		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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0044354

Facility Name: PRESENCE RESURRECTION LIFE C

Address: 7370 W TALCOTT AVE (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: 02/02/98

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code 501C3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

In the event there are further questions about this report, please contact:
Name: GEORGE VIEU Telephone Number: 708-478-7943
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 01/01/2014 to 12/31/2014 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)
	(Type or Print Name) Michael R. Gordon
	(Title) CFO, Vice President Finance
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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 PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	24,540	8,785	12,719	46,044	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	7,330	4,327		11,657	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,870	13,112	12,719	57,701	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.58%

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 [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 03/26/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/26/98 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 11,817

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	85,994	33,583	601,358	720,935		720,935		720,935			1
2	Food Purchase		419,188		419,188		419,188	(11,881)	407,307			2
3	Housekeeping	238,489	37,213	7,362	283,064		283,064		283,064			3
4	Laundry	51,339	212,465		263,804		263,804	(68,433)	195,371			4
5	Heat and Other Utilities			226,219	226,219		226,219	3,315	229,534			5
6	Maintenance	96,187	13,380	180,965	290,532		290,532	956	291,488			6
7	Other (specify):* Pastoral Care	98,757	1,699	19,258	119,714		119,714		119,714			7
8	**TOTAL General Services**	570,766	717,528	1,035,162	2,323,456		2,323,456	(76,043)	2,247,413			8
	B. Health Care and Programs											
9	Medical Director	10,763			10,763		10,763		10,763			9
10	Nursing and Medical Records	4,384,859	202,196	131,694	4,718,749		4,718,749	(35,090)	4,683,659			10
10a	Therapy	2,292	957	1,143,134	1,146,383		1,146,383		1,146,383			10a
11	Activities	136,967	1,616	602	139,185		139,185	539	139,724			11
12	Social Services	125,503			125,503		125,503		125,503			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,660,384	204,769	1,275,430	6,140,583		6,140,583	(34,551)	6,106,032			16
	C. General Administration											
17	Administrative	386,955	18,843	957,417	1,363,215		1,363,215	487,010	1,850,225			17
18	Directors Fees											18
19	Professional Services			61,051	61,051		61,051	24,444	85,495			19
20	Dues, Fees, Subscriptions & Promotions			16,555	16,555		16,555	8,389	24,944			20
21	Clerical & General Office Expenses			2,801	2,801		2,801	2,190	4,991			21
22	Employee Benefits & Payroll Taxes			1,580,675	1,580,675		1,580,675	45,866	1,626,541			22
23	Inservice Training & Education							336	336			23
24	Travel and Seminar			2,820	2,820		2,820	2,140	4,960			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,533	93,533		93,533	(317)	93,216			26
27	Other (specify):*											27
28	**TOTAL General Administration**	386,955	18,843	2,714,852	3,120,650		3,120,650	570,058	3,690,708			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,618,105	941,140	5,025,444	11,584,689		11,584,689	459,464	12,044,153			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			436,127	436,127		436,127	(38,489)	397,638			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			120,291	120,291		120,291	(29,279)	91,012			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							24,997	24,997			34
35	Rent-Equipment & Vehicles			23,430	23,430		23,430	1,502	24,932			35
36	Other (specify):*											36
37	**TOTAL Ownership**			579,848	579,848		579,848	(41,269)	538,579			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,185,430		1,185,430		1,185,430		1,185,430			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			364,526	364,526		364,526		364,526			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,185,430	364,526	1,549,956		1,549,956		1,549,956			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,618,105	2,126,570	5,969,818	13,714,493		13,714,493	418,195	14,132,688			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 C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,676)	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	(68,433)	4		8
9	Non-Straightline Depreciation	12,342	30		9
10	Interest and Other Investment Income	(29,279)	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	(47)	20		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	(35,090)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (133,183)		$	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))**	$ (133,183)		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.		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	**TOTAL (C): (sum of lines 38-46)**			$		47

PRESENCE RESURRECTION LIFE C

ID# 0044354

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Laboratory	$ (35,090)	10	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(35,090)		49

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(12,676)	795	0	0	0	0	0	0	0	0	0	(11,881)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(68,433)	0	0	0	0	0	0	0	0	0	0	(68,433)	4
5	Heat and Other Utilities	0	3,315	0	0	0	0	0	0	0	0	0	3,315	5
6	Maintenance	0	956	0	0	0	0	0	0	0	0	0	956	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(81,109)	5,066	0	0	0	0	0	0	0	0	0	(76,043)	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	(35,090)	0	0	0	0	0	0	0	0	0	0	(35,090)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	539	0	0	0	0	0	0	0	0	0	539	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	(35,090)	539	0	0	0	0	0	0	0	0	0	(34,551)	16
	C. General Administration													
17	Administrative	0	(18,892)	505,902	0	0	0	0	0	0	0	0	487,010	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,444	0	0	0	0	0	0	0	0	0	24,444	19
20	Fees, Subscriptions & Promotions	(47)	8,436	0	0	0	0	0	0	0	0	0	8,389	20
21	Clerical & General Office Expenses	0	2,190	0	0	0	0	0	0	0	0	0	2,190	21
22	Employee Benefits & Payroll Taxes	0	45,866	0	0	0	0	0	0	0	0	0	45,866	22
23	Inservice Training & Education	0	336	0	0	0	0	0	0	0	0	0	336	23
24	Travel and Seminar	0	2,140	0	0	0	0	0	0	0	0	0	2,140	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	(317)	0	0	0	0	0	0	0	0	0	(317)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(47)	64,203	505,902	0	0	0	0	0	0	0	0	570,058	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(116,246)	69,808	505,902	0	0	0	0	0	0	0	0	459,464	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	12,342	0	(50,831)	0	0	0	0	0	0	0	0	(38,489)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,279)	0	0	0	0	0	0	0	0	0	0	(29,279)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	24,997	0	0	0	0	0	0	0	0	24,997	34
35	Rent-Equipment & Vehicles	0	0	1,502	0	0	0	0	0	0	0	0	1,502	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,937)	0	(24,332)	0	0	0	0	0	0	0	0	(41,269)	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)**	(133,183)	69,808	481,570	0	0	0	0	0	0	0	0	418,195	45

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	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. [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	2	Food	$	Presence Life Connections	100.00%	$ 795	$ 795	1
2	V	5	Utilities		Presence Life Connections	100.00%	3,315	3,315	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	956	956	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	539	539	4
5	V	17	Admin - Misc. Other	266,454	Presence Life Connections	100.00%	13,058	(253,396)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	234,504	234,504	6
7	V	19	Professional Services		Presence Life Connections	100.00%	24,444	24,444	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	8,436	8,436	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	2,190	2,190	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	45,866	45,866	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	336	336	11
12	V	24	Travel		Presence Life Connections	100.00%	2,140	2,140	12
13	V	26	Insurance			100.00%	(317)	(317)	13
14	Total			$ 266,454			$ 336,262	$ * 69,808	14

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [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)	
15	V	30	Depreciation	$	Presence Life Connections	100.00%	$ (35,402)	$ (35,402)	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	24,997	24,997	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	1,502	1,502	18
19	V	17	Admin Salaries		Presence Health	100.00%	202,013	202,013	19
20	V	30	Depreciation	78,236	Presence Health	100.00%	62,807	(15,429)	20
21	V	17	Admin Consulting,Other	690,963	Presence Health	100.00%	994,852	303,889	21
22	V	39	Ancillary Services - Other	1,185,430	Presence Senior Services Pharmacy	100.00%	1,185,430		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			$ 1,954,629			$ 2,436,199	$ * 481,570	39

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy T. Dowd	BOD	Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Patricia Gomez	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lod	Kankakee	Supportive Living	3
4	James C. Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Life Connect	Mokena	Management Comp	4
5	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Senior Servic	Kankakee	Pharmacy	5
6	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Ad	Freeport	Adult Day Care	6
7	Joseph G. Hugar	BOD	Presence St Andrew Life Center	Niles	Presence Heritage Day	Kankakee	Adult Day Care	7
8	John Larson	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9	Sr. Marie Mason	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral H	Broadview	Parent	9
10	Sallie Miller	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Phyllis Nichols	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Lawrence R. Pankau	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Tim Phillippe	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14	Thomas E. Smith	BOD			Presence Ambulatory	Various	Parent	14
15					Resurrection Developm	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 Pl	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Esta	Kankakee	Independent Living	30

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	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 C # 0044354 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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: 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

	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	2	Food	Management Fee Income	4,729,991	29	$ 14,111	$	266,454	$ 795	1
2	5	Utilities	Management Fee Income	4,729,991	29	58,852		266,454	3,315	2
3	6	Maintenance - Other	Management Fee Income	4,729,991	29	16,970		266,454	956	3
4	11	Activities-Special Events	Management Fee Income	4,729,991	29	9,560		266,454	539	4
5	17	Admin - Misc. Other	Management Fee Income	4,729,991	29	231,804		266,454	13,058	5
6	17	Administrative Salaries	Management Fee Income	4,729,991	29	4,162,833	4,162,833	266,454	234,504	6
7	19	Professional Services	Management Fee Income	4,729,991	29	433,914		266,454	24,444	7
8	20	Dues,Subscriptions	Management Fee Income	4,729,991	29	149,744		266,454	8,436	8
9	21	Clerical Supplies	Management Fee Income	4,729,991	29	38,881		266,454	2,190	9
10	22	Employee Benefits	Management Fee Income	4,729,991	29	814,191		266,454	45,866	10
11	23	Education/Conference	Management Fee Income	4,729,991	29	5,968		266,454	336	11
12	24	Travel	Management Fee Income	4,729,991	29	37,983		266,454	2,140	12
13	26	Insurance	Management Fee Income	4,729,991	29	(5,634)		266,454	(317)	13
14	30	Depreciation	Management Fee Income	4,729,991	29	(628,443)		266,454	(35,402)	14
15	32	Interest	Management Fee Income	4,729,991	29	0		266,454	0	15
16	34	Rent - Facility	Management Fee Income	4,729,991	29	443,738		266,454	24,997	16
17	35	Rent - Equipment	Management Fee Income	4,729,991	29	26,658		266,454	1,502	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,811,131	$ 4,162,833		$ 327,359	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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

	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	Admin Salaries	Operating Expense	5,276,287	8	$ 1,542,600	$ 1,542,600	690,963	$ 202,013	1
2	30	Depreciation	Operating Expense	553,380	8	604,120		78,236	85,410	2
3	17	Admin Consulting,Other	Operating Expense	5,276,287	8	5,419,417		690,963	709,707	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					$ 7,566,137	$ 1,542,600		$ 997,130	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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

	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	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,185,430	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					$	$		$ 1,185,430	25

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description	Amount	Line
1. Real Estate Tax accrual used on 2013 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 2014 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:		Line
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2013 $	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE RESURRECTION LIFE C 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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? [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 [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	281,600	1996	$ 3,600,000	1
2					2
3	TOTALS	281,600		$ 3,600,000	3

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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		$ 11,520,790	$ 187,314	17	$ 187,314	$	$ 9,033,716	4
5			1999		69,636		12			69,636	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1998	358,866	726	13	726		356,874	9
10	VARIOUS			2000	131,067	8,167	11	8,167		131,067	10
11	VARIOUS			2001	40,516	1,111	12	1,111		33,710	11
12	VARIOUS			2002	1,050		5			1,050	12
13	VARIOUS			2003	45,412	1,794	10	1,794		38,721	13
14	VARIOUS			2004	2,168		10			2,168	14
15	VARIOUS			2005	20,385	1,481	6	1,481		19,354	15
16	VARIOUS			2006	224,654	14,199	18	14,199		116,345	16
17	VARIOUS			2007	99,075	4,655	10	4,655		84,432	17
18	VARIOUS			2008	90,094	2,435	13	2,435		63,337	18
19	VARIOUS			2009	25,921	1,789	7	1,789		17,099	19
20	VARIOUS			2010	22,578	1,129	20	1,129		4,546	20
21											21
22	INSTALL 4 FIRE DAMPERS ON MAIN AHU'S			2011	11,252	1,125	10	1,125		4,501	22
23	FURNISH & INSTALL CARPETING IN LOBBY VESTIBULE & RECE			2011	22,613	4,523	5	4,523		18,090	23
24	INSTALL PLUMBING TO PT ROOM FOR KITCHEN SET-UP			2011	3,900	195	20	195		780	24
25	FURNISH & INSTALL CARPETING IN LOBBY VESTIBULE & RECE			2011	160	32	5	32		128	25
26	NEW FLOORING ON 1ST. FLOOR			2011	74,331	7,433	10	7,433		29,732	26
27	INTERIOR DESIGN FEE			2011	1,430	95	15	95		381	27
28	FURNISH & INSTALL IN SECOND FLOOR CONFERENCE ROOM W			2011	659	66	10	66		198	28
29	CLEAN AND FRAME QUILT			2011	2,184	218	10	218		655	29
30	NEW ART WORK FOR FACILITY			2011	31,999	3,200	10	3,200		9,600	30
31	NEW DROP CEILING IN MAIN KITCHEN			2011	4,923	492	10	492		1,477	31
32	DESIGN FEE FOR DEC. 1ST. 2010 TO MARCH 1ST. 2011			2011	848	55	15	55		164	32
33	NEW PHONE SYSTEM FOR RESIDENT ROOMS & FACILITY			2011	23,445	2,344	10	2,344		7,033	33
34	NEW PHONE SYSTEM FOR RESIDENT ROOMS & FACILITY			2011	26,268	5,627	10	5,627		16,880	34
35	NEW FLOOR IN SHOWER ROOMS			2011	16,489	824	20	824		2,473	35
36	2 - WOOD GRAIN GAZEBOS FOR THE COURTYARD			2011	8,881	592	15	592		1,776	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 PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	WIRING & TAGGING OF PHONE LINES FOR NEW PHONE S	2011	$ 1,129	$ 113	10	$ 113	$	$ 339	37
38	NEW PHONE SYSTEM FOR RESIDENT ROOMS & FACILITY	2011	14,067	1,407	10	1,407		4,221	38
39	INSTALL BELBIEN ON ELEVATOR PANELS IN 3 CABS	2011	8,992	899	10	899		2,698	39
40	NEW DROP CEILING IN MAIN KITCHEN	2011	4,417	442	10	442		1,325	40
41	NEW 2ND. FL. FLOORING - INCLUDES HALLWAYS DINING	2011	275	28	10	28		83	41
42	NEW 2ND. FL. FLOORING - INCLUDES HALLWAYS DINING	2011	60,043	6,004	10	6,004		18,013	42
43	NEW 2ND. FL. FLOORING - INCLUDES HALLWAYS DINING	2011	6,279	628	10	628		1,884	43
44	DEPOSIT - MURAL PROJECT FOR MONARCH UNIT- IN SUN	2011	3,250	325	10	325		975	44
45	NEW PHONE SYSTEM FOR RESIDENT ROOMS & FACILITY	2011	4,564	456	10	456		1,369	45
46	RESURFACE CORNERGUARDS, HANDRAILS THROUGHOU	2011	1		15				46
47									47
48	NEW WORK STATIONS FOR NURSING, REHAB, AND RECEI	2012	25,822	2,582	10	2,582		6,456	48
49	EASYCARE 5 BED LAMINATE PANELS, ASSIST DEVICES-PI	2012	40,453	2,697	15	2,697		6,742	49
50	PREVAMATT DELUXE MATTRESS 35iW X 80iL	2012	5,573	557	10	557		1,393	50
51	DYCEM NON-SLIP ROLL 8 X 10 YARD	2012	100	20	5	20		50	51
52	ECONOMY PULL STRING ALARM	2012	296	30	10	30		74	52
53	RESURFACE CORNERGUARDS, HANDRAILS THROUGHOU	2012	26,806	1,787	15	1,787		4,468	53
54	REPAIR OF FLASHING AROUND FOUNDATION	2012	2,842	189	15	189		474	54
55	SIGMA SPECTRUM NON-WIRELESS PUMP	2012	18,750	1,875	10	1,875		4,688	55
56	NEW FLOOR FINISHING - 2nd FLOOR HALLWAYS & NURSI	2012	6,253	1,251	5	1,251		3,126	56
57	RLC - INSTALLATION OF FIVE DATA DROPS	2012	5,566	371	15	371		928	57
58	DIRECTIONAL BORE W4inch PVC PIPE SWEEPING	2012	1,908	191	10	191		477	58
59	LCD SPEAKER BAR	2012	85	17	5	17		43	59
60	2 DOORS & HARDWARE	2012	780	52	15	52		130	60
61	2 DOORS & HARDWARE	2012	905	60	15	60		151	61
62	DIRECTIONAL BORE W4inch PVC PIPE SWEEPING	2012	5,725	573	10	573		1,431	62
63	UPGRADE CONTROL SYSTEM FOR FACILITY - OPTIONS 1	2012	17,763	1,776	10	1,776		4,441	63
64	CONSTRUCT OXYGEN STORAGE ROOM PER CODE	2012	18,673	1,245	15	1,245		3,112	64
65	UPGRADE CONTROL SYSTEM FOR FACILITY - OPTIONS 1	2012	17,763	1,776	10	1,776		4,441	65
66	DIRECTIONAL BORE W4 inch PVC PIPE SWEEPING	2012	1,200	120	10	120		300	66
67	UPGRADE CONTROL SYSTEM FOR FACILITY - OPTIONS 1	2012	23,683	2,368	10	2,368		5,921	67
68	INSTALL DRYWALL TO ELEVATOR MECHANICAL ROOMS	2012	1,700	113	15	113		283	68
69	DEPOSIT - MURAL PROJECT FOR MONARCH UNIT- IN SUN	2012	3,250	325	10	325		813	69
70	TOTAL (lines 4 thru 69)		$ 13,210,507	$ 281,898		$ 281,898	$	$ 10,146,772	70

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Totals from Page 12A, Carried Forward		$ 13,210,507	$ 281,898		$ 281,898	$	$ 10,146,772	1
2	EMERGENCY GENERATOR 175KW REPAIR	2012	5,172	345	15	345		862	2
3	PREP & PAINT ALL HALLWAYS & PUBLIC ROOMS ON 2 NI	2012	10,000	2,000	5	2,000		5,000	3
4	PREP & PAINT ALL HALLWAYS & PUBLIC ROOMS ON 2 NI	2012	21,760	4,352	5	4,352		10,880	4
5	STORAGE SHED	2012	1,979	396	5	396		990	5
6	LANDSCAPING / PARKING LOT EXPANSION PROJECT	2012	5,483	548	10	548		1,371	6
7	EMPLOYEE PARKING LOT EXPANSION	2012	37,518	2,501	15	2,501		6,253	7
8									8
9	ASPHALT, SEALCOAT & STRIPE PARKING LOT	2013	5,900	738	8	738		1,106	9
10	FIRE RATED WEATHER STRIPPING INSTALLATION PER II	2013	3,850	257	15	257		385	10
11	ANSUL SYSTEM INSTALLATION PER IDPH POC	2013	3,300	132	25	132		198	11
12	ASSIST DEVICE	2013	2,794	186	15	186		279	12
13	PREVAMATT DELUXE STANDARD SIZE	2013	4,090	273	15	273		409	13
14	NEW AJAX BOILER FIREBOX REFRACTORY	2013	10,231	1,023	10	1,023		1,535	14
15									15
16	SEAL, COATING STRIP, ASPHALT PATCHING AND CONCR	2014	9,900	619	8	1,238	619	619	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,332,484	$ 295,268		$ 295,887	$ 619	$ 10,176,659	34

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 509,587	$ 50,101	$ 50,101	$	10	$ 206,352	71
72	Current Year Purchases	269,381	11,723	23,446	11,723	9	11,723	72
73	Fully Depreciated Assets	985,134	799	799		11	985,134	73
74	Home Office Allocation		50,008	50,008				74
75	TOTALS	$ 1,764,102	$ 112,631	$ 124,354	$ 11,723		$ 1,203,209	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)	$ 18,696,586	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 407,899	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 420,241	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,342	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,379,868	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	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				24,997			5
6								6
7	TOTAL				$ 24,997 **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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 [X] NO
16. Rental Amount for movable equipment: $ 24,932 Description: Administration $16175, Nursing $3883, Rehabiliation $2797, Dietary $575, Home Office $1502
    (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 C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

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,3		hrs	$	7,607	$ 451,850	$	7,607	$ 451,850	1
2	Licensed Speech and Language Development Therapist	10a,3	47	hrs	2,292	1,656	101,350		1,703	103,642	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,3		hrs		9,932	589,934		9,932	589,934	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				1,185,430		1,185,430	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				$ 2,292	19,195	$ 1,143,134	$ 1,185,430	19,242	$ 2,330,856	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 C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 410,082	$	1
2	Cash-Patient Deposits	2,150		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,646,930		3
4	Supply Inventory (priced at)	30,192		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	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,089,354	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,395,956		13
14	Buildings, at Historical Cost	324,507		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,009,039		16
17	Accumulated Depreciation (book methods)	(11,379,864)		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)**	$ 7,349,638	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,438,992	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 448,836	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	299,825		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 Related Party**	(15,484,414)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (14,735,753)	$	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)**	$ (14,735,753)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 26,174,745	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,438,992	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 24,246,199	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 24,246,199	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,923,857	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,689	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,928,546	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)**	$ 26,174,745	24 *

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

Facility Name & ID Number PRESENCE RESURRECTION LIFE C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,836,535	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,836,535	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,551,222	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,551,222	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	15,590	13
14	Non-Patient Meals	12,676	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,539,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,090	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	68,433	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,671,488	23
	D. Non-Operating Revenue		
24	Contributions	540,770	24
25	Interest and Other Investment Income***	29,279	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 570,049	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Other Misc Income	9,056	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,056	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,638,350	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,323,456	31
32	Health Care	6,140,583	32
33	General Administration	3,120,650	33
	B. Capital Expense		
34	Ownership	579,848	34
	C. Ancillary Expense		
35	Special Cost Centers	1,185,430	35
36	Provider Participation Fee	364,526	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,714,493	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,923,857	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,923,857	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,683,452	44
45	Private Pay - Net Inpatient Revenue	3,094,870	45
46	Medicare - Net Inpatient Revenue	2,861,748	46
47	Other-(specify)	196,465	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,836,535	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 C # 0044354 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,801	2,087	$ 95,974	$ 45.99	1
2	Assistant Director of Nursing	1,779	2,086	82,523	39.56	2
3	Registered Nurses	51,967	58,440	2,022,904	34.62	3
4	Licensed Practical Nurses	14,006	16,388	419,108	25.57	4
5	CNAs & Orderlies	115,529	129,384	1,695,848	13.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,858	2,124	48,601	22.88	9
10	Activity Assistants	6,382	7,435	87,622	11.79	10
11	Social Service Workers	5,721	6,510	126,699	19.46	11
12	Dietician	482	756	15,878	21.00	12
13	Food Service Supervisor	127	165	6,116	37.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,734	6,909	88,542	12.82	15
16	Dishwashers					16
17	Maintenance Workers	3,975	4,516	96,999	21.48	17
18	Housekeepers	16,966	19,737	239,862	12.15	18
19	Laundry	3,662	4,288	52,118	12.15	19
20	Administrator	1,867	2,126	122,542	57.64	20
21	Assistant Administrator	1,601	1,703	53,950	31.68	21
22	Other Administrative	6,233	6,854	97,661	14.25	22
23	Office Manager	746	817	15,349	18.79	23
24	Clerical	1,878	2,188	43,282	19.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	100	100	10,763	107.63	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	3,629	4,012	97,453	24.29	32
33	Other(specify) Pastoral Care	3,436	3,897	98,311	25.23	33
34	TOTAL (lines 1 - 33)	247,479	282,522	$ 5,618,105 *	$ 19.89	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				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)		$		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Raxo	Administrator		$ 122,542
William Sekalias	Assist Administrator		53,950
Administrative Staff	Office Manager		15,349
Administrative Staff	Receptionist		38,615
Administrative Staff	Administrative Asst		41,085
Administrative Staff	Admissions		97,453
Administrative Staff	Department Heads		17,961
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 386,955

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 957,417
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 957,417

C. Professional Services

Vendor/Payee	Type	Amount
Cielo - recruiter		$ 17,150
Telephone		18,386
Illinois State Police		4,000
Joint Commission		2,500
Beautician/Barber		5,934
Shredding/Storage		6,443
Cable		2,920
Aquarium Maintenance		1,519
Outsourced Services		2,199
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 61,051

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,176
Unemployment Compensation Insurance	14,027
FICA Taxes	400,236
Employee Health Insurance	720,819
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	45,866
Dental	17,120
Life Insurance	3,959
Disability Insurance	37,218
Pension	271,551
Tuition Reimbursement	16,813
Other Benefits	5,756
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,626,541

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 26)	
Patient Background Checks 269	
Dues & Subscription	16,508
Advertising & Public Relations	47
Home Office Allocation	8,436
Less: Public Relations Expense	( )
Non-allowable advertising	(47)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,944

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	781
Seminar Expense	2,039
Home Office Allocation	2,140
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,960

**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
					Amount of Expense Amortized Per Year								
	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													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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 $12238**

(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? **9 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,653** 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. $ **364,526**
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. $ **12,676**

(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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.