FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0044354

Facility Name: Resurrection Life Center

Address: 7370 West Talcott (Number) Chicago (City) 60631 (Zip Code)

County: Cook

Telephone Number: (773) 594-7400 **Fax #** (773) 594-7402

HFS ID Number:

Date of Initial License for Current Owners: 2/2/1998

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501C(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2010 to 06/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 10/28/2011
(Type or Print Name) Nicola Byrne
(Title) Vice President, Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Ext 107 Fax # (630) 530-7106

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 7/15/2010

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	122	44,250	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	5	2,105	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,992	7,950	15,771	43,713	8
9	SNF/PED					9
10	ICF	7,925	3,863	74	11,862	10
11	ICF/DD					11
12	SC			1,825	1,825	12
13	DD 16 OR LESS					13
14	TOTALS	27,917	11,813	17,670	57,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.07%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/26/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/261998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 43,713

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	426,281		17,666	443,947		443,947		443,947			1
2	Food Purchase		376,727		376,727		376,727	(4,500)	372,227			2
3	Housekeeping	233,879	31,259	1,901	267,039		267,039		267,039			3
4	Laundry	51,758	322,457		374,215		374,215	(21,681)	352,534			4
5	Heat and Other Utilities			206,518	206,518		206,518		206,518			5
6	Maintenance	84,363	23,516	151,238	259,117		259,117		259,117			6
7	Other (specify):*											7
8	TOTAL General Services	796,281	753,959	377,323	1,927,563		1,927,563	(26,181)	1,901,382			8
	B. Health Care and Programs											
9	Medical Director			11,400	11,400		11,400		11,400			9
10	Nursing and Medical Records	3,472,509	227,731	154,809	3,855,049		3,855,049	(53,743)	3,801,306			10
10a	Therapy	583,419	11,024	32,221	626,664		626,664		626,664			10a
11	Activities	126,781	2,959	5,112	134,852		134,852		134,852			11
12	Social Services	203,089	16,432	10,527	230,048		230,048		230,048			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,385,798	258,146	214,069	4,858,013		4,858,013	(53,743)	4,804,270			16
	C. General Administration											
17	Administrative			1,208,278	1,208,278		1,208,278	(32,813)	1,175,465			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			18,270	18,270		18,270		18,270			20
21	Clerical & General Office Expenses	522,787	17,362	18,842	558,991		558,991	35,975	594,966			21
22	Employee Benefits & Payroll Taxes			1,847,764	1,847,764		1,847,764		1,847,764			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,285	1,285		1,285		1,285			25
26	Insurance-Prop.Liab.Malpractice			117,374	117,374		117,374		117,374			26
27	Other (specify):*											27
28	TOTAL General Administration	522,787	17,362	3,211,813	3,751,962		3,751,962	3,162	3,755,124			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,704,866	1,029,467	3,803,205	10,537,538		10,537,538	(76,762)	10,460,776			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Resurrection Life Center #0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			824,845	824,845		824,845		824,845			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			210,875	210,875		210,875	(210,875)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Investment exp**							13,233	13,233			36
37	**TOTAL Ownership**			1,035,720	1,035,720		1,035,720	(197,642)	838,078			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,065,030		1,065,030		1,065,030		1,065,030			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**		1,065,030	80,483	1,145,513		1,145,513		1,145,513			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,704,866	2,094,497	4,919,408	12,718,771		12,718,771	(274,404)	12,444,367			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: 07/01/2010 Ending: 06/30/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,336)	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	(21,681)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(210,875)	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 Page 5A	(38,512)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (274,404)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (274,404)		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 Yes	2 No	3 Amount	4 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

Resurrection Life Center

ID# 0044354

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Charity Care CR from hosp-reported as -ve exp on W	$ 36,400	21	1
2	Other Non Op Revenue	(32,813)	17	2
3	Vending Machine Revenue	(1,164)	2	3
4	Beauty/Barber Services Revenue	(53,743)	10	4
5	Marketing Exp	(425)	21	5
6	Investment Exp Add on	13,233	36	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**	(38,512)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Life Center **#** 0044354 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,500)	0	0	0	0	0	0	0	0	0	0	(4,500)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21,681)	0	0	0	0	0	0	0	0	0	0	(21,681)	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**	(26,181)	0	0	0	0	0	0	0	0	0	0	(26,181)	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	(53,743)	0	0	0	0	0	0	0	0	0	0	(53,743)	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**	(53,743)	0	0	0	0	0	0	0	0	0	0	(53,743)	16
	C. General Administration													
17	Administrative	(32,813)	0	0	0	0	0	0	0	0	0	0	(32,813)	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	35,975	0	0	0	0	0	0	0	0	0	0	35,975	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	3,162	0	0	0	0	0	0	0	0	0	0	3,162	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,762)	0	0	0	0	0	0	0	0	0	0	(76,762)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Life Center # 0044354 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(210,875)	0	0	0	0	0	0	0	0	0	0	(210,875)	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):*	13,233	0	0	0	0	0	0	0	0	0	0	13,233	36
37	**TOTAL Ownership**	(197,642)	0	0	0	0	0	0	0	0	0	0	(197,642)	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)**	(274,404)	0	0	0	0	0	0	0	0	0	0	(274,404)	45

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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
Resurrection Health Care	100	See Attached Page 6A		See Attached Page 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 1,208,278	Resurrection Health Care	100.00%	$ 1,208,278	$	1
2	V								2
3	V	30	Depreciation	201,794	Resurrection Health Care	100.00%	201,794		3
4	V	32	Interest	210,875	Resurrection Health Care	100.00%	210,875		4
5	V	39	Intercompany Pharmacy	1,065,030	Resurrection Health Care	100.00%	1,065,030		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,685,977			$ 2,685,977	$ *	14

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

Resurrection Life Center

Schedule for Form 990

Page 5, Part VI, Line 80b

Related Organizations

Twelve Months Ending June 30, 2011

Related Organizations	Fed Tax ID No	Tax Status
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Medical Center	36-2439318	Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Ambulatory Services	36-4286236	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care Corporation	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Ministries of New York	14-1720818	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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See 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 HEALTH CARE CORPORATION

BOARD OF DIRECTORS

October, 2010

	OFFICE
Mr. Thomas D. Settles	1424 West Old Bay Road
Chairperson	Johnsburg, IL 60051
	847/925-1300 (FAX 847/214-6012)
	tsettles@pcec.net
Ms. Sandra Bruce, FACHE	President & CEO
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	7435 West Talcott Avenue
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	Suite 300
	Charlotte, NC 28262
	704-944-5520 (Charlotte Office- Audra Miller)
	312-253-4037 (Chicago office)
	Email: Haven@cockerhamassociates.com
	Email assistant: audra@cockerhamassociates.com
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	Assistant's email: cmross@health-partners.org
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	720/848-7816 (FAX 720-848-5542)
	Email: Anthony.defurio@uch.edu
	Via FedEX:
	University of Colorado Hospital
	Leprino Building, 10th floor
	12401 E. 17th Avenue, #1043
	Aurora, CO 80045
Sister Loretta Theresa Felici, C.S.F.N.	4001 Grant Avenue
	Philadelphia, PA 19114-2999

RESURRECTION HEALTH CARE CORPORATION

BOARD OF DIRECTORS

October, 2010

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	Email: ltfelici@aol.com
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Sister Patricia Ann Koschalke, C.S.F.N.	Chairperson
	Sponsorship Board
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RESURRECTION SENIOR SERVICES
Board of Directors

OFFICERS
EFFECTIVE AS OF SEPTEMBER 30, 2010

TITLE	NAME
Executive Vice President/CEO, Continuum Care Services	John Baird
Vice President	Peter Goschy
Treasurer	John Orsini
Assistant Treasurer	Nicola Byrne
Secretary	Jeannie C. Frey
Assistant Secretary	John Walton

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 813-3722
Fax Number: (847) 813-3785

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative				$	$		$ 1,208,278	1
2										2
3	30	Depreciation							201,794	3
4	32	Interest							210,875	4
5	39	tercompany Pharmacy							1,065,030	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					$	$		$ 2,685,977	25

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10								Expected Allocation from H.O.			210,875	10
11								Offset Interest Income			(210,875)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

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

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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:		
2006		8
2007		9
2008		10
2009		11
2010	N/A	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurrection Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044354

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility is not profit entity and does	not pay real estate taxes	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 07/01/2010 Ending: 06/30/2011

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	281,600	1996	$ 3,600,000	1
2					2
3	TOTALS	281,600		$ 3,600,000	3

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159			1998	$ 11,804,203	$ 486,209	5-25	$ 486,209	$	$ 8,013,234	4
5				1999	69,636	1,127	10-15	1,127		66,817	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	131,067	8,167	11	8,167		102,482	9
10	Various			2001	40,516	2,587	12	2,587		29,308	10
11	Various			2002	1,050	-	5	-		1,050	11
12	Various			2003	45,412	3,115	10	3,115		29,626	12
13	Various			2004	2,168	217	10	217		1,626	13
14	Various			2005	20,385	1,481	6	1,481		14,171	14
15	Various			2006	224,654	14,421	18	14,421		66,315	15
16	Various			2007	99,075	13,383	10	13,383		51,169	16
17											17
18											18
19	INSTALLED NEW PASSENGER ELEVATOR			2008	4,601	230	20	230		805	19
20	REPIPE/REWIRE SHORT IN FIRE ALARM			2008	3,380	169	20	169		592	20
21	POWER WASH AND PAINT COURTYARD			2008	23,775	4,755	5	4,755		16,643	21
22	PAINT WALL PANELING			2008	10,520	2,104	5	2,104		7,364	22
23	CONDUIT FISH DOWN WALL & CUT IN GEM BOX FOR OUTLET IN			2008	3,423	171	20	171		599	23
24	CHAPEL MICROPHONE SYSTEM			2008	1,195	239	5	239		837	24
25	SATTELLITE EQUIPMENT			2008	3,323	665	5	665		1,661	25
26	REMOVE/INSTALL NEW 4" VICTAULIC BUTTERFLY VALVE			2008	6,000	1,200	5	1,200		3,000	26
27	LOCAL FIRETROL PUMP ALARM PANEL			2008	2,321	116	20	116		290	27
28	INSTALL 1 DROP IN EVS OFFICE			2008	1,401	70	20	70		175	28
29	NEW DOOR OPERATOR FOR DOOR IN COURTYARD			2008	3,347	669	5	669		1,674	29
30	INTERMEDIATE SHOWER REPAIR, WALL BOARD BRUSH AND PA			2008	20,270	1,351	15	1,351		3,378	30
31	INSTALL 4 DROPS & ELECTRICAL OUTLETS			2008	5,136	257	20	257		642	31
32	ONE STANDARD DROP IN FOOD SERVICE OFFICE (WIRING)			2008	1,401	70	20	70		175	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	
37			$	$		$	$	$	37
38	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	1,344	3	1,344		3,359	38
39	INSTALLATION - STEAMER, CONVECTION, GAS, FLOOR MODEL(	2009	1,225	123	10	123		306	39
40	Survey of 11 facilities for electrical equipment	2009	4,000	1,333	3	1,333		3,333	40
41	Signs #28, #29, #30, #31 fabrication + installation, part 1/2	2009	8,333	833	10	833		1,250	41
42	Life Center - Sign #28 fabricate & install two new metal faces	2009	8,333	833	10	833		1,250	42
43									43
44									44
45	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM -	2010	6,773	172	20	172		172	45
46	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2010	15,805	422	20	422		422	46
47									47
48									48
49	INSTALL 4 FIRE DAMPERS ON MAIN AHU'S	2011	11,252	563	10	563		563	49
50	FURNISH & INSTALL CARPETING IN LOBBY VESTIBULE & RECEP	2011	22,613	2,261	5	2,261		2,261	50
51	INSTALL PLUMBING TO PT ROOM FOR KITCHEN SET-UP	2011	3,900	98	20	98		98	51
52	REPLACEMENT OF FLOORING ON 1ST. FLOOR	2011	74,331	3,717	10	3,717		3,717	52
53	INTERIOR DESIGN FEE	2011	1,430	48	15	48		48	53
54	FURNISH & INSTALL CARPETING IN LOBBY VESTIBULE & RECEP	2011	160	16	5	16		16	54
55									55
56	Corporate Allocation			201,794		201,794			56
57									57
58	Reconciling Difference			3		3			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)		$ 12,690,443	$ 756,333		$ 756,333	$	$ 8,430,427	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: 07/01/2010 Ending: 06/30/2011

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	$ 1,295,290	$ 62,835	$ 62,835	$	5-20	$ 1,040,819	71
72	Current Year Purchases	100,898	5,677	5,677		5-20	5,677	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,396,188	$ 68,512	$ 68,512	$		$ 1,046,496	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)	$ 17,686,631	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 824,845	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 824,845	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,476,923	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.

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 9,959 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			$	$	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 Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	4022	hrs	$ 175,298	283	$ 18,427	$	4,305	$ 193,725	1
2	Licensed Speech and Language Development Therapist		624	hrs	31,954				624	31,954	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	5779	hrs	240,011	22	1,448		5,801	241,459	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				1,065,030		1,065,030	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				$ 447,263	305	$ 19,875	$ 1,065,030	10,730	$ 1,532,168	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: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 138,393	$ 138,393	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 311,240)	597,114	597,114	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,739	2,739	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Sundry Receivable	64,064	64,064	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 802,310	$ 802,310	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,007,148	6,007,148	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	1,972,875	1,972,875	16
17	Accumulated Depreciation (book methods)	(9,476,925)	(9,476,925)	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)**	$ 14,199,389	$ 14,199,389	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,001,699	$ 15,001,699	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,016	$ 2,016	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates	(4,403,779)	(4,403,779)	36
37	Accrued Exp	79,299	79,299	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (4,322,464)	$ (4,322,464)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (4,322,464)	$ (4,322,464)	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 19,324,163	$ 19,324,163	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,001,699	$ 15,001,699	48

***(See instructions.)**

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,219,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,219,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,033,962	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) **reconcile to income stmt**	70,884	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,104,846	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 19,324,163	24 *

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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 19,919,850	1
2	Discounts and Allowances for all Levels	(5,669,809)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,250,041	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	53,743	13
14	Non-Patient Meals	4,500	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	21,681	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,924	23
	D. Non-Operating Revenue		
24	Contributions	34,925	24
25	Interest and Other Investment Income***	297,381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 332,306	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please Refer To Attached Page 19A for the details	90,462	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 90,462	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,752,733	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,927,563	31
32	Health Care	4,858,013	32
33	General Administration	3,751,962	33
	B. Capital Expense		
34	Ownership	1,035,720	34
	C. Ancillary Expense		
35	Special Cost Centers	1,065,030	35
36	Provider Participation Fee	80,483	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,718,771	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,033,962	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,033,962	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.**

Resurrection Life Center
Medicaid Provider Number: 0044354
FYE 6/30/2011
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	70,882	Not an income
Admin - Other Revenue	32,813	Offset on Page 5A
Investment exp	(13,233)	Add on Page 5A
Total - Other Revenue	90,462	

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

Interest Income	297,381
Interest Exp	210,875
Interest income offset - limited to interest exp	210,875

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,536	1,889	$ 85,306	$ 45.16	1
2	Assistant Director of Nursing	1,480	1,600	63,269	39.54	2
3	Registered Nurses	43,892	48,515	1,729,599	35.65	3
4	Licensed Practical Nurses	6,575	7,339	173,616	23.66	4
5	CNAs & Orderlies	97,729	108,415	1,485,595	13.70	5
6	CNA Trainees					6
7	Licensed Therapist	11,411	12,249	485,826	39.66	7
8	Rehab/Therapy Aides	2,571	2,756	76,875	27.89	8
9	Activity Director	1,819	2,084	45,645	21.90	9
10	Activity Assistants	6,024	7,121	84,921	11.93	10
11	Social Service Workers	3,792	4,160	104,450	25.11	11
12	Dietician	1,815	2,103	44,799	21.30	12
13	Food Service Supervisor	2,060	2,565	60,843	23.72	13
14	Head Cook	5,763	6,661	102,690	15.42	14
15	Cook Helpers/Assistants	18,244	20,700	222,373	10.74	15
16	Dishwashers					16
17	Maintenance Workers	3,810	4,190	85,479	20.40	17
18	Housekeepers	15,377	17,733	199,880	11.27	18
19	Laundry	5,352	6,255	92,360	14.77	19
20	Administrator	1,800	2,080	102,282	49.17	20
21	Assistant Administrator	1,924	2,080	39,296	18.89	21
22	Other Administrative	8,240	9,128	154,403	16.92	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 Care(specify)	4,234	4,648	171,764	36.95	32
33	Other(specify) Religious	1,040	1,040	93,595	90.00	33
34	TOTAL (lines 1 - 33)	246,488	275,311	$ 5,704,866 *	$ 20.72	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Razo, Nancy	Administrator	0	$ 102,282
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,282

B. Administrative - Other

Description	Amount
Management Fees	$ 1,208,278
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,208,278
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,252
Unemployment Compensation Insurance	20,590
FICA Taxes	395,107
Employee Health Insurance	776,433
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	11,629
Employee Group Disablility	35,591
Employee Retirement Plan	477,853
Employee Assistance and Other Benefits	22,309
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,847,764

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 13,405
Advertising: Employee Recruitment	1,111
Health Care Worker Background Check	
(Indicate # of checks performed)	
All Script	561
City of Chicago	2,200
CLIA Lab	150
Other	706
Faith Cat	101
Med Pass	36
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,270

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	N/A											
3													
4													
5													
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12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Resurrection Life Center # 0044354 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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? **No**
If YES, give association name and amount.

(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. $ **None** 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.

(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. $ **3,336**

(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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

Resurrection Life Center - Fiscal Year 2011

Pending

Page No	Remark
6A & 7B	To be updated once info recd
14A	Equip Leasing cost schedule - Sub Acct 7020
16	Direct patient care - therapist on staff hours and $ amount
17 thru 19	Financial Statements - completed based on trial balance
19A	Financial Statements - completed based on trial balance
20	Payroll Report