



Facility Name & ID Number Providence Downers Grove

# 0028605 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,040	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	87,965	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,448	5,648	18,127	37,223	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		22,115		22,115	12
13	DD 16 OR LESS					13
14	TOTALS	13,448	27,763	18,127	59,338	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.46%

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

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

YES  NO

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

Date started 05/01/1984

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

YES  Date 05/01/1984 NO

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

YES  NO  If YES, enter number of beds certified 145 and days of care provided 15,150

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	644,396	82,237	157,717	884,350	884,350		884,350		1	
2	Food Purchase		562,162		562,162	562,162	4,810	566,972		2	
3	Housekeeping	192,459	54,016		246,475	246,475		246,475		3	
4	Laundry	25,097	124,677		149,774	149,774		149,774		4	
5	Heat and Other Utilities			230,276	230,276	230,276	14,892	245,168		5	
6	Maintenance	177,905		372,365	550,270	550,270	4,744	555,014		6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	1,039,857	823,092	760,358	2,623,307	2,623,307	24,446	2,647,753		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,128	16,128	16,128		16,128		9	
10	Nursing and Medical Records	3,199,180	409,175	501,021	4,109,376	4,109,376		4,109,376		10	
10a	Therapy		1,668	1,454,263	1,455,931	1,455,931		1,455,931		10a	
11	Activities	252,904	28,363	840	282,107	282,107		282,107		11	
12	Social Services	188,980		2,952	191,932	191,932		191,932		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	3,641,064	439,206	1,975,204	6,055,474	6,055,474		6,055,474		16	
	<b>C. General Administration</b>										
17	Administrative			1,268,322	1,268,322	1,268,322	(1,125,907)	142,415		17	
18	Directors Fees									18	
19	Professional Services			89,804	89,804	89,804	10,749	100,553		19	
20	Dues, Fees, Subscriptions & Promotions			27,696	27,696	27,696	1,272	28,968		20	
21	Clerical & General Office Expenses	664,052	66,953	56,445	787,450	787,450	608,850	1,396,300		21	
22	Employee Benefits & Payroll Taxes			1,166,923	1,166,923	1,166,923		1,166,923		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			3,574	3,574	3,574	16,362	19,936		24	
25	Other Admin. Staff Transportation			3,460	3,460	3,460	3,427	6,887		25	
26	Insurance-Prop.Liab.Malpractice			208,935	208,935	208,935	6,817	215,752		26	
27	Other (specify):* <b>Mgmt - EE Benefits</b>						177,996	177,996		27	
28	<b>TOTAL General Administration</b>	664,052	66,953	2,825,159	3,556,164	3,556,164	(300,434)	3,255,730		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,344,973	1,329,251	5,560,721	12,234,945	12,234,945	(275,988)	11,958,957		29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			534,177	534,177		534,177	112,232	646,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			316,278	316,278		316,278	(69,796)	246,482			32
33	Real Estate Taxes			20,400	20,400		20,400	(10,718)	9,682			33
34	Rent-Facility & Grounds							8,328	8,328			34
35	Rent-Equipment & Vehicles			2,457	2,457		2,457		2,457			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			873,312	873,312		873,312	40,046	913,358			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,047,278		1,047,278		1,047,278		1,047,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):* <b>Non-allowable cost</b>			586,511	586,511		586,511	(586,511)				43
44	<b>TOTAL Special Cost Centers</b>		1,047,278	665,899	1,713,177		1,713,177	(586,511)	1,126,666			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,344,973	2,376,529	7,099,932	14,821,434		14,821,434	(822,453)	13,998,981			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Downers Grove

# 0028605

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,474)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,720)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,097	30		9
10	Interest and Other Investment Income	(9,508)	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	(12,323)	43		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	(88,508)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(41,107)	43		28
29	Other-Attach Schedule See PG5A	(553,546)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (673,089)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(149,364)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (149,364)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (822,453)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Providence Downers Grove

ID# 0028605

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing costs	\$ (225,418)	43	1
2	Labs - Part A	(40,878)	44	2
3	X-Rays - Part A	(47,803)	45	3
4	Interrehab Physiatry	(87,878)	46	4
5	Residents Welfare	(40,064)	47	5
6	Accretion Expense	(2,532)	48	6
7	Offset miscellaneous income	(159)	21	7
8	Offset Postage	(3)	21	8
9	Nonallowable Chamber Dues	(1,060)	20	9
10	NonCare Real Estate Taxes	(20,400)	33	10
11	Non-Care Related Interest	(87,351)	32	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(553,546)	49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,474)	16,624	0	2,660	0	0	0	0	0	0	0	4,810	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	12,838	0	2,054	0	0	0	0	0	0	0	14,892	5
6	Maintenance	0	4,090	0	654	0	0	0	0	0	0	0	4,744	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,474)</b>	<b>33,552</b>	<b>0</b>	<b>5,368</b>	<b>0</b>	<b>24,446</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(903,505)	0	(222,402)	0	0	0	0	0	0	0	(1,125,907)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,041	0	1,607	0	0	0	0	0	0	0	11,648	19
20	Fees, Subscriptions & Promotions	(1,060)	2,010	0	322	0	0	0	0	0	0	0	1,272	20
21	Clerical & General Office Expenses	(17,882)	539,502	0	86,331	0	0	0	0	0	0	0	607,951	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	14,105	0	2,257	0	0	0	0	0	0	0	16,362	24
25	Other Admin. Staff Transportation	0	2,954	0	473	0	0	0	0	0	0	0	3,427	25
26	Insurance-Prop.Liab.Malpractice	0	5,877	0	940	0	0	0	0	0	0	0	6,817	26
27	Other (specify):*	0	153,442	0	24,554	0	0	0	0	0	0	0	177,996	27
28	<b>TOTAL General Administration</b>	<b>(18,942)</b>	<b>(175,574)</b>	<b>0</b>	<b>(105,918)</b>	<b>0</b>	<b>(300,434)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(33,416)</b>	<b>(142,022)</b>	<b>0</b>	<b>(100,550)</b>	<b>0</b>	<b>(275,988)</b>	<b>29</b>						

STATE OF ILLINOIS

Facility Name & ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	64,097	41,495	0	6,640	0	0	0	0	0	0	0	112,232	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(96,859)	0	23,330	3,733	0	0	0	0	0	0	0	(69,796)	32
33	Real Estate Taxes	(20,400)	0	8,346	1,336	0	0	0	0	0	0	0	(10,718)	33
34	Rent-Facility & Grounds	0	0	7,179	1,149	0	0	0	0	0	0	0	8,328	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(53,162)</b>	<b>41,495</b>	<b>38,855</b>	<b>12,858</b>	<b>0</b>	<b>40,046</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(367,356)	0	0	0	0	0	0	0	0	0	0	(367,356)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(367,356)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(367,356)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(453,934)	(100,527)	38,855	(87,692)	0	0	0	0	0	0	0	(603,298)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home		Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
		Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
		Haven Park	Zeeland, MI	Providence Mgmt. & Development Co.	Tinley Park	Management Co.
		Plymouth Place	LaGrange Park, IL	Providence Home		
				Health Care	Tinley Park	Home Health
				Saratoga Grove	Downers Grove	Supportive Living

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

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

1 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	\$	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	\$ 16,624	\$ 16,624	1
2	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	12,838	12,838	2
3	V	6 Maintenance - other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	4,090	4,090	3
4	V	17 Administrative	1,031,891	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	128,386	(903,505)	4
5	V	19 Professional services - Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	10,041	10,041	5
6	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	2,010	2,010	6
7	V	21 Clerical & general - salary		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	470,224	470,224	7
8	V	21 Clerical & general - other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	69,278	69,278	8
9	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	14,105	14,105	9
10	V	25 Other Admin. Staff transportation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	2,954	2,954	10
11	V	26 Insurance - Prop., Liab & Malpractice		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	5,877	5,877	11
12	V	27 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	153,442	153,442	12
13	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	41,495	41,495	13
14	Total		\$ 1,031,891			\$ 931,364	\$ * (100,527)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest	\$	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	\$ 23,330	\$	23,330	15
16	V	33 Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	8,346		8,346	16
17	V	34 Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	7,179		7,179	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								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		\$			\$ 38,855	\$ *	38,855	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	\$ 2,660	\$ 2,660
16	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	2,054	2,054
17	V	6 Maintenance - other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	654	654
18	V	17 Administrative	236,431	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	14,029	(222,402)
19	V	19 Professional services - Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	1,607	1,607
20	V	20 Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	322	322
21	V	21 Clerical & general - salary		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	75,245	75,245
22	V	21 Clerical & general - other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	11,086	11,086
23	V	24 Travel & seminar		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	2,257	2,257
24	V	25 Other Admin. Staff transportation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	473	473
25	V	26 Insurance - Prop., Liab & Malpractice		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	940	940
26	V	27 Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	24,554	24,554
27	V	30 Depreciation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	6,640	6,640
28	V	32 Interest		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	3,733	3,733
29	V	33 Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	1,336	1,336
30	V	34 Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	1,149	1,149
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 236,431			\$ 148,739	\$ * (87,692)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Downers Grove # 0028605 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5	N/A - Voluntary Board with no compensation. See Attached Schedule 7A									5
6										6
7										7
8										8
9	No board member or related business provided services to this facility.									9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Downers Grove

# 0028605 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Rest Haven Illiana Christian Conv. Home  
 Street Address 18601 North Creek Drive  
 City / State / Zip Code Tinley Park, IL 60477  
 Phone Number (708) 342-8100  
 Fax Number (708) 342-8006

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated Cost B	86,768,654	17	\$ 130,519	\$ 11,051,653	\$ 16,624	1
2	5	Utilities	Accumulated Cost B	86,768,654	17	100,790	11,051,653	12,838	2
3	6	Maintenance - other	Accumulated Cost B	86,768,654	17	32,112	11,051,653	4,090	3
4	17	Administrative	Direct Cost A	86,768,654	1	1,219,555	1,219,555	128,386	4
5	19	Professional services - Other	Accumulated Cost B	86,768,654	17	78,837	11,051,653	10,041	5
6	20	Dues, fees & subscriptions	Accumulated Cost B	86,768,654	17	15,780	11,051,653	2,010	6
7	21	Clerical & general - salary	Accumulated Cost B	86,768,654	17	3,691,821	3,691,821	470,224	7
8	21	Clerical & general - other	Accumulated Cost B	86,768,654	17	543,911	11,051,653	69,278	8
9	24	Travel & seminar	Accumulated Cost B	86,768,654	17	110,742	11,051,653	14,105	9
10	25	Other Admin. Staff transportation	Accumulated Cost B	86,768,654	17	23,189	11,051,653	2,954	10
11	26	Insurance - Prop., Liab & Malpra	Accumulated Cost B	86,768,654	17	46,139	11,051,653	5,877	11
12	27	Mgmt. allocation of benefits	Accumulated Cost B	86,768,654	17	1,204,704	11,051,653	153,442	12
13	30	Depreciation	Accumulated Cost B	86,768,654	17	325,788	11,051,653	41,495	13
14	32	Interest	Accumulated Cost B	86,768,654	17	183,166	11,051,653	23,330	14
15	33	Real Estate Taxes	Accumulated Cost B	86,768,654	17	65,528	11,051,653	8,346	15
16	34	Rent - facility & grounds	Accumulated Cost B	86,768,654	17	56,363	11,051,653	7,179	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,828,944	\$ 4,911,376	\$ 970,219	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Downers Grove

# 0028605 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Rest Haven Illiana Christian Conv. Home  
 Street Address 18601 North Creek Drive  
 City / State / Zip Code Tinley Park, IL 60477  
 Phone Number (708) 342-8100  
 Fax Number (708) 342-8006

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated Cost B	86,768,654	17	\$ 130,519	\$ 1,768,469	\$ 2,660	1
2	5	Utilities	Accumulated Cost B	86,768,654	17	100,790	1,768,469	2,054	2
3	6	Maintenance - other	Accumulated Cost B	86,768,654	17	32,112	1,768,469	654	3
4	17	Administrative	Direct Cost A	86,768,654	1	1,219,555	1,219,555	14,029	4
5	19	Professional services - Other	Accumulated Cost B	86,768,654	17	78,837	1,768,469	1,607	5
6	20	Dues, fees & subscriptions	Accumulated Cost B	86,768,654	17	15,780	1,768,469	322	6
7	21	Clerical & general - salary	Accumulated Cost B	86,768,654	17	3,691,821	3,691,821	75,245	7
8	21	Clerical & general - other	Accumulated Cost B	86,768,654	17	543,911	1,768,469	11,086	8
9	24	Travel & seminar	Accumulated Cost B	86,768,654	17	110,742	1,768,469	2,257	9
10	25	Other Admin. Staff transportation	Accumulated Cost B	86,768,654	17	23,189	1,768,469	473	10
11	26	Insurance - Prop., Liab & Malpra	Accumulated Cost B	86,768,654	17	46,139	1,768,469	940	11
12	27	Mgmt. allocation of benefits	Accumulated Cost B	86,768,654	17	1,204,704	1,768,469	24,554	12
13	30	Depreciation	Accumulated Cost B	86,768,654	17	325,788	1,768,469	6,640	13
14	32	Interest	Accumulated Cost B	86,768,654	17	183,166	1,768,469	3,733	14
15	33	Real Estate Taxes	Accumulated Cost B	86,768,654	17	65,528	1,768,469	1,336	15
16	34	Rent - facility & grounds	Accumulated Cost B	86,768,654	17	56,363	1,768,469	1,149	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,828,944	\$ 4,911,376	\$ 148,739	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Tax Exempt Bonds		X	Additions & Renovations	Varies	11/01/04	\$ 9,450,000	\$ 5,233,376	10/31/34	Variable	\$ 315,478	1						
2	Notes		X	Facility Improvements	Varies	Various	763,564	86,935	Various	Variable	800	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 10,213,564	\$ 5,320,311			\$ 316,278	9						
<b>B. Non-Facility Related*</b>																		
10											27,063	10						
11											(87,351)	11						
12											(9,508)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (69,796)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 10,213,564	\$ 5,320,311			\$ 246,482	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Providence Downers Grove COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028605

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 342-8100 FAX #: (708) 348-8006

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>19-09-01-203-007-1001</u>	<u>Home Office Building</u>	\$ <u>16,585.56</u>	\$ _____
2.	<u>19-09-01-203-007-1006</u>	<u>Home Office Building</u>	\$ <u>24,068.88</u>	\$ _____
3.	<u>19-09-01-203-007-1007</u>	<u>Home Office Building</u>	\$ <u>24,473.66</u>	\$ _____



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>29,200</u>	<u>1984</u>	<u>\$ 339,570</u>	1
2					2
3	<b>TOTALS</b>	<b>29,200</b>		<b>\$ 339,570</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	241	1984	1962	\$ 86,903	\$	40	\$	\$	\$ 86,903	4
5			1972	889,527	22,238	40	22,238		845,044	5
6			1976	34,742	869	40	869		32,153	6
7			1974	7,414	185	40	185		6,660	7
8			1975	55,878	1,397	40	1,397		48,895	8
	<b>Improvement Type**</b>									
9	Improvement		1976	4,115	103	40	103		3,502	9
10	Improvement		1977	33,527	838	40	838		27,654	10
11	Improvement		1980	6,049	151	40	151		4,530	11
12	Improvement		1981	7,380	185	40	185		5,365	12
13	Improvement		1983	22,839	571	40	571		15,417	13
14	Improvement		1984	253,714	9,250	40	9,250		212,903	14
15	Improvement		1985	297,491	7,437	40	7,437		185,925	15
16	Improvement		1986	275,406	6,885	40	6,885		165,240	16
17	Improvement		1987	24,035	601	40	601		13,823	17
18	Improvement		1988	509,896	12,747	40	12,747		280,434	18
19	Improvement		1989	4,381,420	109,536	40	109,536		2,300,256	19
20	Improvement		1989	90,660	2,267	40	2,267		47,607	20
21	Improvement		1990	155,196	3,880	40	3,880		77,600	21
22	Improvement		1991	5,021	126	40	126		2,394	22
23	Improvement		1992	75,453	1,886	40	1,886		33,948	23
24	Improvement		1993	26,281	657	40	657		11,169	24
25	Improvement		1994	16,231	405	40	405		6,480	25
26	Improvement		1995	128,962	3,224	40	3,224		46,748	26
27	Sign and landscaping		1996	4,764	119	40	119		1,607	27
28	Fence		1996	1,565	40	40	40		540	28
29	Renovate laundry and break rooms		1996	4,400	110	40	110		1,485	29
30	Whirlpool tubs		1996	20,200	505	40	505		6,817	30
31	Side rail		1996	2,293	57	40	57		770	31
32	Phone system		1996	35,085	877	40	877		19,662	32
33	Parking lot		1997	15,078	377	40	377		4,713	33
34	Landscaping		1997	10,839	271	40	271		3,387	34
35	Dining room renovation		1997	1,193	30	40	30		375	35
36			1997	34,830	871	40	871		10,887	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Activity / class room renovation	1997	\$ 3,476	\$ 87	40	\$ 87	\$	\$ 1,087	37
38	Carpeting	1997	1,521	38	40	38		475	38
39	Railing	1997	500	13	40	13		162	39
40	Laundry / break room renovation	1998	6,864	172	40	172		1,978	40
41	Compressor	1998	917	92	10	92		1,009	41
42	Roof repair	1998	2,320		10			2,320	42
43	Alarm system	1998	1,056		10			1,056	43
44	Hospitality room renovation	1998	12,605	316	40	316		3,634	44
45	Carpeting	1998	76,503		5			76,503	45
46	Wallpaper	1998	40,287		5			40,287	46
47	Roofing	1999	208,749	10,446	10	10,446		208,749	47
48	Therapy room renovation	1999	23,731	1,178	10	1,178		23,731	48
49	Resident room lighting	1999	23,965	1,196	10	1,196		23,965	49
50	Phone upgrade	1999	2,470	114	10	114		2,470	50
51	Renovations	1999	47,385	2,372	10	2,372		47,385	51
52	New door on oxygen room	1999	1,993	149	10	149		1,993	52
53	Landscaping	2000	59,350	1,484	40	1,484		14,098	53
54	Benches	2000	2,500	63	40	63		598	54
55	Room 18 renovation , wallcover, painting, tiling and carpet	2000	7,682	768	10	768		7,296	55
56	Therapy room renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		27,407	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		30,172	57
58	Common renovation, wallcover, painting, tiling and carpteing	2000	36,699	3,540	10	3,540		36,699	58
59	Kitchen renovation, wallcover, painting and tiling	2000	24,995	2,500	10	2,500		23,750	59
60	HVAC	2000	32,028	3,203	10	3,203		30,428	60
61	Doors	2000	3,300	330	10	330		3,135	61
62	Countertop	2000	654	65	10	65		618	62
63									63
64									64
65	Room renovation	2001	1,124,343	112,434	10	112,434		1,024,214	65
66	Rehab renovation	2001	82,557	9,808	10	8,256	(1,552)	74,056	66
67	Nurse call system	2001	114,755	11,476	10	11,476		97,546	67
68	Kitchen renovations	2001	3,800	380	10	380		3,230	68
69	HVAC	2001	3,000	300	10	300		2,550	69
70	TOTAL (lines 4 thru 69)		\$ 9,529,005	\$ 357,280		\$ 355,728	\$ (1,552)	\$ 6,323,494	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,529,005	\$ 357,280		\$ 355,728	\$ (1,552)	\$ 6,323,494	1
2	Doors	2001	3,187	319	10	319		2,711	2
3	Office remodeling	2001	35,071	3,507	10	3,507		29,810	3
4	HVAC	2001	28,200	2,820	10	2,820		23,970	4
5									5
6	landscaping	2002	25,539	2,554	10	2,554		19,155	6
7	Fence	2002	4,675	468	10	468		3,511	7
8	Nurse Call Station Renovation	2002	26,950	2,695	40	674	(2,021)	5,055	8
9	HVAC	2002	12,424	1,242	40	311	(931)	2,332	9
10									10
11	Renovations	2002	33,960	3,396	40	849	(2,547)	6,367	11
12	New Therapy Addition	2002	69,218	6,922	40	1,730	(5,192)	13,132	12
13	Landscaping	2001	10,400	1,040	40	260	(780)	1,950	13
14	Repair R3000 System	2002	3,922	98	40	98		735	14
15	Carpeting	2002	9,713	243	40	243		1,822	15
16	Bathroom remodeling	2003	12,350	618	20	618		4,017	16
17	Wallcoverings	2003	36,922	923	40	923		6,000	17
18	Floorcoverings	2003	42,356	1,059	40	1,059		6,883	18
19	Curtains and Blinds	2003	65,815	1,645	40	1,645		10,693	19
20	Landscaping and Fencing	2003	150,886	3,772	40	3,772		24,518	20
21	Parking, Curbs, and Sidewalks	2003	276,160	6,904	40	6,904		44,876	21
22	PT Wing / New Entry / New Admin. Offices	2003	1,754,047	55,699	40	43,852	(11,847)	290,961	22
23	Signage	2003	9,043	904	10	904		5,876	23
24	Gazebo	2003	5,436	272	20	272		1,666	24
25									25
26	Shelving	2003	1,328	133	10	133		864	26
27	Nurse call system	2004	33,450	3,345	10	3,345		18,398	27
28	Bath tub resurfacing	2004	4,750	238	20	238		1,309	28
29	Alzheimer Unit Renovation	2004	77,906	1,948	40	1,948		10,714	29
30	Fire Alarm	2004	1,795	180	10	180		1,028	30
31	Lighting	2004	501	50	10	50		286	31
32	Carpet	2004	2,374	237	10	237		1,355	32
33	Cabinets	2004	2,626	263	10	263		1,503	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,270,009	\$ 460,774		\$ 435,904	\$ (24,870)	\$ 6,864,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 12,270,009	\$ 460,774		\$ 435,904	\$ (24,870)	\$ 6,864,991	1
2	Water heater	2004	2,997	300	10	300		1,650	2
3	Dentist office	2004	8,981	224	40	224		1,232	3
4	Expansion	2004	1,928	48	40	48		264	4
5									5
6	Carpeting	2005	2,050	205	10	205		923	6
7	Thermostats	2005	4,500	300	15	300		1,350	7
8	Handrails	2005	1,375	92	15	92		414	8
9	Sidewalks	2005	10,927	546	20	546		2,457	9
10	Bath Tub Conversions	2005	5,700	390	15	390		1,750	10
11	Carpeting	2005	7,904	1,130	7	1,130		5,085	11
12	Chiller	2005	6,101	306	20	306		1,377	12
13	Paving	2005	19,642	982	20	982		4,419	13
14	Boilers & HVAC	2005	13,435	672	20	672		3,024	14
15	Storage Tank & Water Lines	2005	1,125	56	20	56		252	15
16	Chiller	2005	540	28	20	28		126	16
17	Carpeting	2005	3,040	434	7	434		1,953	17
18	Smoke Detectors	2005	2,316	116	20	116		522	18
19	Generator	2005	1,122	56	20	56		252	19
20									20
21	Asbestos Retirement Obligation - West	2006	39,569		7	5,652	5,652	19,782	21
22	Sirens - West	2006	3,063	438	7	438		1,533	22
23	Door Alarm System - West	2006	33,453	3,346	10	3,346		11,711	23
24	West Office Remodel - West	2006	19,770	988	20	988		3,458	24
25	Heat A/C Valve - West	2006	4,400	294	15	294		1,029	25
26	Grading & Sodding of Front lawn - West	2006	5,060	338	15	338		1,183	26
27	Asbestos Retirement Obligation - Saratoga Grove	2006	9,695	1,386	7	1,386		4,851	27
28	Boilers	2006	37,695	2,512	15	2,512		8,792	28
29	Reception area renovation	2006	6,500	434	15	434		1,519	29
30	Gift Shop Lighting & Fixtures	2006	29,057	1,452	20	1,452		5,082	30
31	Office & Exit Doors	2006	5,164	258	20	258		903	31
32	Carpeting	2006	7,138	1,102	7	1,020	(82)	3,570	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,564,256	\$ 479,207		\$ 459,907	\$ (19,300)	\$ 6,955,454	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 12,564,256	\$ 479,207		\$ 459,907	\$ (19,300)	\$ 6,955,454	1
2	Door Repair - West	2007	5,670	284	20	284		994	2
3	Phone System - West	2007	70,262	7,026	10	7,026		24,591	3
4	Boiler	2007	9,686	969	15	969		3,230	4
5	Electrical Work - West	2007	3,120	156	20	156		546	5
6	Door Alarm Enhancement - West	2007	16,695	1,670	10	1,670		5,845	6
7	A/C Unit - West	2007	11,550	770	15	770		2,695	7
8	Water Heater - West	2007	9,370	625	15	625		2,187	8
9	Carpeting for Resident Rooms - West	2007	3,221	460	7	460		1,610	9
10	Rooftop HVAC unit	2007	15,300	1,020	15	1,020		3,570	10
11	Phone System - Saratoga Grove	2007	46,842	4,684	10	4,684		16,394	11
12	Replace bathtubs in 11 resident rooms - Saratoga Grove	2007	5,500	367	15	367		1,284	12
13	A/C Valve & ductwork replacement - Saratoga Grove	2007	6,227	311	20	311		1,089	13
14	Carpeting for Resident Rooms - Saratoga Grove	2007	15,453	2,208	7	2,208		7,728	14
15									15
16	Outdoor Lighting - West	2008	2,538	169	15	169		254	16
17	Landscapitng - Junipers	2008	8,895	593	15	593		890	17
18	Enlarge Oxygen Room	2008	4,513	113	40	113		169	18
19	Replace doors - Interior Main & Dining Room	2008	14,560	728	20	728		1,092	19
20	Dining Room - Architect	2008	2,800	140	20	140		210	20
21	Phone System - Labor/Wiring	2008	6,029	603	10	603		904	21
22	#64 & #74 Vinyl Planking	2008	6,442	644	10	644		966	22
23	Carpeting (SG)	2008	62,031	8,862	7	8,862		13,293	23
24	Window Treatments (SG)	2008	7,210	1,030	7	1,030		1,545	24
25									25
26	Remove & Replace sewer under nurses supply room & bathroom	2008	16,545		10	1,655	1,655	2,482	26
27	Remove wallpaper, repair wall, install new rail, paint	2008	4,000		10	400	400	600	27
28									28
29	SG-security camera	2009	3,347		7	239	239	112	29
30	Canopy sprinklers	2009	21,850		20	546	546	546	30
31	Fire Doors	2009	13,630		40	170	170	170	31
32	Main Dining Room Roof	2009	22,667		10	1,133	1,133	1,133	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,980,209	\$ 512,639		\$ 497,482	\$ (15,157)	\$ 7,051,583	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,980,209	\$ 512,639		\$ 497,482	\$ (15,157)	\$ 7,051,583	1
2	Emergency Outlets - Generator	2009	13,200		20	330	330	330	2
3	Fire Sprinkler Updates	2009	3,275		10	164	164	164	3
4	Flooring	2009	141,155		10	7,057	7,057	7,057	4
5	Plumbing	2009	33,500		20	838	838	838	5
6	Brick work	2009	4,575		20	114	114	114	6
7	Generator	2009	10,500		20	262	262	262	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	Allocation from Home Office		621,993			27,698	27,698	118,879	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,808,407	\$ 512,639		\$ 533,945	\$ 21,306	\$ 7,179,227	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,479,863	\$ 9,749	\$ 80,238	\$ 70,489	3-10	\$ 3,316,299	71
72	Current Year Purchases	49,908	7,014	7,014		3-10	7,014	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office	624,172		19,905	19,905		522,028	74
75	TOTALS	\$ 4,153,943	\$ 16,763	\$ 107,157	\$ 90,394		\$ 3,845,341	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1984 Ford Bus	1989	\$ 47,590	\$	\$	\$	5	\$ 47,590	76
77	Resident care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78	Resident care	2009 Ford 12 Passenger Bus	2009	47,748	4,775	4,775			4,775	78
79	Allocation from home office			8,446		532	532		6,428	79
80	TOTALS			\$ 126,278	\$ 4,775	\$ 5,307	\$ 532		\$ 81,287	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)	\$ 18,428,198	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 534,177	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 646,409	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 112,232	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,105,855	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Home Office				8,328			6
7	TOTAL				\$ 8,328			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. \_\_\_\_\_ /2010                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012                      \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

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

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

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

16. Rental Amount for movable equipment: \$ 2,457 Description: Dietary Equipment

(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			<u>N/A</u>		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	7,665	\$	574,907	\$	7,665	\$	574,907	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,659		199,436		2,659		199,436	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A(2,3)	hrs		9,066		679,920		9,066		681,588	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					1,047,278			1,047,278	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify):											12	
13	Other (specify):											13	
14	<b>TOTAL</b>			\$	19,390	\$	1,454,263	\$	1,048,946	19,390	\$	2,503,209	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Downers Grove# 0028605Report Period Beginning: 01/01/2009

Ending:

12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 22,019	\$ 22,019	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>299,394</u> )	1,316,159	1,316,159	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,255	16,255	7
8	Accounts Receivable (owners or related parties)	6,851	6,851	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,361,284	\$ 1,361,284	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	15,159,877	13,808,407	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,724,207	4,280,221	16
17	Accumulated Depreciation (book methods)	(11,007,690)	(11,105,855)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 8,235,312	\$ 7,322,343	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,596,596	\$ 8,683,627	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 808,712	\$ 808,712	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,065	93,065	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,084	20,084	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Parties</u>	6,380,945	6,380,945	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,302,806	\$ 7,302,806	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	86,935	86,935	39
40	Mortgage Payable			40
41	Bonds Payable		5,233,376	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 86,935	\$ 5,320,311	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,389,741	\$ 12,623,117	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,206,855	\$ (3,939,490)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,596,596	\$ 8,683,627	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,050,027	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(166,429)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,883,598	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(676,743)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (676,743)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,206,855	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1		
Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 12,262,544	1	
2	Discounts and Allowances for all Levels	(2,825,693)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,436,851</b>	<b>3</b>	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	3,034,850	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,034,850</b>	<b>8</b>	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care	3,983	13	
14	Non-Patient Meals	14,474	14	
15	Telephone, Television and Radio	17,720	15	
16	Rental of Facility Space		16	
17	Sale of Drugs	1,018,068	17	
18	Sale of Supplies to Non-Patients	360,847	18	
19	Laboratory	86,006	19	
20	Radiology and X-Ray	80,899	20	
21	Other Medical Services	53,876	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,635,873</b>	<b>23</b>	
<b>D. Non-Operating Revenue</b>				
24	Contributions	4,500	24	
25	Interest and Other Investment Income***	9,508	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 14,008</b>	<b>26</b>	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Miscellaneous Income</b>	23,109	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 23,109</b>	<b>29</b>	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 14,144,691</b>	<b>30</b>	

		2		
Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	2,623,307	31	
32	Health Care	6,055,474	32	
33	General Administration	3,556,164	33	
<b>B. Capital Expense</b>				
34	Ownership	873,312	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,633,789	35	
36	Provider Participation Fee	79,388	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 14,821,434</b>	<b>40</b>	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(676,743)</b>	<b>41</b>	
42	<b>Income Taxes</b>		<b>42</b>	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (676,743)</b>	<b>43</b>	

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

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

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

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

Facility Name & ID Number Providence Downers Grove

# 0028605

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

12/31/2009

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	1,136	1,176	\$ 51,672	\$ 43.94	1
2	Assistant Director of Nursing	1,008	1,064	35,732	33.58	2
3	Registered Nurses	41,060	42,897	877,740	20.46	3
4	Licensed Practical Nurses	27,040	27,864	512,792	18.40	4
5	CNAs & Orderlies	114,409	123,297	1,672,714	13.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,080	44,766	21.52	9
10	Activity Assistants	12,402	13,431	208,138	15.50	10
11	Social Service Workers	7,954	8,371	188,980	22.58	11
12	Dietician	466	473	11,959	25.28	12
13	Food Service Supervisor	1,159	5,390	125,331	23.25	13
14	Head Cook	758	11,942	166,475	13.94	14
15	Cook Helpers/Assistants	30,859	32,005	340,631	10.64	15
16	Dishwashers					16
17	Maintenance Workers	11,327	12,213	177,905	14.57	17
18	Housekeepers	14,326	15,724	192,459	12.24	18
19	Laundry	1,932	2,059	25,097	12.19	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,280	1,360	49,730	36.57	23
24	Clerical	35,008	38,050	614,322	16.15	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	2,406	2,636	48,530	18.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	306,482	342,032	\$ 5,344,973 *	\$ 15.63	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	Monthly	\$ 1,832	1(3)	35
36	Medical Director	Monthly	16,128	9(3)	36
37	Medical Records Consultant	Monthly	2,730	10(3)	37
38	Nurse Consultant	Monthly	21,133	10(3)	38
39	Pharmacist Consultant	Monthly	1,740	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	840	11(3)	44
45	Social Service Consultant	Monthly	900		45
46	Other(specify) Chapel Ministry	Monthly	1,602	12(3)	46
47	Psychology Consultant	Monthly	450	12(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 47,355		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8,943	\$ 447,158	10(3)	50
51	Licensed Practical Nurses	807	28,260	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,750	\$ 475,418		53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jackie Terpstra	Administrator		\$ 142,415	Workers' Compensation Insurance	\$ 283,921	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	53,945	Advertising: Employee Recruitment	7,425	
				FICA Taxes	384,230	Health Care Worker Background Check		
				Employee Health Insurance	301,269	(Indicate # of checks performed 94 )	1,133	
Amounts paid out of Home Office allocated in column 7.				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	8,039	
				Employee Education	3,065	AAHSA Dues	3,349	
				Employee Welfare	56,782	Miscellaneous Licenses & Dues & Subs	5,695	
				Drug Testing	13,996	Chamber of Commerce	1,060	
				TDA Expense	64,410	Allocated from Home Office	2,332	
				Uniforms	5,305	Less: Public Relations Expense	(1,060)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 142,415	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,166,923	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,968	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (Eliminated in Col. 7)			\$ 1,268,322	N/A			Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,268,322				Seminar Expense	
							See Attached Schedule	3,574
C. Professional Services							Allocated From Home Office	16,362
Vendor/Payee	Type		Amount				Entertainment Expense	( )
Reed, Smith, Sachnoff & Weaver	Legal		\$ 9,137				(agree to Sch. V, line 24, col. 8)	
Myers, Miller & Krauskopf	Legal		3,898				TOTAL	\$ 19,936
Laner Muchin Dombrow Becker Lev	Legal		388					
Arch Consultants	Computer Services		4,929					
Life Services Network	Surveys		2,150					
KPMG	Accounting		9,360					
McGladrey & Pullen LLP	Accounting		11,045					
Environmental Systems Design Inc	Computer Services		83					
OSG Global	Computer Services		45,125					
Method Management	Surveys		3,250					
PEL VIP Medical Staffing	Employment Services		439					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 89,804	TOTAL		\$		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Providence Life Services**  
**Provider #: 0028605**  
**1/1/2009 to 12/31/2009**

**Schedule 21A**

XIX. SUPPORT SCHEDULE  
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	89,804
Plus: Home Office Allocation	11,648
Less: Reclassed cost	(899)
Total (agree to Schedule V, line 19, column 8)	<u>100,553</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Providence Downers Grove

# 0028605

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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 - \$8,039 ; AAHSA - \$3,349
- (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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,338 Line 10(2)
- (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. \$ 79,388  
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. \$ 14,474
- (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? 0
- 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. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**