

		FOR OHF USE				

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0044354</u></p> <p>Facility Name: <u>RESURRECTION LIFE CENTER</u></p> <p>Address: <u>7370 WEST TALCOTT</u> <u>CHICAGO</u> <u>60631</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 594-7400</u> Fax # <u>(773)594-7402</u></p> <p>IDPA ID Number: <u>362235165002</u></p> <p>Date of Initial License for Current Owners: <u>02/02/1998</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501-C-3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>MICHAEL LAWRENCE</u> Telephone Number: <u>(312) 980-2973</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501-C-3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2002</u> to <u>06/30/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Title) _____</td> </tr> </table> <table border="1"> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>MICHAEL LAWRENCE, CPA</u> <u>SENIOR MANAGER</u></td> </tr> <tr> <td>(Firm Name & Address) <u>BLACKMAN KALLICK BARTELSTEIN LLP</u> <u>10 S. RIVERSIDE PLAZA CHICAGO, IL 60606</u></td> </tr> <tr> <td>(Telephone) <u>(312) 207-1040</u> Fax # <u>(312) 756-3973</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	(Print Name and Title) <u>MICHAEL LAWRENCE, CPA</u> <u>SENIOR MANAGER</u>	(Firm Name & Address) <u>BLACKMAN KALLICK BARTELSTEIN LLP</u> <u>10 S. RIVERSIDE PLAZA CHICAGO, IL 60606</u>	(Telephone) <u>(312) 207-1040</u> Fax # <u>(312) 756-3973</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																															
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																															
IRS Exemption Code <u>501-C-3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																															
	<input type="checkbox"/> "Sub-S" Corp.																																
	<input type="checkbox"/> Limited Liability Co.																																
	<input type="checkbox"/> Trust																																
	<input type="checkbox"/> Other _____																																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																																
	(Type or Print Name) _____ (Title) _____																																
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																																
	(Print Name and Title) <u>MICHAEL LAWRENCE, CPA</u> <u>SENIOR MANAGER</u>																																
	(Firm Name & Address) <u>BLACKMAN KALLICK BARTELSTEIN LLP</u> <u>10 S. RIVERSIDE PLAZA CHICAGO, IL 60606</u>																																
	(Telephone) <u>(312) 207-1040</u> Fax # <u>(312) 756-3973</u>																																

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER

0044354 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

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 _____

	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	73	Skilled (SNF)	83	28,455	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	52	Sheltered Care (SC)	42	17,170	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	15,175	10,940	1,867	27,982	8
9	SNF/PED					9
10	ICF	9,681	2,591		12,272	10
11	ICF/DD					11
12	SC	287	16,767		17,054	12
13	DD 16 OR LESS					13
14	TOTALS	25,143	30,298	1,867	57,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.75%

D. How many bed-hold days during this year were paid by Public Aid? 161 (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 _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 1,812

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/03 Fiscal Year: 6/30/03
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	347,315	25,111		372,426		372,426		372,426		1
2	Food Purchase		329,082		329,082		329,082	(2,932)	326,150		2
3	Housekeeping	233,412	29,633	1,845	264,890		264,890		264,890		3
4	Laundry	33,054	179,742	239	213,035		213,035		213,035		4
5	Heat and Other Utilities			137,960	137,960		137,960		137,960		5
6	Maintenance	61,753	84,135	25,095	170,983		170,983	1,547	172,530		6
7	Other (specify):*										7
8	TOTAL General Services	675,534	647,703	165,139	1,488,376		1,488,376	(1,385)	1,486,991		8
B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,653,618	100,144	56,011	2,809,773	(9,859)	2,799,914	1,937	2,801,851		10
10a	Therapy	87,467	3,727	1,204	92,398		92,398		92,398		10a
11	Activities	100,645	17,284	2,136	120,065		120,065		120,065		11
12	Social Services	217,147	1,348	2,673	221,168		221,168		221,168		12
13	Nurse Aide Training										13
14	Program Transportation			371	371		371		371		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,058,877	122,503	71,395	3,252,775	(9,859)	3,242,916	1,937	3,244,853		16
C. General Administration											
17	Administrative	85,145		600,793	685,938		685,938	(599,293)	86,645		17
18	Directors Fees										18
19	Professional Services			104	104		104	117,757	117,861		19
20	Dues, Fees, Subscriptions & Promotions			5,702	5,702		5,702		5,702		20
21	Clerical & General Office Expenses	88,444	21,318	2,158	111,920		111,920	158,534	270,454		21
22	Employee Benefits & Payroll Taxes			1,122,876	1,122,876		1,122,876	36,706	1,159,582		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,829	5,829		5,829		5,829		24
25	Other Admin. Staff Transportation			746	746		746		746		25
26	Insurance-Prop.Liab.Malpractice			129,487	129,487		129,487		129,487		26
27	Other (specify):*										27
28	TOTAL General Administration	173,589	21,318	1,867,695	2,062,602		2,062,602	(286,296)	1,776,306		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,908,000	791,524	2,104,229	6,803,753	(9,859)	6,793,894	(285,744)	6,508,150		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Resurrection Life Center
 Operating Expenses Reclasp
 YTD as of June 30, 2003
 Schedule 3A

1) Reclass Outside Services Cost

<u>Vendor</u>	<u>Account #</u>	<u>Date Paid</u>	<u>Amount</u>
<i>Outside services-chargeable supplies</i>			
22552 UNIVERSAL PORTABLE XRAY	8930-810	8/15/2002	92.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	10/16/2002	263.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	11/13/2002	258.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	2/20/2003	438.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	4/23/2003	979.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	5/13/2003	268.00
22552 UNIVERSAL PORTABLE XRAY	8930-810	6/27/2003	698.00
	8930-810 Total		2,996.00
	<u>Debit</u>	<u>Credit</u>	<u>Sch V line</u>
Reclass from line 10, column 3 to line 42 Other Ancillary	2,996.00	2,996.00	10 42

2) Reclass Beauty Shop Expense

JOSEPH INSOLIA	8930-810		
MARIE NEHRU			
	<u>Debit</u>	<u>Credit</u>	<u>Sch V line</u>
Reclass from line 10, column 3 to line 40 Barber and Beauty Shop	6,863.00	6,863.00	10 40

Facility Name & ID Number

RESURRECTION LIFE CENTER

#0044354

Report Period Beginning:

07/01/2002

Ending:

06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			733,964	733,964		733,964	816	734,780			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			19,711	19,711		19,711		19,711			35
36	Other (specify):*											36
37	TOTAL Ownership			753,675	753,675		753,675	816	754,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		672,605		672,605		672,605		672,605			39
40	Barber and Beauty Shops					6,863	6,863	(6,863)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,298	61,298		61,298		61,298			42
43	Other (specify):* Radiology					2,996	2,996		2,996			43
44	TOTAL Special Cost Centers		672,605	61,298	733,903	9,859	743,762	(6,863)	736,899			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,908,000	1,464,129	2,919,202	8,291,331		8,291,331	(291,791)	7,999,540			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER

0044354

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,932)	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	816	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule BEAUTY SHOP INCOME	(6,863)	40		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,979)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(282,812)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (282,812)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (291,791)		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.			\$		38
39						39
40	Gift and Coffee Shops	X		6,863	10	40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		2,996	10	42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 9,859		47

SEE ACCOUNTANTS' COMPILATION REPORT

RESURRECTION LIFE CENTER

ID# 0044354

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Barber and Beauty Income	\$ (6,863)	40	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				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,863)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESURRECTION LIFE CENTER

0044354 Report Period Beginning:

07/01/2002 Ending: 06/30/2003

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,932)	0	0	0	0	0	0	0	0	0	0	(2,932)	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	1,547	0	0	0	0	0	0	0	0	0	1,547	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,932)	1,547	0	(1,385)	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	1,937	0	0	0	0	0	0	0	0	0	1,937	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	Nurse Aide 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	1,937	0	1,937	16								
	C. General Administration													
17	Administrative	0	(599,293)	0	0	0	0	0	0	0	0	0	(599,293)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	117,757	0	0	0	0	0	0	0	0	0	117,757	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	158,534	0	0	0	0	0	0	0	0	0	158,534	21
22	Employee Benefits & Payroll Taxes	0	36,706	0	0	0	0	0	0	0	0	0	36,706	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	0	(286,296)	0	(286,296)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,932)	(282,812)	0	(285,744)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESURRECTION LIFE CENTER# 0044354

Report Period Beginning:

07/01/2002 Ending:06/30/2003

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	816	0	0	0	0	0	0	0	0	0	0	816 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	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	816	0	0	0	0	0	0	0	0	0	0	816 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	(6,863)	0	0	0	0	0	0	0	0	0	0	(6,863) 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	(6,863)	0	0	0	0	0	0	0	0	0	0	(6,863) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(8,979)	(282,812)	0	(291,791) 45								

Facility Name & ID Number **RESURRECTION LIFE CENTER**

0044354

Report Period Beginning: **07/01/2002** Ending: **06/30/2003**

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				

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	21 Salary-Clerical	\$	Resurrection Health Care	100.00%	\$ 129,095	\$ 129,095
2	V	21 Misc A&G		Resurrection Health Care	100.00%	29,439	29,439
3	V	22 Employee benefits		Resurrection Health Care	100.00%	36,706	36,706
4	V	19 Data processing-professional svc		Resurrection Health Care	100.00%	100,601	100,601
5	V	19 Purchasing- professional svc		Resurrection Health Care	100.00%	17,156	17,156
6	V	6 Maintenance		Resurrection Health Care	100.00%	1,547	1,547
7	V	10 Nursing admin		Resurrection Health Care	100.00%	1,937	1,937
8	V						
9	V	17 Intercompany Expense	599,293				(599,293)
10	V	39 Intercompany Pharmacy	666,471			666,471	
11	V						
12	V						
13	V						
14	Total		\$ 1,265,764			\$ 982,952	\$ * (282,812)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER # 0044354 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21 Salary-Clerical				\$	\$		129,095	1
2	21 Misc A&G							29,439	2
3	22 Employee benefits							36,706	3
4	19 Data processing-professional svc							100,601	4
5	19 Purchasing- professional svc							17,156	5
6	6 Maintenance							1,547	6
7	10 Nursing admin							1,937	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				\$	\$		316,481	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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. \$ _____ 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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **RESURRECTION LIFE CENTER**# **0044354** Report Period Beginning: **07/01/2002** Ending: **06/30/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2002 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 2003 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:		1998	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	
NOT APPLICABLE																			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RESURRECTION LIFE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044354

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	<u>NOT APPLICABLE</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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 NO
If so, please complete the following:

1. Total Amount Incurred: 299,050 2. Number of Years Over Which it is Being Amortized: FIVE
3. Current Period Amortization: _____ 4. Dates Incurred: November 1996-February 1998

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	281,860	1996	\$ 3,600,000	1
2					2
3	TOTALS	281,860		\$ 3,600,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER# 0044354

Report Period Beginning:

07/01/2002 Ending: 06/30/2003**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159		1998	\$ 11,711,085	\$ 626,575	Various	\$ 626,575	\$	\$ 3,421,078	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Window for chapel		1998	16,500	1,650	10	1,650		7,425	9
10	Interior sign system		1998	1,898	190	10	190		855	10
11	Modify nurse call system		1998	4,692	313	15	313		1,408	11
12	Install water softner		1998	2,325	233	10	233		1,048	12
13	Exterior directional illuminated sign		1999	15,825	1,583	10	1,583		7,121	13
14	Exterior main illuminated sign		1999	12,265	1,227	10	1,227		5,521	14
15	Five foot fence and gate		1999	7,974	532	15	532		2,393	15
16	Spacesaver medical records system		1999	12,661	1,266	10	1,266		5,697	16
17	Electrical work-kitchen door holders		1999	900	60	15	60		270	17
18	Replacement flooring shower and tub rooms		1999	8,037	536	15	536		2,422	18
19	Electric water heater		1999	2,570	257	10	257		1,157	19
20	Work on second floor		2000	3,144	157	20	157		628	20
21	Digital access control system		2000	3,252	163	20	163		652	21
22	Electrical work-kitchen door holders		2000	2,165	108	20	108		432	22
23	Architect fees		2000	3,145	105	30	105		420	23
24	Site lighting		2000	7,686	256	30	256		1,024	24
25	Site lighting		2000	14,947	498	30	498		1,992	25
26	Electrical work-Chapel		2000	1,354	45	30	45		180	26
27	Front entrance canopy		2000	60,000	2,000	30	2,000		8,000	27
28	Laundry plumbing and piping		2000	16,600	553	30	553		2,212	28
29	Construction work		2000	10,110	337	30	337		1,348	29
30	Flooring		2000	600	40	15	40		140	30
31	Flooring		2000	625	42	15	42		147	31
32	Raceway for signs		2000	1,504	75	20	75		263	32
33	Rubrail		2000	903	45	20	45		158	33
34	Rubrail		2000	875	44	20	44		154	34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Assets reclassified from equipment to improvements:								37
38	Message waiting line cards	1998	2,919	291	5	291		2,919	38
39	Closed circuit monitoring system	1998	17,882	1,787	5	1,787		17,882	39
40	Security system equipment	1998	9,790	653	15	653		3,590	40
41	Message waiting line cards	1998	16,200	1,620	5	1,620		16,200	41
42	Custom work counter	1998	1,657	110	15	110		606	42
43	Sharpen prep sink	1998	2,392	159	15	159		876	43
44	Walk-in refrigerator freezer	1998	40,774	4,077	10	4,077		22,425	44
45	Custom wall panel	1998	7,272	727	10	727		3,999	45
46	Three compartment sink	1998	3,248	217	15	217		1,192	46
47	Fire protection system	1998	3,887	389	10	389		2,138	47
48	Wall guards	1999	2,596	519	5	519		2,336	48
49									49
50	Electrical installation	2001	3,681	184	20	184		552	50
51	Parking lot light fixtures	2001	421	21	20	21		63	51
52	Exit signs	2001	1,510	76	20	76		228	52
53	Nurse call box	2001	1,796	90	20	90		270	53
54	Time recorder system R & M	2001	5,363		20	268	268	804	54
55	Time recorder system R & M	2001	1,204		20	60	60	180	55
56	Water line R & M	2001	522		20	26	26	78	56
57	Chiller fuses R & M	2001	1,546		20	77	77	154	57
58	Disposal R & M	2001	571		20	29	29	58	58
59	Hot water tank R & M	2001	1,048		20	52	52	104	59
60	Cobbles R & M	2001	2,794		20	140	140	280	60
61	Door alarms R & M	2001	705		20	35	35	70	61
62	Exhaust R & M	2001	1,175		20	59	59	118	62
63	Disposal R & M	2001	1,412		20	70	70	141	63
64	Nurse call master	2001	1,595	80	20	80		160	64
65	Drywall/soffit	2001	2,874	144	20	144		288	65
66	Information system module	2001	18,330	917	20	917		1,834	66
67	Information system module	2001	1,050	53	20	53		106	67
68	Concrete sections	2002	2,923	146	20	146		292	68
69	Floor	2001	2,410	121	20	121		242	69
70	TOTAL (lines 4 thru 69)		\$ 12,085,189	\$ 651,268		\$ 652,084	\$ 816	\$ 3,554,327	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
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	\$ 651,268		\$ 652,084	\$ 816	\$ 3,554,327		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									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)	\$ 12,085,189	\$ 651,268		\$ 652,084	\$ 816	\$ 3,554,327		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 980,672	\$ 81,887	\$ 81,887	\$	10	\$ 523,470	71
72	Current Year Purchases	16,172	809	809		10	809	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 996,844	\$ 82,696	\$ 82,696	\$		\$ 524,279	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,682,033	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 733,964	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 734,780	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 816	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,078,606	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

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? YES NO
 If NO, see instructions.

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

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

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

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: \$ 19,711 Description: SEE ATTACHED PAGE 25

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

RESURRECTION LIFE CENTER
FYE 6/30/03
SCHEDULE OF RENTAL EQUIPMENT
14a

IMAGISTICS	8910-710	5,669
PROFESSIONAL MEDICAL	8930-710	10,116
UNIVERSAL HOSPITAL SERVICE	8930-710	150
UNIVERSAL HOSPITAL SERVICE	8938-710	1,961
COZZINI	8990-710	590
EVENTS CHICAGO	8990-710	<u>1,225</u>
TOTAL		19,711

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5 Supplies (Actual or Allocated)	6 Total Units (Column 2 + 4)	7 Total Cost (Col. 3 + 5 + 6)	8
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	10a-1	hrs	\$ 18,646				\$ 1,031		\$ 19,677	1	
2	Licensed Speech and Language Development Therapist	10a-1	hrs	3,750				1,165		4,915	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10a-1	hrs	43,451				73		43,524	4	
5	Physician Care		visits								5	
6	Dental Care		visits								6	
7	Work Related Program		hrs								7	
8	Habilitation		hrs								8	
9	Pharmacy	39-2	# of prescripts					666,531		666,531	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Exceptional Care Program										12	
13	Other (specify): DME supplies and gase	39-2						6,074		6,074	13	
14	TOTAL			\$ 65,847			\$	\$ 674,874		\$ 740,721	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER

STATE OF ILLINOIS

0044354

Report Period Beginning: 07/01/2002

Ending:

06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2003

(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	\$ 18,228	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (283,948))	1,133,537	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	2,611	6
7	Other Prepaid Expenses	5,060	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,159,436	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	3,600,000	13
14	Buildings, at Historical Cost	11,933,764	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	1,148,269	16
17	Accumulated Depreciation (book methods)	(4,078,606)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,603,427	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,762,863	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 28,402	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable		30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>Related party notes</u>	4,883,091	36
37	<u>SEE PAGE 17A</u>		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,911,493	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)	\$ 4,911,493	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,851,370	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,762,863	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

RESURRECTION LIFE CENTER
FYE 6/30/03
SCHEDULE OF RELATED PARTY NOTES
PAGE 17A

<u>ACCOUNT</u>	<u>DESCRIPTION</u>	<u>AMOUNT</u>
22000-00500	INTE-DUE TO OLRMC	(16,722)
22000-00600	INTE-DUE TO RNRC	(162,751)
22000-00700	INTE-DUE TO RMC	(3,592,206)
22000-00800	INTE-DUE TO RHC	(1,105,620)
22000-00920	INTE-DUE TO SFH	(5,791)
	TOTAL	<hr/> (4,883,091) TRANSFER TO SCH. XV LINE36

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,719,536	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,719,536	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	131,834	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)	\$ 131,834	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,851,370	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number RESURRECTION LIFE CENTER

0044354

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

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	\$ 9,807,135	1
2	Discounts and Allowances for all Levels	(2,912,209)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,894,926	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	352,779	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 352,779	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	62,550	13
14	Non-Patient Meals	2,932	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	833,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	73,609	21
22	Laundry	53,168	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,026,243	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	149,217	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149,217	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,423,165	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,488,376	31
32	Health Care	3,242,916	32
33	General Administration	2,062,602	33
B. Capital Expense			
34	Ownership	753,675	34
C. Ancillary Expense			
35	Special Cost Centers	675,601	35
36	Provider Participation Fee	61,298	36
D. Other Expenses (specify):			
37	Barber and Beauty	6,863	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,291,331	40
41	Income before Income Taxes (line 30 minus line 40)**	131,834	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 131,834	43

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

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

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

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

Facility Name & ID Number **RESURRECTION LIFE CENTER**

0044354

Report Period Beginning: 07/01/2002

Ending:

06/30/2003

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	1,903	2,200	\$ 71,842	\$ 32.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,523	47,381	1,254,370	26.47	3
4	Licensed Practical Nurses	7,451	8,460	180,779	21.37	4
5	Nurse Aides & Orderlies	90,194	98,643	1,112,604	11.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,162	2,277	65,847	28.92	7
8	Rehab/Therapy Aides	1,444	1,596	21,621	13.55	8
9	Activity Director	1,520	2,088	31,796	15.23	9
10	Activity Assistants	7,260	8,103	68,849	8.50	10
11	Social Service Workers	7,746	10,044	217,148	21.62	11
12	Dietician	1,875	2,281	37,058	16.25	12
13	Food Service Supervisor	1,891	2,096	29,529	14.09	13
14	Head Cook	5,960	6,862	92,028	13.41	14
15	Cook Helpers/Assistants	20,149	21,649	188,700	8.72	15
16	Dishwashers					16
17	Maintenance Workers	3,792	4,044	61,753	15.27	17
18	Housekeepers	22,764	24,853	233,411	9.39	18
19	Laundry	3,346	3,586	33,054	9.22	19
20	Administrator	1,632	2,032	85,145	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,320	7,113	88,444	12.43	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	1,694	2,152	34,022	15.81	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	228,626	257,460	\$ 3,908,000 *	\$ 15.18	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	9,000	L9,C3	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	Monthly	300	L11,C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	UR Physician	Monthly	1,500	L21,C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,800		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

RESURRECTION LIFE CENTER
 FYE 6/30/03
 SCHEDULE OF SEMINARS AND TRAVEL
PAGE 21A

<u>Vendor</u>		<u>Check #</u>	<u>Account #</u>	<u>Date Paid</u>	<u>Amount</u>
<i>Personnel Development-administration</i>					
PANKAU, LAWRENCE	REIMB.	1/17/2003	751958 8910-690	1/21/2003	383
PANKAU, LAWRENCE	REIMB.	3/20/2003	769260 8910-690	3/24/2003	485
ROG,IWONA	REIMB.	1/27/2003	754962 8910-690	2/3/2003	240
CHABLEWSKI, BARBARA	REIMBURS	4/30/2003	786879 8910-690	5/15/2003	160
VIRGINIA OPITZ	REIMBURS	8/2/2002	728186 8910-690	8/5/2002	250
RESURRECTION LIFE CENTER	REPLENIS	2/3/2003	756390 8910-690	2/6/2003	10
RESURRECTION LIFE CENTER	REPLENIS	3/24/2003	770892 8910-690	3/27/2003	30
RESURRECTION LIFE CENTER	REPLENIS	4/22/2003	780445 8910-690	4/24/2003	90
RESURRECTION LIFE CENTER	REPLENIS	5/1/2003	784490 8910-690	5/6/2003	25
COMPREHENSIVE THERAPEUTICS	SEMINAR	10/18/2002	732579 8910-690	11/6/2002	90
COMPREHENSIVE THERAPEUTICS	SEMINAR	5/21/2003	789378 8910-690	5/23/2003	250
ILLINOIS COUNCIL ON LONG TERM CARE	SEMINAR	6/25/2003	802288 8910-690	7/9/2003	300
OAKTON COMMUNITY COLLEGE	SEMINAR	10/18/2002	727564 8910-690	10/21/2002	90
OAKTON COMMUNITY COLLEGE	SEMINAR	2/18/2003	760282 8910-690	2/20/2003	85
PESI	SEMINAR	2/4/2003	759276 8910-690	2/11/2003	417
PESI	SEMINAR	4/25/2003	782395 8910-690	4/29/2003	174
ROCHE DIETICIANS	SEMINAR	2/21/2003	761477 8910-690	2/24/2003	85
ADVOCATE HEALTH CARE	SEMINAR	8/1/2002	707057 8920-690	8/2/2002	40
CHABLEWSKI, BARBARA	SEMINAR	11/30/2002	742323 8925-690	12/16/2002	85
FROST RUTTENBERGAND ROTHBLATT PC	REGISTRA	1/30/2003	756417 8910-690	2/4/2003	250
LIFE SERVICES NETWORK FOUNDATION	REGISTRA	10/15/2002	727578 8910-690	10/18/2002	95
LIFE SERVICES NETWORK FOUNDATION	REGISTRA	3/13/2003	768092 8910-690	3/19/2003	790
LIFE SERVICES NETWORK FOUNDATION	REGISTRA	5/15/2003	787209 8910-690	5/19/2003	195
LIFE SERVICES NETWORK FOUNDATION	REGISTRA	6/9/2003	793779 8910-690	6/11/2003	790
LIFE SERVICES NETWORK FOUNDATION	REGISTRA	7/8/2003	804494 8910-690	7/18/2003	315
RAINBOW LIFE SERVICES	REGISTRA	4/29/2003	782731 8920-690	4/30/2003	30
FIRS-PERSONNEL DE			08935-00690		45
NURS-PERSONNEL DE			08937-00690		15
NURS-PERSONNEL DE			08938-00690		15
TOTAL					5,829
AGREES WITH SCH XIX, SECTI					

ION G

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2	NOT APPLICABLE													
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

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. LSN-\$4,615
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 61,298
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 of Public Aid, 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. \$ 2,932
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
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? No
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not yet available, will forward
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

RESURRECTION LIFE CENTER

Diaper Expense

Fiscal Year 2003

page 23A

Facility uses non-disposable diapers. However, their supply expense is included in monthly corporate laundry expense allocation.