,504	34.25	32
33	Other(specify) <u>Spiritual</u>	5,670	6,225	148,911	23.92	33
34	TOTAL (lines 1 - 33)	428,816	491,880	\$ 9,617,217 *	\$ 19.55	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 25,200	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 25,200		49

**C. CONTRACT NURSES**

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





Facility Name & ID Number Resurrection Nursing & Rehab Center# 0044362Report 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? Yes  
If YES, give association name and amount. Life Service Network \$4,217
- (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? 11.5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,045 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. \$ 163,155  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed 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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ \_\_\_\_\_
- (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? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG, LLP
- (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

Resurrection Nursing & Rehab Center  
 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

**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

Provider Number: 0044362

FYE: 39994

Attachment to Schedule XII, Line 16- Equipment Rental Cost

<u>Equipment</u>	<u>Amount</u>
Copiers	27,879
CUTLERY SHARPENING & CUTTING EDGE SERVICE	2,039
MEDICAL EQUIPMENT	14,235
SPECIAL BEDS	60
	<hr/>
Total Equipment Lease Exp	<u>44,213</u>

Resurrection Nursing and Rehab Center  
 Medicaid Provider Number: 0044362  
 FYE 6/30/2009  
 Attachment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	644	Not an income
Admin - Other Revenue	6,459	Offset on Page 5A
Medical Supply Revenue	33,261	Patient Revenue- not subject to offset
Laundry _ Private Patient Revenue	9,771	Pvt Pt. Not subject to offset
Total - Other Revenue	<u>50,135</u>	

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

Interest Income	939,176
Less: Investment Fees	(98,048)
Net Interest Income	<u>841,128</u>
Interest Expense thru home office - Page 6	40,016
Interest income offset - limited to interest exp	<u>40,016</u>