

Facility Name & ID Number Resurrection Life Center

0044354 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,125	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,369	10,126	8,515	37,010	8
9	SNF/PED					9
10	ICF	8,389	4,363		12,752	10
11	ICF/DD					11
12	SC			7,213	7,213	12
13	DD 16 OR LESS					13
14	TOTALS	26,758	14,489	15,728	56,975	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.36%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 03/26/1998

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

YES Date 03/26/1998 NO

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

YES NO If YES, enter number of beds certified 102 and days of care provided 37,010

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	431,345		33,441	464,786		464,786		464,786		1
2	Food Purchase		358,758		358,758		358,758	(2,625)	356,133		2
3	Housekeeping	239,457	26,478	2,725	268,660		268,660		268,660		3
4	Laundry	54,815	341,422	(500)	395,737		395,737		395,737		4
5	Heat and Other Utilities			221,872	221,872		221,872		221,872		5
6	Maintenance	72,086	8,517	163,410	244,013		244,013		244,013		6
7	Other (specify):*										7
8	TOTAL General Services	797,703	735,175	420,948	1,953,826		1,953,826	(2,625)	1,951,201		8
	B. Health Care and Programs										
9	Medical Director			11,400	11,400		11,400		11,400		9
10	Nursing and Medical Records	3,340,342	148,042	108,069	3,596,453		3,596,453		3,596,453		10
10a	Therapy	241,920	889	84,293	327,102		327,102		327,102		10a
11	Activities	125,037	3,572	5,439	134,048		134,048		134,048		11
12	Social Services	184,732	18,176	2,321	205,229		205,229		205,229		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,892,031	170,679	211,522	4,274,232		4,274,232		4,274,232		16
	C. General Administration										
17	Administrative			1,320,301	1,320,301		1,320,301	(527,676)	792,625		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			8,931	8,931		8,931		8,931		20
21	Clerical & General Office Expenses	394,878	21,700	35,626	452,204		452,204	(15,881)	436,323		21
22	Employee Benefits & Payroll Taxes			2,036,077	2,036,077		2,036,077	80,162	2,116,239		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			25	25		25		25		25
26	Insurance-Prop.Liab.Malpractice			(12,268)	(12,268)		(12,268)		(12,268)		26
27	Other (specify):*										27
28	TOTAL General Administration	394,878	21,700	3,388,692	3,805,270		3,805,270	(463,395)	3,341,875		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,084,612	927,554	4,021,162	10,033,328		10,033,328	(466,020)	9,567,308		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			612,872	612,872		612,872	85,025	697,897		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			152,856	152,856		152,856	(142,221)	10,635		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			765,728	765,728		765,728	(57,196)	708,532		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		977,290		977,290		977,290		977,290		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			80,483	80,483		80,483		80,483		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		977,290	80,483	1,057,773		1,057,773		1,057,773		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,084,612	1,904,844	4,867,373	11,856,829		11,856,829	(523,216)	11,333,613		45

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

Facility Name & ID Number **Resurrection Life Center**

0044354

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,030)	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	1,203	30		9
10	Interest and Other Investment Income	(20,636)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule From Page 5A	(5,841)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,304)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(495,912)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (495,912)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (523,216)		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					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Resurrection Life Center

ID# 0044354

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Vending Machine	(595)	2	2
3	Investment exp - recorded under non operating rev	10,635	32	3
4	Other Non Operating Revenue	(15,881)	21	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	(5,841)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Life Center# 0044354

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	(2,625)	0	0	0	0	0	0	0	0	0	0	(2,625)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,625)	0	0	0	0	0	0	0	0	0	0	(2,625)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(527,676)	0	0	0	0	0	0	0	0	0	(527,676)	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	(15,881)	0	0	0	0	0	0	0	0	0	0	(15,881)	21
22	Employee Benefits & Payroll Taxes	0	80,162	0	0	0	0	0	0	0	0	0	80,162	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	(15,881)	(447,514)	0	(463,395)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,506)	(447,514)	0	(466,020)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Life Center# 0044354

Report Period Beginning:

07/01/2009 Ending:06/30/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,203	83,822	0	0	0	0	0	0	0	0	0	85,025	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,001)	(132,220)	0	0	0	0	0	0	0	0	0	(142,221)	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	(8,798)	(48,398)	0	(57,196)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(27,304)	(495,912)	0	(523,216)	45								

Facility Name & ID Number

Resurrection Life Center

0044354

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	11	Please Refer to Attached Page 6A		Please Refer to Attached Page 6A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Administrative	\$ 1,320,301	Resurrection Health Care	100.00%	\$ 792,625	\$ (527,676)	1
2	V	22 Employee Benefits		Resurrection Health Care	100.00%	80,162	80,162	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	83,822	83,822	3
4	V	32 Interest Expenses	152,856	Resurrection Health Care	100.00%	20,636	(132,220)	4
5	V							5
6	V							6
7	V	39 Intercompany Pharmacy	977,290	Resurrection Health Care	100.00%	977,290		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,450,447			\$ 1,954,535	\$ * (495,912)	14

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

Resurrection Health Care
 Schedule for Form 990
 Page 5, Part VI, Line 80b
 Related Organizations
 Twelve Months Ending June 30, 2010

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	Please Refer to Attached Pages 7A & 7B								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

**RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS**

Sandra Bruce <i>Ex Officio</i>	<u>Office</u> President & CEO Resurrection Health Care 7435 W. Talcott Avenue Suite 520 Chicago, IL 60631 Phone: 773-792-5555 Fax: 773-990-8601 SBruce01@reshealthcare.org
John Baird	Executive Vice President/CEO Holy Family Medical Center 100 N. River Road Des Plaines, IL 60016 Phone: 847-813-3161 Fax: 847-297-1863 John.Baird@reshealthcare.org
Connie March	President Provena Senior Services 19065 Hickory Creek Drive Suite 310 Mokena, IL 60448-8507 Phone: 708-478-7922 Fax: 708-478-5143 Connie.march@provena.org
Michael J. Nabolotny, M.D.	Resurrection Medical Center 7447 W. Talcott Avenue Suite 262 Chicago, IL 60631 Phone: 773-775-1900 Fax: 773-775-8034 Time262@sbcglobal.net
Lawrence Pankau, M.D.	132 S. Prospect Park Ridge, IL 60068 Phone: 847-825-6631 Fax: 847-825-8684 Lawrence.Pankau@reshealthcare.org
Sr. Elizabeth Trem, CSFN	Executive Director Casa San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-562-4300 Fax: 708-492-0548 ETrem@reshealthcare.org
Sr. Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Medical Center 7435 W. Talcott Avenue Chicago, IL 60631 Phone: 773-774-8000 Fax: 773-990-7626 Sdonna@reshealthcare.org
John Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 Fax: 847-813-3876 jwalton@reshealthcare.org

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2008

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

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2009

Ending: 6/30/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administrative			\$	\$		792,625	1
2	22	Employee Benefits						80,162	2
3	30	Depreciation						83,822	3
4	32	Interest Expenses						20,636	4
5									5
6									6
7	39	Intercompany Pharmacy						977,290	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				\$	\$		1,954,535	25

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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

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.)

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2009 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 2010 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:	2005	_____	8	FOR BHF USE ONLY		
	2006	_____	9			
	2007	_____	10			
	2008	_____	11			
	2009	N/A	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2009 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 G Groenwald

TELEPHONE (847) 813-3722 FAX #: (847) 813-3785

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(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. _____	_____	\$ _____	\$ _____
2. _____	N/A	\$ _____	\$ _____
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? N/A YES _____ NO _____

If YES, attach an explanation and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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:

07/01/2009 Ending:

06/30/2010

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

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

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

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

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

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

Empty lines for listing other business entities.

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

If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	159		1998	\$ 11,711,085	\$ 449,307	Various	\$ 449,307	\$	\$ 7,471,845
5			2006	627,772	25,772	Various	26,589	817	328,442
6									
7									
8									
Improvement Type**									
9									
10	Painting		2007	21,720	3,103	7	3,103		10,859
11	Code Alert Model 70 Wanderer & Flush Mount Accessory		2007	4,928	493	10	493		1,232
12	Install Additional Downspouts & repair roof		2007	6,775	678	10	678		1,694
13	Remove/Replace piping & valves on hot water line & in boiler room		2007	3,790	253	15	253		632
14	Exterior Painting - East side, Phase 3 of 4		2007	22,655	2,266	10	2,266		5,664
15	Paint/Install Wall Coverings		2007	24,255	4,851	5	4,851		12,127
16	R&M Reclass - Install one chilled water air handler		2007	2,704		7	386	386	1,043
17									
18	Paint/Install Wall Coverings		2008	10,520	2,104	5	2,104		5,260
19	Install new passenger elevator		2008	4,601	230	20	230		575
20	Repipe/Rewire short in fire alarm		2008	3,380	169	20	169		423
21	Power wash & paint courtyard		2008	23,775	4,755	5	4,755		11,888
22	Conduit down wall & cut in gem for outlet in kitchen		2008	3,423	171	20	171		428
23									
24	Signs #28, #29, #30, #31 fabrication + installation, part 1/2		2009	8,333	417	10	417		417
25	Life Center - Sign #28 fabricate & install two new metal faces		2009	8,333	417	10	417		417
26									
27	Home Office Allocation		2010		(8,824)		(8,824)		
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 12,488,048	\$ 486,160		\$ 487,363	\$ 1,203	\$ 7,852,946	70

**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:

07/01/2009

Ending:

06/30/2010

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	\$ 1,316,884	\$ 116,275	\$ 116,275	\$	Various	\$ 1,065,001	71
72	Current Year Purchases	44,641	1,613	1,613		Various	1,613	72
73	Fully Depreciated Assets							73
74	Home Office Allocation		92,646	92,646				74
75	TOTALS	\$ 1,361,525	\$ 210,534	\$ 210,534	\$		\$ 1,066,614	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,449,573	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 696,694	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 697,897	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,203	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,919,560	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A
N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,048

Description: Copiers

(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.	<u>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		1252 hrs	\$ 54,782	1,095	\$ 70,969		2,347	\$ 125,751	1
2	Licensed Speech and Language Development Therapist		190 hrs	9,395				190	9,395	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		3201 hrs	133,716	4	239		3,205	133,955	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				977,290		977,290	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 197,893	1,099	\$ 71,208	\$ 977,290	5,742	\$ 1,246,391	14

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

Facility Name & ID Number **Resurrection Life Center**

0044354

Report Period Beginning: **07/01/2009**

Ending:

06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2010**

(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	\$ 160,200	\$ 160,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>139,783</u>)	1,072,275	<u>1,072,275</u>	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,458	4,458	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Investment Interest</u>	38,183	38,183	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,275,116	\$ 1,275,116	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,715,500	5,715,500	12
13	Land	3,600,000	3,600,000	13
14	Buildings, at Historical Cost	11,877,171	11,877,171	14
15	Leasehold Improvements, at Historical Cost	219,120	219,120	15
16	Equipment, at Historical Cost	1,753,282	1,753,282	16
17	Accumulated Depreciation (book methods)	(8,853,874)	(8,919,560)	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)	\$ 14,311,199	\$ 14,245,513	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,586,315	\$ 15,520,629	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 86,314	\$ 86,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120	120	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to RMC</u>	(1,802,287)	(1,867,973)	36
37	<u>Medicare Settlement</u>	82,853	82,853	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (1,633,000)	\$ (1,698,686)	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)	\$ (1,633,000)	\$ (1,698,686)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,219,315	\$ <u>17,219,315</u>	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,586,315	\$ 15,520,629	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,969,395	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,969,395	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,215,255	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,215,255	17
	B. Transfers (Itemize):		
18	Net Assets Released	34,665	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 34,665	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 17,219,315	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 17,455,502	1
2	Discounts and Allowances for all Levels	(4,379,845)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,075,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,030	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,030	23
	D. Non-Operating Revenue		
24	Contributions	10,550	24
25	Interest and Other Investment Income***	246,305	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 256,855	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>From Page 19A</u>	84,906	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 84,906	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,419,448	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,953,826	31
32	Health Care	4,274,232	32
33	General Administration	3,805,270	33
	B. Capital Expense		
34	Ownership	765,728	34
	C. Ancillary Expense		
35	Special Cost Centers	977,290	35
36	Provider Participation Fee	80,483	36
	D. Other Expenses (specify):		
37	<u>Provision for Bad Debts</u>	347,364	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,204,193	40
41	Income before Income Taxes (line 30 minus line 40)**	1,215,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,215,255	43

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

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

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

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

Vending Machine Revenue	595	Offset on Page 5A
Investment Expenses	(10,635)	Add on Page 5A
Admin - Other Revenue	15,881	Offset on Page 5A
Medical Supply Revenue	59,616	Patient Revenue- not subject to offset
Laundry _ Private Patient Revenue	19,449	Pvt Pt. Not subject to offset
Total - Other Revenue	<u>84,906</u>	
Interest Income	246,305	
Interest exp per book	\$ 152,856	
Interest exp adjusted to home ofc cost - page 6	20,636	
Interest income offset - limited to interest exp	<u>20,636</u>	

Facility Name & ID Number Resurrection Life Center

0044354

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

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	1,876	2,080	\$ 97,312	\$ 46.78	1
2	Assistant Director of Nursing	1,832	2,040	78,791	38.62	2
3	Registered Nurses	38,765	43,918	1,523,552	34.69	3
4	Licensed Practical Nurses	6,049	7,116	164,616	23.13	4
5	CNAs & Orderlies	94,859	104,682	1,413,516	13.50	5
6	CNA Trainees					6
7	Licensed Therapist	4,567	4,865	206,826	42.51	7
8	Rehab/Therapy Aides	2,045	2,284	38,365	16.80	8
9	Activity Director	1,804	2,080	44,670	21.48	9
10	Activity Assistants	6,442	7,160	81,054	11.32	10
11	Social Service Workers	3,243	3,792	94,841	25.01	11
12	Dietician	1,793	2,098	43,745	20.85	12
13	Food Service Supervisor	2,338	2,573	59,919	23.29	13
14	Head Cook	5,881	6,726	101,849	15.14	14
15	Cook Helpers/Assistants	18,951	21,507	225,295	10.48	15
16	Dishwashers					16
17	Maintenance Workers	3,174	3,486	68,104	19.54	17
18	Housekeepers	17,731	20,432	239,816	11.74	18
19	Laundry	3,821	4,233	52,539	12.41	19
20	Administrator	1,760	2,080	109,606	52.70	20
21	Assistant Administrator	1,784	2,008	46,290	23.05	21
22	Other Administrative	8,113	9,361	151,329	16.17	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>MDS Care Plan</u>	3,724	4,355	152,296	34.97	32
33	Other(specify) <u>Religious</u>	4,217	4,532	90,281	19.92	33
34	TOTAL (lines 1 - 33)	234,769	263,408	\$ 5,084,612 *	\$ 19.30	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 11,400	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 11,400		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Razo, Nancy	Administrator		\$ 109,606	Workers' Compensation Insurance	\$ 53,247	IDPH License Fee	\$	
				Unemployment Compensation Insurance	30,753	Advertising: Employee Recruitment		
				FICA Taxes	354,074	Health Care Worker Background Check		
				Employee Health Insurance	1,048,982	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Allscript	2,145	
				Disability Ins	34,436	Illinois	2,118	
				Life Ins	10,116	License	1,921	
				Retirement Contribution	478,251	LSN	2,281	
				Tuition and Other Employee Assistance	26,218	Other	466	
				Home office adjustment	80,162	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 109,606	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 2,116,239		\$ 8,931		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees			\$ 1,320,301				Out-of-State Travel	\$ N/A
							In-State Travel	N/A
							Seminar Expense	N/A
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,320,301	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$	
C. Professional Services								
Vendor/Payee	Type							
N/A		\$						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$					

* Attach copy of IMRF notifications

**See instructions.

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2		N/A											
3													
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19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Resurrection Life Center# 0044354Report Period Beginning: 07/01/2009Ending: 06/30/2010**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 - \$2,281
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 80,483
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,030
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate Records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees