



Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	5	Sheltered Care (SC)	5	1,825	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	24,901	9,652	12,822	47,375	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	7,438	2,883		10,321	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,339	12,535	12,822	57,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.57%

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

0 (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)

N/A-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 03/26/98

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

YES  Date 03/26/98 NO

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

YES  NO  If YES, enter number of beds certified 122 and days of care provided 12,364

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR # 0044354 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	444,999	28,730	2,933	476,662		476,662		476,662		1
2	Food Purchase		365,098		365,098		365,098	(6,819)	358,279		2
3	Housekeeping	239,587	37,342	5,290	282,219		282,219		282,219		3
4	Laundry	51,943	250,031		301,974		301,974	(32,641)	269,333		4
5	Heat and Other Utilities			152,141	152,141		152,141	3,444	155,585		5
6	Maintenance	92,850	19,564	174,216	286,630		286,630	1,397	288,027		6
7	Other (specify):* <b>Pastoral Care</b>	96,381	4,224	22,746	123,351		123,351		123,351		7
8	<b>TOTAL General Services</b>	925,760	704,989	357,326	1,988,075		1,988,075	(34,619)	1,953,456		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			93,776	93,776		93,776		93,776		9
10	Nursing and Medical Records	4,374,976	214,557	97,417	4,686,950		4,686,950	(27,245)	4,659,705		10
10a	Therapy	4,043	489	1,120,435	1,124,967		1,124,967		1,124,967		10a
11	Activities	133,249	8,143	27	141,419		141,419	1,031	142,450		11
12	Social Services	121,609			121,609		121,609		121,609		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,633,877	223,189	1,311,655	6,168,721		6,168,721	(26,214)	6,142,507		16
	<b>C. General Administration</b>										
17	Administrative	350,331	34,869	1,188,539	1,573,739		1,573,739	330,916	1,904,655		17
18	Directors Fees										18
19	Professional Services							13,371	13,371		19
20	Dues, Fees, Subscriptions & Promotions			11,269	11,269		11,269	9,078	20,347		20
21	Clerical & General Office Expenses			2,538	2,538		2,538	3,737	6,275		21
22	Employee Benefits & Payroll Taxes			1,754,020	1,754,020		1,754,020	39,916	1,793,936		22
23	Inservice Training & Education							1,022	1,022		23
24	Travel and Seminar			14,296	14,296		14,296	3,187	17,483		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			(38,089)	(38,089)		(38,089)	228	(37,861)		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	350,331	34,869	2,932,573	3,317,773		3,317,773	401,455	3,719,228		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,909,968	963,047	4,601,554	11,474,569		11,474,569	340,622	11,815,191		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			658,212	658,212		658,212	(53,846)	604,366			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			200,741	200,741		200,741	(466,867)	(266,126)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							16,932	16,932			34
35	Rent-Equipment & Vehicles			29,310	29,310		29,310	1,384	30,694			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			888,263	888,263		888,263	(502,397)	385,866			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,225,275		1,225,275		1,225,275		1,225,275			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			358,715	358,715		358,715		358,715			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,225,275	358,715	1,583,990		1,583,990		1,583,990			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,909,968	2,188,322	5,848,532	13,946,822		13,946,822	(161,775)	13,785,047			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 **PRESENCE RESURRECTION LIFE CTR**

# **0044354**

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

**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>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,355)	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	(32,641)	4		8
9	Non-Straightline Depreciation	4,964	30		9
10	Interest and Other Investment Income	(466,871)	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	(32)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(236,419)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (739,354)</b>		<b>\$</b>	<b>30</b>

**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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (739,354)</b>		<b>37</b>

\*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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

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

STATE OF ILLINOIS  
 PRESENCE RESURRECTION LIFE CTR

Report Period Beginning: 01/01/2013  
 Ending: 12/31/2013

ID# 0044354

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Laboratory	\$ (27,245)	10	1
2	Merger Related Home Office Allocation	(209,174)	17	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(236,419)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	(8,355)	1,536	0	0	0	0	0	0	0	0	0	(6,819)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(32,641)	0	0	0	0	0	0	0	0	0	0	(32,641)	4
5	Heat and Other Utilities	0	3,444	0	0	0	0	0	0	0	0	0	3,444	5
6	Maintenance	0	1,397	0	0	0	0	0	0	0	0	0	1,397	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(40,996)</b>	<b>6,377</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>(34,619)</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	(27,245)	0	0	0	0	0	0	0	0	0	0	(27,245)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,031	0	0	0	0	0	0	0	0	0	1,031	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>(27,245)</b>	<b>1,031</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>(26,214)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(209,174)	57,392	482,698	0	0	0	0	0	0	0	0	330,916	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,371	0	0	0	0	0	0	0	0	0	13,371	19
20	Fees, Subscriptions & Promotions	(32)	9,110	0	0	0	0	0	0	0	0	0	9,078	20
21	Clerical & General Office Expenses	0	3,737	0	0	0	0	0	0	0	0	0	3,737	21
22	Employee Benefits & Payroll Taxes	0	39,916	0	0	0	0	0	0	0	0	0	39,916	22
23	Inservice Training & Education	0	1,022	0	0	0	0	0	0	0	0	0	1,022	23
24	Travel and Seminar	0	3,187	0	0	0	0	0	0	0	0	0	3,187	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	228	0	0	0	0	0	0	0	0	0	228	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(209,206)</b>	<b>127,963</b>	<b>482,698</b>	<b>0</b>	<b>401,455</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(277,447)</b>	<b>135,371</b>	<b>482,698</b>	<b>0</b>	<b>340,622</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR# 0044354

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

## 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	4,964	0	(58,810)	0	0	0	0	0	0	0	0	(53,846)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(466,871)	0	4	0	0	0	0	0	0	0	0	(466,867)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,932	0	0	0	0	0	0	0	0	16,932	34
35	Rent-Equipment & Vehicles	0	0	1,384	0	0	0	0	0	0	0	0	1,384	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(461,907)</b>	<b>0</b>	<b>(40,490)</b>	<b>0</b>	<b>(502,397)</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</b> (sum of lines 29, 37 & 44)	<b>(739,354)</b>	<b>135,371</b>	<b>442,208</b>	<b>0</b>	<b>(161,775)</b>	<b>45</b>							

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		<a href="#">Presence Our Lady of Victory</a>	<a href="#">Bourbonnais</a>	Presence Service C	Various	Physician's Clinics
		<a href="#">Presence Pine View Care Center</a>	<a href="#">St. Charles</a>	Presence Fortin Vill	Bourbonnais	Childrens Center
		<a href="#">Presence Cor Mariae Center</a>	<a href="#">Rockford</a>	Presence Fox Knoll	Aurora	Retirement Comm
		<a href="#">Presence St. Joseph Center</a>	<a href="#">Freeport</a>	Presence Health	Frankfort	Parent Company
		<a href="#">Presence McAuley Manor</a>	<a href="#">Aurora</a>	Presence Home Cai	Various	Home Health
		<a href="#">Presence St. Anne Center</a>	<a href="#">Rockford</a>	Presence Care @ H	Various	Home Equipment
		<a href="#">Presence Villa Franciscan</a>	<a href="#">Joliet</a>	Presence Hospice	Various	Hospice

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	<a href="#">Presence Life Connections</a>	100.00%	\$ 1,536	\$ 1,536	1
2	V	5 Utilities		<a href="#">Presence Life Connections</a>	100.00%	3,444	3,444	2
3	V	6 Maintenance - Other		<a href="#">Presence Life Connections</a>	100.00%	1,397	1,397	3
4	V	11 Activities-Special Events		<a href="#">Presence Life Connections</a>	100.00%	1,031	1,031	4
5	V	17 Admin - Misc. Other	360,840	<a href="#">Presence Life Connections</a>	100.00%	208,215	(152,625)	5
6	V	17 Administrative Salaries		<a href="#">Presence Life Connections</a>	100.00%	210,017	210,017	6
7	V	19 Professional Services		<a href="#">Presence Life Connections</a>	100.00%	13,371	13,371	7
8	V	20 Dues,Subscriptions		<a href="#">Presence Life Connections</a>	100.00%	9,110	9,110	8
9	V	21 Clerical Supplies		<a href="#">Presence Life Connections</a>	100.00%	3,737	3,737	9
10	V	22 Employee Benefits		<a href="#">Presence Life Connections</a>	100.00%	39,916	39,916	10
11	V	23 Education/Conference		<a href="#">Presence Life Connections</a>	100.00%	1,022	1,022	11
12	V	24 Travel		<a href="#">Presence Life Connections</a>	100.00%	3,187	3,187	12
13	V	26 Insurance		<a href="#">Presence Life Connections</a>	100.00%	228	228	13
14	Total		\$ 360,840			\$ 496,211	\$ * 135,371	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 2,547	\$	2,547	15
16	V	32 Interest		Presence Life Connections	100.00%	4		4	16
17	V	34 Rent - Facility		Presence Life Connections	100.00%	16,932		16,932	17
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	1,384		1,384	18
19	V	17 Admin Salaries		Presence Health	100.00%	242,256		242,256	19
20	V	30 Depreciation	109,072	Presence Health	100.00%	47,715		(61,357)	20
21	V	17 Admin Consulting, Other	827,699	Presence Health	100.00%	1,068,141		240,442	21
22	V	39 Ancillary Services - Other	1,225,275	Presence Senior Services Pharmacy	100.00%	1,225,275			22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 2,162,046			\$ 2,604,254	\$ *	442,208	39

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

Facility Name & ID Number

PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compat	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Ca	Northlake	Independent Living	13
14					Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

Facility Name & ID Number

PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JO-ANN COSTANTINO	BOD						1
2	NANCY T. DOWD	BOD						2
3	FLORIDA FREEMAN	BOD						3
4	PATRICIA GOMEZ	BOD						4
5	JAMES C. HAGEN	BOD						5
6	LUCIA JONES	BOD						6
7	TERESA (TESS) KWIATKOWSKI	BOD						7
8	CONNIE S. MARCH	BOD						8
9	SR. MARIE MASON	BOD						9
10	SALLIE MILLER	BOD						10
11	PHYLLIS NICHOLS	BOD						11
12	LAWRENCE R. PANKAU	BOD						12
13	PAUL SKIEM	BOD						13
14	THOMAS E. SMITH	BOD						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

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR # 0044354 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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 Presence Life Connections  
 Street Address 18927 Hickory Creek Dr, Ste 300  
 City / State / Zip Code Mokena, IL 60448  
 Phone Number (708)478-7900  
 Fax Number (708)478-5387

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	2	Food	7,173,919	29	\$ 30,538		360,840	\$ 1,536	1
2	5	Utilities	7,173,919	29	68,461		360,840	3,444	2
3	6	Maintenance - Other	7,173,919	29	27,769		360,840	1,397	3
4	11	Activities-Special Events	7,173,919	29	20,505		360,840	1,031	4
5	17	Admin - Misc. Other	7,173,919	29	4,139,560		360,840	208,215	5
6	17	Administrative Salaries	7,173,919	29	4,175,380	4,175,380	360,840	210,017	6
7	19	Professional Services	7,173,919	29	265,828		360,840	13,371	7
8	20	Dues,Subscriptions	7,173,919	29	181,120		360,840	9,110	8
9	21	Clerical Supplies	7,173,919	29	74,289		360,840	3,737	9
10	22	Employee Benefits	7,173,919	29	793,578		360,840	39,916	10
11	23	Education/Conference	7,173,919	29	20,317		360,840	1,022	11
12	24	Travel	7,173,919	29	63,365		360,840	3,187	12
13	26	Insurance	7,173,919	29	4,528		360,840	228	13
14	30	Depreciation	7,173,919	29	50,634		360,840	2,547	14
15	32	Interest	7,173,919	29	87		360,840	4	15
16	34	Rent - Facility	7,173,919	29	336,621		360,840	16,932	16
17	35	Rent - Equipment	7,173,919	29	27,511		360,840	1,384	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 10,280,091	\$ 4,175,380		\$ 517,078	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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 Presence Health  
 Street Address 100 North River Road  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number (815)806-2327  
 Fax Number

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	6,637,889	8	\$ 1,942,819	\$ 1,942,819	827,699	\$ 242,256	1
2	30	Depreciation	Operating Expense	704,065	8	308,000		109,072	47,715	2
3	17	Admin Consulting,Other	Operating Expense	6,637,889	8	8,566,162		827,699	1,068,141	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 10,816,981	\$ 1,942,819		\$ 1,358,112	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

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 Presence Senior Services Pharmacy  
 Street Address 100 North River Road  
 City / State / Zip Code DesPlaines, IL 60016  
 Phone Number ( 847-410-4900  
 Fax Number (

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 1,225,275	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,225,275	25

Facility Name & ID Number

PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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		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	Home Office Allocation						\$	\$			\$ 4 1						
2											2						
3											3						
4											4						
5											5						
	<b>Working Capital</b>																
6											6						
7											7						
8											8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 4 9						
	<b>B. Non-Facility Related*</b>																
10											10						
11											11						
12											12						
13											13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 4 15						

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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 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 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<b>FOR BHF USE ONLY</b>		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE RESURRECTION LIFE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044354

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
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 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**

**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).

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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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>281,600</u>	<u>1996</u>	<u>\$ 3,600,000</u>	1
2					2
3	<b>TOTALS</b>	<b>281,600</b>		<b>\$ 3,600,000</b>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 11,520,790	\$ 383,511	14	\$ 383,511	\$	\$ 8,846,402
5			1999	69,636	1,127	12	1,127		69,636
6									
7									
8									
<b>Improvement Type**</b>									
9	VARIOUS		1998	358,866	1,038	13	1,038		356,148
10	VARIOUS		2000	131,067	8,167	12	8,167		122,900
11	VARIOUS		2001	40,516	1,111	5	1,111		32,599
12	VARIOUS		2002	1,050		10			1,050
13	VARIOUS		2003	45,412	2,628	10	2,628		36,927
14	VARIOUS		2004	2,168	217	6	217		2,168
15	VARIOUS		2005	20,385	1,481	18	1,481		17,873
16	VARIOUS		2006	224,654	14,199	10	14,199		102,145
17	VARIOUS		2007	99,075	8,532	13	8,532		79,777
18	VARIOUS		2008	90,094	4,968	7	4,968		60,902
19	VARIOUS		2009	25,921	1,789	20	1,789		15,310
20									
21	L & M TO INSTALL COMPLETE MELINK IN		2010	6,773	339	20	339		1,019
22	L & M TO INSTALL COMPLETE MELINK IN		2010	15,805	790	20	790		2,398
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	INSTALL 4 FIRE DAMPERS ON MAIN AHU	2011	\$ 11,252	\$ 1,125	10	\$ 1,125	\$	\$ 3,376	37
38	FURNISH & INSTALL CARPETING IN LOBB	2011	22,613	4,523	5	4,523		13,568	38
39	INSTALL PLUMBING TO PT ROOM FOR K	2011	3,900	195	20	195		585	39
40	FURNISH & INSTALL CARPETING IN LOBB	2011	160	32	5	32		96	40
41	FLOORING ON 1ST. F	2011	74,331	7,433	10	7,433		22,299	41
42	INTERIOR DESIGN FEE	2011	1,430	95	15	95		286	42
43	FURNISH & INSTALL IN SECOND FLOOR	2011	659	66	10	66		132	43
44	CLEAN AND FRAME QUILT	2011	2,184	218	10	218		437	44
45	NEW ART WORK FOR FACILITY	2011	31,999	3,200	10	3,200		6,400	45
46	NEW DROP CEILING IN MAIN KITCH	2011	4,923	492	10	492		985	46
47	DESIGN FEE FOR DEC. 1ST. 2010 TO MAR	2011	818	55	15	55		109	47
48	NEW PHONE SYSTEM FOR RESIDENT RO	2011	23,445	2,344	10	2,344		4,689	48
49	NEW PHONE SYSTEM FOR RESIDENT RO	2011	56,268	5,627	10	5,627		11,254	49
50	NEW FLOOR IN SHOWER ROO	2011	16,489	824	20	824		1,649	50
51	2 - WOOD GRAIN GAZEBOS FOR THE CO	2011	8,881	592	15	592		1,184	51
52	WIRING & TAGGING OF PHONE LINES FO	2011	1,129	113	10	113		226	52
53	NEW PHONE SYSTEM FOR RESIDENT RO	2011	14,067	1,407	10	1,407		2,813	53
54	INSTALL BELBIEN ON ELEVATOR PANEL	2011	8,992	899	10	899		1,798	54
55	DROP CEILING IN MAIN KITCH	2011	4,417	442	10	442		883	55
56	2ND. FL. FLOORING -	2011	275	28	10	28		55	56
57	2ND. FL. FLOORING -	2011	60,043	6,004	10	6,004		12,009	57
58	2ND. FL. FLOORING -	2011	6,279	628	10	628		1,256	58
59	DEPOSIT - MURAL PROJECT FOR MONAR	2011	3,250	325	10	325		650	59
60	NEW PHONE SYSTEM FOR RESIDENT RO	2011	4,564	456	10	456		913	60
61	RESURFACE CORNERGUARD	2011	1		15				61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,014,581	\$ 467,020		\$ 467,020	\$	\$ 9,834,906	70

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

Facility Name &amp; ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 13,014,581	\$ 467,020		\$ 467,020	\$	\$ 9,834,906	1
2	NEW WORK STATIONS FOR NURSING, R	2012	25,822	2,582	10	2,582		3,873	2
3	EASycARE 5 BED LAMINATE PANELS, AS	2012	40,453	2,697	15	2,697		4,045	3
4	PREVAMATT DELUXE MATTRESS 35iW X	2012	5,573	557	10	557		836	4
5	DYCEM NON-SLIP ROLL 8 X 10 YARD	2012	100	20	5	20		30	5
6	ECONOMY PULL STRING ALARM	2012	296	30	10	30		44	6
7	RESURFACE CORNERGUARD	2012	26,806	1,787	15	1,787		2,681	7
8	FLASHING AROUND FOUNDA	2012	2,842	189	15	189		284	8
9	SIGMA SPECTRUM NON-WIRELESS PUM	2012	18,750	1,875	10	1,875		2,813	9
10	NEW FLOOR FINISHING - 2nd FLOOR HAL	2012	6,253	1,251	5	1,251		1,876	10
11	RLC - INSTALLATION OF FIVE DATA DRO	2012	5,566	371	15	371		557	11
12	DIRECTIONAL BORE W4inch PVC PIPE SW	2012	1,908	191	10	191		286	12
13	LCD SPEAKER BAR	2012	85	17	5	17		26	13
14	2 DOORS & HARDWARE	2012	780	52	15	52		78	14
15	2 DOORS & HARDWARE	2012	905	60	15	60		91	15
16	DIRECTIONAL BORE W4inch PVC PIPE SW	2012	5,725	573	10	573		859	16
17	UPGRADE CONTROL SYSTEM FOR FACI	2012	17,763	1,776	10	1,776		2,664	17
18	CONSTRUCT OXYGEN STORAGE ROOM	2012	18,673	1,245	15	1,245		1,867	18
19	UPGRADE CONTROL SYSTEM FOR FACI	2012	17,763	1,776	10	1,776		2,664	19
20	DIRECTIONAL BORE W4 inch PVC PIPE S	2012	1,200	120	10	120		180	20
21	UPGRADE CONTROL SYSTEM FOR FACI	2012	23,683	2,368	10	2,368		3,552	21
22	INSTALL DRYWALL TO ELEVATOR MECH	2012	1,700	113	15	113		170	22
23	DEPOSIT - MURAL PROJECT FOR MONAR	2012	3,250	325	10	325		488	23
24	EMPLOYEE PARKING LOT EXPANSION	2012	37,518	2,501	15	2,501		3,752	24
25	EMERGENCY GENERATOR 175KW REPA	2012	5,172	345	15	345		517	25
26	LANDSCAPING / PARKING LOT EXPANSIO	2012	5,483	548	10	548		822	26
27	PREP & PAINT ALL HALLWAYS & PUBLIC	2012	21,760	4,352	5	4,352		6,528	27
28	PREP & PAINT ALL HALLWAYS & PUBLIC	2012	10,000	2,000	5	2,000		3,000	28
29	STORAGE SHED	2012	1,979	396	5	396		594	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,322,389	\$ 497,137		\$ 497,137	\$	\$ 9,880,083	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12B, Carried Forward</b>		\$ 13,322,389	\$ 497,137		\$ 497,137	\$	\$ 9,880,083	1
2	ANSUL SYSTEM INSTALLATION PER IDPH	2013	3,300	66	25	132	66	66	2
3	PREVAMATT DELUXE STANDARD SIZE	2013	4,090	136	15	272	136	136	3
4	FIRE RATED WEATHER STRIPPING INST	2013	3,850	128	15	256	128	128	4
5	ASSIST DEVICE	2013	2,794	93	15	186	93	93	5
6	AJAX BOILER FIREBOX REFRACTORY RE	2013	10,231	512	10	1,024	512	512	6
7	ASPHALT, SEALCOAT & STRIPE PARKING	2013	5,900	369	8	738	369	369	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,352,554	\$ 498,441		\$ 499,745	\$ 1,304	\$ 9,881,387	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 468,583	\$ 47,039	\$ 47,039	\$	9	\$ 175,879	71
72	Current Year Purchases	65,088	3,660	7,320	3,660	10	3,660	72
73	Fully Depreciated Assets	961,051				11	961,051	73
74	Home Office Allocation		50,262	50,262				74
75	TOTALS	\$ 1,494,722	\$ 100,961	\$ 104,621	\$ 3,660		\$ 1,140,590	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 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)	\$ 18,447,276	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 599,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 604,366	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,964	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,021,977	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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	Home Office Allocation				16,932			5
6								6
7	TOTAL				\$ 16,932			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 30,694 Description: Nursing \$4940, Administration \$20174, Dietary \$951, Rehabilitation \$3245, Home Office \$1384

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE CTR # 0044354 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**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. <b>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>3. <b>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	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**

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

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

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

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

	Service	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, 3	hrs	\$	8,162	\$	479,585	\$	8,162	\$	479,585	1			
2	Licensed Speech and Language Development Therapist	10a,1& 3	103 hrs		4,043		1,664	97,779		1,767	101,822	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	10a, 3	hrs				9,242	543,071		9,242	543,071	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy	39, 3	# of prescrpts					1,225,275			1,225,275	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Other (specify):											12			
13	Other (specify):											13			
14	<b>TOTAL</b>			\$	4,043		19,068	\$	1,120,435	\$	1,225,275	19,171	\$	2,349,753	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 **PRESENCE RESURRECTION LIFE CTR**# **0044354**Report Period Beginning: **01/01/2013**Ending: **12/31/2013****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,594	\$	1
2	Cash-Patient Deposits	2,305		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,935,150		3
4	Supply Inventory (priced at )	23,496		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,962,545	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,600,000		13
14	Buildings, at Historical Cost	12,120,463		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,732,868		16
17	Accumulated Depreciation (book methods)	(11,021,972)		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 (spec <u>Deferred Comp</u> )			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,431,359	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,393,904	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 248,771	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	426,261		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 Party</u>	(14,527,327)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ (13,852,295)	\$	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	<u>Conditional Asset Retirement</u>			43
44	<u>Deferred Lease Payable</u>			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (13,852,295)	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 24,246,199	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,393,904	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,289,846	1
2	Restatements (describe):		2
3			3
4			4
5	Transition of Equity from CY 06/30 to FY 12/31/12	933,574	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 22,223,420	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	2,022,779	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)	\$ 2,022,779	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 24,246,199	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,572,837	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,572,837	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,025,447	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,025,447	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,355	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,273,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,245	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	32,641	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,341,419	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	504,410	24
25	Interest and Other Investment Income***	466,871	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 971,281	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purchase Rebates</b>		28
28a		58,617	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 58,617	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,969,601	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,988,075	31
32	Health Care	6,168,721	32
33	General Administration	3,317,773	33
<b>B. Capital Expense</b>			
34	Ownership	888,263	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,225,275	35
36	Provider Participation Fee	358,715	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,946,822	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,022,779	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,022,779	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,719,132	44
45	Private Pay - Net Inpatient Revenue	3,018,188	45
46	Medicare - Net Inpatient Revenue	1,569,072	46
47	Other-(specify) <u>Insurance</u>	266,445	47
48	Other-(specify) _____		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,572,837	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number **PRESENCE RESURRECTION LIFE CTR**

# **0044354**

Report Period Beginning: **01/01/2013**

Ending:

**12/31/2013**

**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	1,946	2,152	\$ 97,122	\$ 45.13	1
2	Assistant Director of Nursing	1,873	2,135	83,047	38.90	2
3	Registered Nurses	55,303	62,196	2,166,115	34.83	3
4	Licensed Practical Nurses	10,029	11,375	254,272	22.35	4
5	CNAs & Orderlies	113,199	125,409	1,687,012	13.45	5
6	CNA Trainees					6
7	Licensed Therapist		328	10,373	31.63	7
8	Rehab/Therapy Aides	1,483	1,664	29,159	17.52	8
9	Activity Director	1,934	2,160	48,555	22.48	9
10	Activity Assistants	6,498	7,413	87,123	11.75	10
11	Social Service Workers	5,574	6,074	118,300	19.48	11
12	Dietician	2,009	2,167	45,043	20.79	12
13	Food Service Supervisor	664	750	27,842	37.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,635	30,075	375,567	12.49	15
16	Dishwashers					16
17	Maintenance Workers	4,166	4,624	95,470	20.65	17
18	Housekeepers	17,021	19,690	242,025	12.29	18
19	Laundry	3,907	4,441	53,074	11.95	19
20	Administrator	1,856	2,135	113,594	53.21	20
21	Assistant Administrator	402	411	12,834	31.23	21
22	Other Administrative	6,475	7,246	102,101	14.09	22
23	Office Manager	771	815	16,261	19.95	23
24	Clerical	2,020	2,267	43,976	19.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	95	95	8,061	84.85	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: Admissions	3,723	4,140	97,480	23.55	32
33	Other(specify) Pastoral Care	3,595	3,913	95,562	24.42	33
34	TOTAL (lines 1 - 33)	271,178	303,675	\$ 5,909,968 *	\$ 19.46	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 93,776	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)	\$ 93,776		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	
Nancy Razo	Administrator		\$ 113,594	Workers' Compensation Insurance	\$ 99,500	IDPH License Fee	\$	
Administrative Staff	Office Manager		16,261	Unemployment Compensation Insurance	19,632	Advertising: Employee Recruitment		
William Sekalias	Assist Administrator		12,834	FICA Taxes	412,709	Health Care Worker Background Check		
Administrative Staff	Receptionist		50,105	Employee Health Insurance	766,964	(Indicate # of checks performed <u>42</u> )		
Administrative Staff	Administrative Asst		41,669	Employee Meals		Patient Background Checks	391	
Administrative Staff	Admissions		97,480	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	0	
Administrative Staff	Department Heads		18,388	Dental	21,854	Dues & Subscription	11,237	
TOTAL (agree to Schedule V, line 17, col. 1)				Life Insurance	(3,983)	Advertisiosg & Public Relations	32	
(List each licensed administrator separately.)			\$ 350,331	Disability Insurance	43,692			
B. Administrative - Other				Pension	363,750	Home Office Allocation	9,110	
Description			Amount	Tuition Reimbursement	21,648	Less: Public Relations Expense	( )	
Corp Office Management Fee			\$ 1,188,539	Other Benefits	8,254	Non-allowable advertising	(32)	
				Home Office Allocation	39,916	Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,793,936	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,347	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,188,539	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services				N/A		\$	Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
			\$				In-State Travel	14,296
							Seminar Expense	
							Home Office Allocation	3,187
							Entertainment Expense	( )
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 17,483
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL		\$		
(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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number PRESENCE RESURRECTION LIFE CTR

# 0044354

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

## 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 \$10957
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,501 Line 10
- (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. \$ 358,715  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 8,355
- (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? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.