

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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><b>I. IDPH Facility ID Number:</b> <u>0044354</u></p> <p><b>Facility Name:</b> <u>Resurrection Life Center</u></p> <p><b>Address:</b> <u>7370 West Talcott Avenue</u> <u>Chicago</u> <u>60631</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 594-7400</u> Fax # <u>(773) 594-7402</u></p> <p><b>HFS ID Number:</b> <u>362235165002</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>02/02/1998</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> <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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Christine A. Hanover</u> <b>Telephone Number:</b> <u>(312) 634-4581</u>  <b>Please send copies of desk review and audit adjustments to address on this page.</b></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	<b>IRS Exemption Code</b> <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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2005</u> to <u>06/30/2006</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;"><b>Paid Preparer</b></td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b> </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b>	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

# 0044354 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,206	13,601	4,539	32,346	8
9	SNF/PED					9
10	ICF	10,256	1,401		11,657	10
11	ICF/DD					11
12	SC			12,833	12,833	12
13	DD 16 OR LESS					13
14	TOTALS	24,462	15,002	17,372	56,836	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.93%

D. How many bed-hold days during this year were paid by the Department?

1 (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

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 03/26/1998

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 93 and days of care provided 4,539

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	378,027	36,847		414,874		414,874		414,874		1
2	Food Purchase		345,694		345,694		345,694	(4,669)	341,025		2
3	Housekeeping	207,058	26,050		233,108		233,108		233,108		3
4	Laundry	70,439	246,449		316,888		316,888		316,888		4
5	Heat and Other Utilities			237,022	237,022		237,022		237,022		5
6	Maintenance	56,817	18,664	97,530	173,011		173,011		173,011		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	712,341	673,704	334,552	1,720,597		1,720,597	(4,669)	1,715,928		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,889,133	119,053	63,578	3,071,764		3,071,764	7,221	3,078,985		10
10a	Therapy	67,136	6,233	65,219	138,588		138,588		138,588		10a
11	Activities	119,703	3,740	6,134	129,577		129,577		129,577		11
12	Social Services	108,670	52	546	109,268		109,268		109,268		12
13	CNA Training										13
14	Program Transportation			28	28		28		28		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,184,642	129,078	144,505	3,458,225		3,458,225	7,221	3,465,446		16
	<b>C. General Administration</b>										
17	Administrative	83,267		653,622	736,889		736,889	(653,622)	83,267		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			10,623	10,623		10,623		10,623		20
21	Clerical & General Office Expenses	340,395	26,914	32,645	399,954		399,954	525,410	925,364		21
22	Employee Benefits & Payroll Taxes			1,480,578	1,480,578		1,480,578	270,880	1,751,458		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,994	1,994		1,994		1,994		24
25	Other Admin. Staff Transportation			42	42		42		42		25
26	Insurance-Prop.Liab.Malpractice			127,655	127,655		127,655	15,030	142,685		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	423,662	26,914	2,307,159	2,757,735		2,757,735	157,698	2,915,433		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,320,645	829,696	2,786,216	7,936,557		7,936,557	160,250	8,096,807		29

SEE ACCOUNTANTS' COMPILATION REPORT

\*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.

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

## 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	
	<b>D. Ownership</b>											
30	Depreciation			720,219	720,219		720,219	59,199	779,418			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			19,374	19,374		19,374		19,374			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			739,593	739,593		739,593	59,199	798,792			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		899,702		899,702		899,702		899,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):* <b>Nonallowable Cost</b>											43
44	<b>TOTAL Special Cost Centers</b>		899,702	69,533	969,235		969,235		969,235			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,320,645	1,729,398	3,595,342	9,645,385		9,645,385	219,449	9,864,834			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,669)	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	(5,639)	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	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	67,894			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 57,586		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	161,863		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 161,863		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 219,449		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Resurrection Life Center

ID# 0044354

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Record Additional Pension Expense	\$ 53,030	22	1
2	Offset miscellaneous revenue against related expense	(166)	21	2
3	Record Additional Malpractice Insurance Expense	15,030	26	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
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	67,894		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Life Center# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

## 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	(4,669)	0	0	0	0	0	0	0	0	0	0	(4,669)	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>(4,669)</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>(4,669)</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	7,221	0	0	0	0	0	0	0	0	0	7,221	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>7,221</b>	<b>0</b>	<b>7,221</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	(653,622)	0	0	0	0	0	0	0	0	0	(653,622)	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	(166)	525,576	0	0	0	0	0	0	0	0	0	525,410	21
22	Employee Benefits & Payroll Taxes	53,030	217,850	0	0	0	0	0	0	0	0	0	270,880	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	15,030	0	0	0	0	0	0	0	0	0	0	15,030	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>67,894</b>	<b>89,804</b>	<b>0</b>	<b>157,698</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>63,225</b>	<b>97,025</b>	<b>0</b>	<b>160,250</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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	(5,639)	64,838	0	0	0	0	0	0	0	0	0	59,199	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	<b>TOTAL Ownership</b>	<b>(5,639)</b>	<b>64,838</b>	<b>0</b>	<b>59,199</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>57,586</b>	<b>161,863</b>	<b>0</b>	<b>219,449</b>	<b>45</b>								

Facility Name & ID Number

Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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 Center	100	See Attached		See attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 Nursing Supplies	\$	Resurrection Health Care	100.00%	\$ 7,221	\$ 7,221	1
2	V	21 Clerical & Data Processing		Resurrection Health Care	100.00%	235,604	235,604	2
3	V	21 Other Administrative Expenses		Resurrection Health Care	100.00%	289,972	289,972	3
4	V	22 Employee Benefits		Resurrection Health Care	100.00%	217,850	217,850	4
5	V	30 Depreciation		Resurrection Health Care	100.00%	64,838	64,838	5
6	V							6
7	V	17 Intercompany Expense	653,622	Resurrection Health Care	100.00%		(653,622)	7
8	V	39 Intercompany Pharmacy	884,870	Resurrection Health Care	100.00%	884,870		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,538,492			\$ 1,700,355	\$ * 161,863	14

\* 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: 07/01/2005 Ending: 06/30/2006

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1								\$		1
2	See Attached pg 7A									2
3										3
4										4
5										5
6										6
7	Sister Elizabeth Trembczynski	Director	Board of Directors	0.00	107,120					7
8										8
9	Note: Sister Elizabeth Trembczynski is the Administrator for Holy Family Health Center, a related facility.									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:

07/01/2005

Ending: 6/30/2006

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	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	10	Nursing Supplies			\$	\$		\$ 7,221	1
2	21	Clerical & Data Processing						235,604	2
3	21	Other Administrative Expenses						289,972	3
4	22	Employee Benefits						217,850	4
5	30	Depreciation						64,838	5
6	39	Intercompany Pharmacy						884,870	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,700,355	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	N/A						\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	N/A											6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9						
	<b>B. Non-Facility Related*</b>																	
10	N/A											10						
11												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.     \$ None                      Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Resurrection Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044354

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>N/A</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005 Ending:

06/30/2006

**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, 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  NO  
If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>281,860</u>	<u>1996</u>	<u>\$ 3,600,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>281,860</b>		<b>\$ 3,600,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	159		1998	\$ 11,711,085	\$ 626,575	Various	\$ 626,575	\$	\$ 5,300,803	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Window for chapel		1998	16,500	1,650	10	1,650		12,375	9
10	Interior sign system		1998	1,898	190	10	190		1,425	10
11	Modify nurse call system		1998	4,692	313	15	313		2,347	11
12	Install water softener		1998	2,325	233	10	233		1,747	12
13	Exterior directional illuminated sign		1999	15,825	1,583	10	1,583		11,870	13
14	Exterior main illuminated sign		1999	12,265	1,227	10	1,227		9,202	14
15	Five foot fence and gate		1999	7,974	532	15	532		3,989	15
16	Spacesaver medical records system		1999	12,661	1,266	10	1,266		9,495	16
17	Electrical work-kitchen door holders		1999	900	60	15	60		450	17
18	Replacement flooring shower and tub rooms		1999	8,037	536	15	536		4,030	18
19	Electric water heater		1999	2,570	257	10	257		1,928	19
20	Work on second floor		2000	3,144	157	20	157		1,099	20
21	Digital access control system		2000	3,252	163	20	163		1,141	21
22	Electrical work - kitchen door holders		2000	2,165	108	20	108		756	22
23	Architect fees		2000	3,145	105	30	105		735	23
24	Site lighting		2000	7,686	256	30	256		1,792	24
25	Site lighting		2000	14,947	498	30	498		3,486	25
26	Electrical work - Chapel		2000	1,354	45	30	45		315	26
27	Front entrance canopy		2000	60,000	2,000	30	2,000		14,000	27
28	Laundry plumbing and piping		2000	16,600	553	30	553		3,871	28
29	Construction work		2000	10,110	337	30	337		2,359	29
30	Flooring		2000	600	40	15	40		260	30
31	Flooring		2000	625	42	15	42		273	31
32	Raceway for signs		2000	1,504	75	20	75		488	32
33	Rubrail		2000	903	45	20	45		293	33
34	Rubrail		2000	875	44	20	44		286	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Assets reclassified from equipment to improvements:		\$	\$		\$	\$	\$	37
38	Message waiting line cards	1998	2,919		5			2,919	38
39	Closed circuit monitoring system	1998	17,882		5			17,882	39
40	Security system equipment	1998	9,790	653	15	653		5,549	40
41	Message waiting line	1998	16,200		5			16,200	41
42	Custom work counter	1998	1,657	110	15	110		936	42
43	Sharpen prep sink	1998	2,392	159	15	159		1,353	43
44	Walk-in refrigerator freezer	1998	40,774	4,077	10	4,077		34,656	44
45	Custom wall panel	1998	7,272	727	10	727		6,180	45
46	Three compartment sink	1998	3,248	217	15	217		1,843	46
47	Fire protection system	1998	3,887	389	10	389		3,305	47
48	Wall guards	1999	2,596		5			2,596	48
49									49
50	Electrical installation	2001	3,681	184	20	184		1,104	50
51	Parking lot light fixtures	2001	421	21	20	21		126	51
52	Exit signs	2001	1,510	76	20	76		456	52
53	Nurse call box	2001	1,796	90	20	90		540	53
54	Time recorder system R&M	2001	5,363		20	268	268	1,608	54
55	Time recorder system R&M	2001	1,204		20	60	60	360	55
56	Water line R&M	2001	522		20	26	26	156	56
57	Chiller fuses R&M	2001	1,546		20	77	77	385	57
58	Disposal R&M	2001	571		20	29	29	145	58
59	Hot water tank R&M	2001	1,048		20	52	52	260	59
60	Cobbles R&M	2001	2,794		20	140	140	700	60
61	Door alarms R&M	2001	705		20	35	35	175	61
62	Exhaust R&M	2001	1,175		20	59	59	295	62
63	Disposal R&M	2001	1,412		20	70	70	351	63
64	Nurse call master	2001	1,595	80	20	80		400	64
65	Drywall/soffit	2001	2,874	144	20	144		720	65
66	Information system module	2001	18,330	914	20	914		4,576	66
67	Information system module	2001	1,050	53	20	53		265	67
68	Concrete sections	2002	2,923	146	20	146		730	68
69	Floor	2001	2,410	121	20	121		605	69
70	TOTAL (lines 4 thru 69)		\$ 12,085,189	\$ 647,051		\$ 647,867	\$ 816	\$ 5,498,191	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 12,085,189	\$ 647,051		\$ 647,867	\$ 816	\$ 5,498,191	1
2	Code alarm system	2003	3,109	311	10	311		777	2
3	Boiler repairs	2003	5,230	523	10	523		1,308	3
4	VCT sanitary sewer	2003	19,635	1,309	15	1,309		3,273	4
5	Sewer line in corridor	2005	1,944	194	10	194		388	5
6									6
7	Install Plants, Trees, Mulch, Soil & Sod	2006	10,309	515	10	515		515	7
8	Wire Nurse Call System	2006	2,600		10	130	130	130	8
9	Remove & Replace 5 wall temperature transmitters	2006	4,000	200	10	200		200	9
10	Hot Water Main Repair	2006	5,246	262	10	262		262	10
11	Walk in Cooler Evaporator Coil	2006	1,550	111	7	111		111	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	Home Office Allocation					64,838	64,838		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,138,812	\$ 650,476		\$ 716,260	\$ 65,784	\$ 5,505,155	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,025,487	\$ 69,494	\$ 62,909	\$ (6,585)	10	\$ 716,464	71
72	Current Year Purchases	5,252	249	249		8-15	249	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,030,739	\$ 69,743	\$ 63,158	\$ (6,585)		\$ 716,713	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,769,551	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 720,219	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 779,418	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,199	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,221,868	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

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

This amount was calculated by dividing the total amount to be amortized N/A  
by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 19,374 Description: Copier - \$7,838; Special Beds - \$10,504; Medical Eqpt. - \$215; Dietary Eqpt. - \$817

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2007 \$ \_\_\_\_\_

13. /2008 \$ \_\_\_\_\_

14. /2009 \$ \_\_\_\_\_

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A (1,3)	467	hrs	\$ 14,297	543	\$ 26,063	\$	1,010	\$ 40,360	1
2	Licensed Speech and Language Development Therapist	10A (1,2,3)	65	hrs	1,841	417	20,037	5,264	482	27,142	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	1549	hrs	50,998	398	19,119	969	1,947	71,086	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				885,216		885,216	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): <u>See Sch 16A</u>	39 (2)						14,486		14,486	13
14	<b>TOTAL</b>				\$ 67,136	1,358	\$ 65,219	\$ 905,935	3,439	\$ 1,038,290	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Resurrection Life Center**  
**Provider #: 0044354**  
**7/1/2005 to 6/30/2006**

**Schedule 16A**

XIV. Special Services  
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
Medical & Surgical Supplies	39(2)			\$ 331.00
Oxygen & Gas	39(2)			\$14,155.00
<b>Total Line 13 - Other</b>				<b><u><u>\$14,486.00</u></u></b>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name &amp; ID Number      Resurrection Life Center

#      0044354

Report Period Beginning:    07/01/2005

Ending:      06/30/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      06/30/2006

(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	\$ 335,422	\$ 335,422	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>424,231</u> )	1,547,545	1,547,545	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,875	2,875	6
7	Other Prepaid Expenses	3,212	3,212	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,889,054	\$ 1,889,054	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,600,000	3,600,000	13
14	Buildings, at Historical Cost	11,765,690	11,726,425	14
15	Leasehold Improvements, at Historical Cost	212,030	412,387	15
16	Equipment, at Historical Cost	1,187,510	1,030,739	16
17	Accumulated Depreciation (book methods)	(6,231,751)	(6,221,868)	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</b> (sum of lines 11 thru 23)	\$ 10,533,479	\$ 10,547,683	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 12,422,533	\$ 12,436,737	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 49,597	\$ 49,597	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Parties</u>	1,575,776	1,575,776	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,625,373	\$ 1,625,373	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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,625,373	\$ 1,625,373	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 10,797,160	\$ 10,811,364	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 12,422,533	\$ 12,436,737	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(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>9,901,908</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>9,901,908</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>895,251</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>Rounding</b>	<b>1</b>	<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>895,252</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>10,797,160</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,791,389	1
2	Discounts and Allowances for all Levels	(3,035,264)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,756,125	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	291,035	6
7	Oxygen	7,094	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 298,129	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	58,981	13
14	Non-Patient Meals	4,669	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,045,094	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,190	20
21	Other Medical Services	12,400	21
22	Laundry	57,770	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,180,104	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	305,227	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 305,227	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	1,051	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,051	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,540,636	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,720,597	31
32	Health Care	3,458,225	32
33	General Administration	2,757,735	33
<b>B. Capital Expense</b>			
34	Ownership	739,593	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	899,702	35
36	Provider Participation Fee	69,533	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,645,385	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	895,251	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 895,251	43

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

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

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

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

Resurrection Life Center  
Provider # 0044354  
7/1/2005 - 6/30/2006

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

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

XVII - Income Statement: Line 28 - Other Revenue

	<u>Amount</u>
Vending Commission	885
Miscellaneous	166
	<u>1,051</u>

Facility Name & ID Number Resurrection Life Center

# 0044354

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

**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	1,384	1,680	\$ 65,876	\$ 39.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	37,088	42,501	1,327,067	31.22	3
4	Licensed Practical Nurses	8,646	9,454	201,757	21.34	4
5	CNAs & Orderlies	94,880	105,423	1,288,387	12.22	5
6	CNA Trainees					6
7	Licensed Therapist	1,921	2,081	67,136	32.26	7
8	Rehab/Therapy Aides	308	432	5,138	11.89	8
9	Activity Director	1,880	2,080	39,729	19.10	9
10	Activity Assistants	7,004	7,775	79,974	10.29	10
11	Social Service Workers	4,424	4,880	108,670	22.27	11
12	Dietician	1,747	2,052	39,104	19.06	12
13	Food Service Supervisor	2,976	3,325	61,013	18.35	13
14	Head Cook	5,993	6,548	89,632	13.69	14
15	Cook Helpers/Assistants	18,689	20,727	188,278	9.08	15
16	Dishwashers					16
17	Maintenance Workers	3,199	3,531	56,817	16.09	17
18	Housekeepers	18,496	20,897	207,058	9.91	18
19	Laundry	5,287	5,665	70,439	12.43	19
20	Administrator	1,888	2,080	83,267	40.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,602	18,283	340,395	18.62	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	26	26	908	34.92	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,438	259,440	\$ 4,320,645 *	\$ 16.65	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

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

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	54	\$ 2,880	10(3)	50
51	Licensed Practical Nurses	14	336	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	68	\$ 3,216		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Resurrection Life Center# 0044354Report Period Beginning: 07/01/2005Ending: 06/30/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network - \$4,965
- (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. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,533  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,669
- (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? 40%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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