

Facility Name & ID Number Providence Palos Heights

0007534 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	<u>95</u>	Skilled (SNF)	<u>95</u>	<u>34,675</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>98</u>	<u>35,770</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>193</u>	TOTALS	<u>193</u>	<u>70,445</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>16</u>	<u>23</u>	<u>24,656</u>	<u>24,695</u>	8	
9	SNF/PED					9	
10	ICF	<u>17,082</u>	<u>9,525</u>	<u>1</u>	<u>26,608</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>17,098</u>	<u>9,548</u>	<u>24,657</u>	<u>51,303</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.83%

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 02/01/1960

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 95 and days of care provided 21,971

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Providence Palos Heights # 0007534 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
	A. General Services										
1	Dietary	600,327	65,037	128,831	794,195		794,195		794,195		1
2	Food Purchase		476,743		476,743		476,743	19,291	496,034		2
3	Housekeeping	308,839	87,421		396,260		396,260		396,260		3
4	Laundry	104,009	18,380		122,389		122,389		122,389		4
5	Heat and Other Utilities			160,754	160,754		160,754	16,469	177,223		5
6	Maintenance	219,841		297,512	517,353		517,353	1,727	519,080		6
7	Other (specify):*										7
8	TOTAL General Services	1,233,016	647,581	587,097	2,467,694		2,467,694	37,487	2,505,181		8
	B. Health Care and Programs										
9	Medical Director			16,080	16,080		16,080		16,080		9
10	Nursing and Medical Records	4,095,579	741,961	6,138	4,843,678		4,843,678		4,843,678		10
10a	Therapy			1,908,168	1,908,168		1,908,168		1,908,168		10a
11	Activities	208,926	11,719		220,645		220,645		220,645		11
12	Social Services	181,325		5,093	186,418		186,418		186,418		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,485,830	753,680	1,935,479	7,174,989		7,174,989		7,174,989		16
	C. General Administration										
17	Administrative			1,261,958	1,261,958		1,261,958	(1,110,601)	151,357		17
18	Directors Fees										18
19	Professional Services			172,071	172,071		172,071	12,882	184,953		19
20	Dues, Fees, Subscriptions & Promotions			39,952	39,952		39,952	2,578	42,530		20
21	Clerical & General Office Expenses	459,635	81,351	63,324	604,310		604,310	675,116	1,279,426		21
22	Employee Benefits & Payroll Taxes			1,273,393	1,273,393		1,273,393		1,273,393		22
23	Inservice Training & Education			337	337		337		337		23
24	Travel and Seminar			3,161	3,161		3,161	17,945	21,106		24
25	Other Admin. Staff Transportation			1,996	1,996		1,996	3,789	5,785		25
26	Insurance-Prop.Liab.Malpractice			338,453	338,453		338,453	7,539	345,992		26
27	Other (specify):*							196,850	196,850		27
28	TOTAL General Administration	459,635	81,351	3,154,645	3,695,631		3,695,631	(193,902)	3,501,729		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,178,481	1,482,612	5,677,221	13,338,314		13,338,314	(156,415)	13,181,899		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.

Facility Name & ID Number

Providence Palos Heights

#0007534

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	
	D. Ownership											
30	Depreciation			424,697	424,697		424,697	90,301	514,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,702	167,702		167,702	(21,898)	145,804			32
33	Real Estate Taxes							10,707	10,707			33
34	Rent-Facility & Grounds							9,210	9,210			34
35	Rent-Equipment & Vehicles			3,072	3,072		3,072		3,072			35
36	Other (specify):*											36
37	TOTAL Ownership			595,471	595,471		595,471	88,320	683,791			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,244,536		1,244,536		1,244,536		1,244,536			39
40	Barber and Beauty Shops	7,899	1,547		9,446		9,446		9,446			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,668	105,668		105,668		105,668			42
43	Other (specify):* Non-allowable cost			744,655	744,655		744,655	(744,655)				43
44	TOTAL Special Cost Centers	7,899	1,246,083	850,323	2,104,305		2,104,305	(744,655)	1,359,650			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,186,380	2,728,695	7,123,015	16,038,090		16,038,090	(812,750)	15,225,340			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,036)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,008)	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	37,067	30		9
10	Interest and Other Investment Income	(51,828)	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	(13,087)	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	(150,000)	43		24
25	Fund Raising, Advertising and Promotional	(769)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(19,589)	43		28
29	Other-Attach Schedule See PG5A	(564,880)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (782,130)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,620)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (30,620)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (812,750)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Providence Palos Heights

ID# 0007534
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow non-allowable Lab Expense	\$ (58,723)	43	1
2	Disallow non-allowable X-Ray Expense	(75,019)	43	2
3	Disallow Interehab Physiatry	(120,767)	43	3
4	Disallow non-allowable residents welfare	(25,407)	43	4
5	Disallow non-allowable marketing expense	(274,020)	43	5
6	Disallow non-allowable accretion expense	(4,074)	43	6
7	Offset office income against related expense	(3,200)	43	7
8	Capitalize Repair costs in excess of \$2,500	(3,520)	6	8
9	Disallow undocumented travel expense	(150)	24	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	(564,880)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Providence Palos Heights# 0007534

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	(2,036)	21,327	0	0	0	0	0	0	0	0	0	19,291	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	16,469	0	0	0	0	0	0	0	0	0	16,469	5
6	Maintenance	(3,520)	5,247	0	0	0	0	0	0	0	0	0	1,727	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,556)	43,043	0	37,487	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(1,110,601)	0	0	0	0	0	0	0	0	0	(1,110,601)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,882	0	0	0	0	0	0	0	0	0	12,882	19
20	Fees, Subscriptions & Promotions	0	2,578	0	0	0	0	0	0	0	0	0	2,578	20
21	Clerical & General Office Expenses	(17,008)	692,124	0	0	0	0	0	0	0	0	0	675,116	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	(150)	18,095	0	0	0	0	0	0	0	0	0	17,945	24
25	Other Admin. Staff Transportation	0	3,789	0	0	0	0	0	0	0	0	0	3,789	25
26	Insurance-Prop.Liab.Malpractice	0	7,539	0	0	0	0	0	0	0	0	0	7,539	26
27	Other (specify):*	0	196,850	0	0	0	0	0	0	0	0	0	196,850	27
28	TOTAL General Administration	(17,158)	(176,744)	0	(193,902)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,714)	(133,701)	0	(156,415)	29								

STATE OF ILLINOIS

Facility Name & ID Number Providence Palos Heights

0007534

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)	
	D. Ownership													
30	Depreciation	37,067	0	53,234	0	0	0	0	0	0	0	0	90,301	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,828)	0	29,930	0	0	0	0	0	0	0	0	(21,898)	32
33	Real Estate Taxes	0	0	10,707	0	0	0	0	0	0	0	0	10,707	33
34	Rent-Facility & Grounds	0	0	9,210	0	0	0	0	0	0	0	0	9,210	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,761)	0	103,081	0	88,320	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):*	(744,655)	0	0	0	0	0	0	0	0	0	0	(744,655)	43
44	TOTAL Special Cost Centers	(744,655)	0	0	0	0	0	0	0	0	0	0	(744,655)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(782,130)	(133,701)	103,081	0	(812,750)	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.
		Rest Haven West	Downers Grove	Providence Mgmt. & Development Co.	Tinley Park	Management Co.
		Haven Park	Zeeland, MI	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%	\$ 21,327	\$ 21,327 1
2	V	5 Utilities		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	16,469	16,469 2
3	V	6 Maintenance-Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	5,247	5,247 3
4	V	17 Administrative	1,261,958	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	151,357	(1,110,601) 4
5	V	19 Professional Services		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	12,882	12,882 5
6	V	20 Dues,fees & subscriptions		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	2,578	2,578 6
7	V	21 Clerical & General-Salary		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	603,248	603,248 7
8	V	21 Clerical & General-Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	88,876	88,876 8
9	V	24 Travel & Seminar		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	18,095	18,095 9
10	V	25 Other admin. Staff transporation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	3,789	3,789 10
11	V	26 Insurance-prop,liab. & malpractice		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	7,539	7,539 11
12	V						
13	V	27 Mgmt allocation of EE benefits		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	196,850	196,850 13
14	Total		\$ 1,261,958			\$ 1,128,257	\$ * (133,701) 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	30 Depreciation	\$	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	\$ 53,234	\$	53,234	15
16	V	32 Interest expense		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	29,930		29,930	16
17	V	33 Real Estate taxes		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	10,707		10,707	17
18	V	34 Rent-facility & grounds		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	9,210		9,210	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		\$			\$ 103,081	\$ *	103,081	39

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

Facility Name & ID Number

Providence Palos Heights

0007534

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	No Board Members or businesses that they control has business dealings with the facility.											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights

0007534 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

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

Name of Related Organization Providence Mgmt & Development Co.
 Street Address 18601 North Creek Drive, Suite A
 City / State / Zip Code Tinley Park,IL 60477
 Phone Number (708) 342-8100
 Fax Number (708) 342-8006

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	\$ 14,178,092	\$ 21,327	1
2	5	Utilities	Accumulated Cost B	86,768,654	17	100,790	14,178,092	16,469	2
3									3
4	6	Maintenance	Accumulated Cost B	86,768,654	17	32,112	14,178,092	5,247	4
5									5
6	17	Administrative	Direct Cost A	86,768,654	1	1,219,555	1,219,555	14,178,092	151,357
7	19	Professional services	Accumulated Cost B	86,768,654	17	78,837	14,178,092	12,882	7
8	20	Dues, fees & subscriptions	Accumulated Cost B	86,768,654	17	15,780	14,178,092	2,578	8
9	21	Clerical & general - salary	Accumulated Cost B	86,768,654	17	3,691,821	3,691,821	14,178,092	603,248
10	21	Clerical & general - Other	Accumulated Cost B	86,768,654	17	543,911	14,178,092	88,876	10
11	24	Travel & seminar	Accumulated Cost B	86,768,654	17	110,742	14,178,092	18,095	11
12	25	Other Admin. Staff transportation	Accumulated Cost B	86,768,654	17	23,189	14,178,092	3,789	12
13	26	Insurance-prop.,liab. & malpract	Accumulated Cost B	86,768,654	17	46,139	14,178,092	7,539	13
14	27	Mgmt allocation of ee benefits	Accumulated Cost B	86,768,654	17	1,204,704	14,178,092	196,850	14
15	30	Depreciation	Accumulated Cost B	86,768,654	17	325,788	14,178,092	53,234	15
16	32	Interest expense	Accumulated Cost B	86,768,654	17	183,166	14,178,092	29,930	16
17	33	Real Estate taxes	Accumulated Cost B	86,768,654	17	65,525	14,178,092	10,707	17
18	34	Rent-facility & grounds	Accumulated Cost B	86,768,654	17	56,363	14,178,092	9,210	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,828,941	\$ 4,911,376	\$ 1,231,338	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Providence Palos Heights

0007534

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	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Tax Exempt Bonds		X	Mortgage & Additions	Varies	11/01/04	\$ 4,800,000	\$ 2,658,223	10/31/34	Variable	\$ 167,702	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 4,800,000	\$ 2,658,223			\$ 167,702	9							
B. Non-Facility Related*																			
10												10							
11										Disallow non-care related interest	(51,828)	11							
12										Allocated from Home Office	29,930	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (21,898)	14							
15	TOTALS (line 9+line14)						\$ 4,800,000	\$ 2,658,223			\$ 145,804	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ No 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.)

Facility Name & ID Number Providence Palos Heights

0007534

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,845 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).

None

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>441,662</u>	<u>1960</u>	<u>\$ 30,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	441,662		\$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	50			1960	\$ 341,041	\$	40	\$	\$	\$ 341,041	4
5	50			1962	122,119		40			122,119	5
6				1963	86,546		40			86,546	6
7	93			1967	585,862		40			585,862	7
8				1975	147,301	3,683	40	3,683		128,884	8
	Improvement Type**										
9	Improvements			1967	312,475		40			312,475	9
10	Improvements			1970	74,824	1,855	40	1,855		74,824	10
11	Improvements			1971	10,740	269	40	269		10,491	11
12	Improvements			1972	3,992	100	40	100		3,800	12
13	Improvements			1973	2,002	50	40	50		1,817	13
14	Improvements			1974	1,001	25	40	25		880	14
15	Improvements			1976	8,418	210	40	210		7,030	15
16	Improvements			1977	1,073	27	40	27		873	16
17	Improvements			1979	450	11	40	11		341	17
18	Improvements			1980	629	16	40	16		480	18
19	Improvements			1982	3,077	77	40	77		2,156	19
20	Improvements			1983	4,063	102	40	102		2,754	20
21	Improvements			1984	11,366	284	40	284		7,384	21
22	Improvements			1985	5,552	139	40	139		3,475	22
23	Improvements			1986	308,545	7,714	40	7,714		185,136	23
24	Improvements			1987	242,285	6,057	40	6,057		139,311	24
25	Improvements			1988	144,720	3,618	40	3,618		68,264	25
26	Improvements			1989	75,090	1,877	40	1,877		39,408	26
27	Improvements			1990	258,016	6,450	40	6,450		132,380	27
28	Improvements			1991	88,476	2,212	40	2,212		43,760	28
29	Improvements			1992	51,572	1,289	40	1,289		23,202	29
30	Improvements			1993	283,946	7,099	40	7,099		121,272	30
31	Improvements			1994	396,618	9,915	40	9,915		159,654	31
32	Improvements			1995	207,113	5,526	40	5,526		79,396	32
33	Improvements			1995	13,913	928	15	928		13,456	33
34	Parking Lot Expansion			1996	74,714	1,868	40	1,868		25,218	34
35	Wing C & D Renovations			1996	226,501	5,662	40	5,662		76,437	35
36				1996	279,308	6,982	40	6,982		94,257	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

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	Dental Office Renovations	1996	\$ 4,642	\$ 310	15	\$ 310	\$	\$ 4,185	37
38	Lighting System	1996	49,263	1,232	40	1,232		16,632	38
39	Architect Fees	1996	13,512	338	40	338		4,563	39
40	Alarm System	1996	4,704	314	15	314		4,239	40
41	Whirlpool Renovation	1996	11,914	794	15	794		10,719	41
42	Door	1996	656	44	15	44		594	42
43	Unit I & II Renovation	1996	22,981	574	40	574		7,749	43
44	Landscaping	1997	5,984	398	15	398		4,975	44
45	Unit I A & B remodel:Carpentry, elec. Plumb	1997	236,778	9,472	25	9,472		118,401	45
46	Unit I C & D remodel:Carpentry, elec. plumb.	1997	211,804	8,472	25	8,472		105,900	46
47	Unit I Whirlpool Renovation	1997	3,264	130	25	130		1,625	47
48	Unit II Whirlpool Renovation	1997	3,910	156	25	156		1,950	48
49	Plumbing	1997	1,595	64	25	64		800	49
50	Unit II Laundry Room Cabinets	1997	729	30	25	30		375	50
51	Chapel Roof	1997	8,750	350	25	350		4,375	51
52	Ramp Entrance	1997	32,456	1,298	25	1,298		16,225	52
53	Employee Patio	1997	3,975	159	25	159		1,988	53
54	Ramp Curbing	1997	1,396	56	25	56		700	54
55	Stairwell Doors	1997	1,833	74	25	74		925	55
56	Handicap Ramp	1997	12,166	486	25	486		6,075	56
57	Medical Supply Room Renovation	1997	20,773	830	25	830		10,375	57
58	Unit II A & B remodel:Carpentry, fire protection	1997	78,500	3,140	25	3,140		39,250	58
59	A & B Basement Remodeling	1997	2,331	94	25	94		1,175	59
60	Unit II Storage Room	1997	3,458	138	25	138		1,725	60
61	Unit I A & B remodel:Carpentry, elec., tile	1998	18,389	736	25	736		18,374	61
62	Unit II Handicap Ramp	1998	2,002	80	25	80		920	62
63	Unit II Storage Room	1998	8,807	352	25	352		4,048	63
64	Unit II A & B Bsmnt remodel:Carpty, elec, plumb.	1998	83,634	3,345	25	3,345		38,468	64
65	Unit I A & B remodel:Carpty,plmg, elec.	1998	19,906	796	25	796		9,154	65
66	Unit II A & B Bsmt remodel:Carpty & fire prot.	1998	10,676	427	25	427		4,911	66
67	Design Plan for Renovation	1998	706	28	25	28		322	67
68	Unit II A & B Bsmt remodel:Carpentry & fee	1998	2,314	93	25	93		1,069	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,257,156	\$ 108,855		\$ 108,855	\$	\$ 3,337,169	70

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	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	Totals from Page 12A, Carried Forward		\$ 5,257,156	\$ 108,855		\$ 108,855		\$ 3,337,169	1
2	Painting for Renovation	1998	3,873	154	25	154		1,771	2
3	Unit I A & B remodel:Carpty,& finishing	1998	20,171	806	25	806		9,269	3
4	Carpeting	1998	13,997		5			13,997	4
5	Unit I A & B remodel:Carpty, plmg, fire	1998	8,026	322	25	322		3,703	5
6	Unit II Patio /Alzheimer's Garden	1998	49,519	1,980	25	1,980		22,770	6
7	Hot Water Heater	1998	831	56	15	56		644	7
8	Roof	1998	991		10	(59)	(59)	991	8
9	A/C Circulator	1998	1,115	74	15	74		851	9
10	Chimney Vent	1998	519	20	25	20		230	10
11	Fascia	1998	789	32	25	32		368	11
12	Smoke Detectors	1998	1,081	72	15	72		828	12
13	Speed Bumps for Parking Lot	1998	781		5			781	13
14	Heating & Cooling System	1998	34,826	1,394	25	1,394		16,031	14
15	Nurses' Alarm System	1998	13,917	556	25	556		6,394	15
16	Piping	1998	682	28	25	28		322	16
17	Patio	1999	10,472	262	40	262		2,751	17
18	Carpeting	1999	6,283	317	10	317		6,283	18
19	Electrical Generator	1999	66,394	3,314	10	3,314		66,394	19
20	Wall Firestopping	1999	15,000	750	10	750		15,000	20
21	Interior design fee	1999	228	19	10	19		228	21
22	Electrical	1999	4,383	222	10	222		4,383	22
23	Wall Firestopping	1999	35,000	1,750	10	1,750		35,000	23
24	Switchboard	1999	5,696	281	10	281		5,696	24
25	Landscaping	1999	48,376	1,210	40	1,210		12,705	25
26	Parking Lot	1999	8,610	216	40	216		2,268	26
27	Air Conditioners	1999	80,030	3,992	40	3,992		80,030	27
28	Boiler Repairs	1999	9,060		10	452	452	9,060	28
29	Landscaping	2000	10,704	712	15	712		6,764	29
30	Patio Shelter	2000	5,150	256	20	256		2,432	30
31	Garden	2000	7,768	516	15	516		4,902	31
32	Benches	2000	958	94	10	94		893	32
33	Lobby remodel	2000	102,660	10,266	10	10,266		97,527	33
34	TOTAL (lines 1 thru 33)		\$ 5,825,046	\$ 138,526		\$ 138,919	\$ 393	\$ 3,768,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights

0007534

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	Totals from Page 12B, Carried Forward		\$ 5,825,046	\$ 138,526		\$ 138,919	\$ 393	\$ 3,768,435	1
2	Dining Room Renovation	2000	6,269	416	15	416		3,952	2
3	Wing Renovation	2000	102,095	2,552	40	2,552		24,244	3
4	Boiler and Pump	2000	10,450	696	15	696		6,612	4
5	Ansul	2000	3,728	248	15	248		2,356	5
6	Generator	2000	8,629	430	20	430		4,085	6
7	Fire Alarm System	2000	10,135	252	40	252		2,394	7
8	Exhaust Fan	2000	2,780	184	15	184		1,748	8
9	Landscaping	2001	5,680		5			5,680	9
10	Lobby remodel	2001	41,806	1,045	40	1,045		8,883	10
11	A-Wing remodel	2001	51,393	1,285	40	1,285		10,923	11
12	Sinks	2001	5,165	344	15	344		2,924	12
13	Doors	2001	5,278	352	15	352		2,992	13
14	Ejector Pump	2001	9,674	645	15	645		5,483	14
15	Automatic door	2001	4,817		7			4,817	15
16	Dining Room Renovation	2001	3,076		7			3,076	16
17	Exam Room Decoration	2001	14,068		7			14,068	17
18	Sewage Pump	2002	718	48	15	48		360	18
19	Whirlpool renovation	2002	2,177	145	15	145		1,088	19
20	Roof renovation	2002	90,250	9,025	10	9,025		67,688	20
21	Code Alert	2002	3,164	316	10	316		2,370	21
22	Firestopping work	2002	3,108	78	40	78		585	22
23	Dining Room Renovation	2002	135,527	3,388	40	3,388		25,410	23
24	Cabinets	2002	4,928	352	7	352		4,928	24
25	Blinds	2002	1,045	76	7	76		1,045	25
26	File cabinets	2002	2,327	169	7	169		2,327	26
27	Furniture	2002	1,814	130	7	130		1,814	27
28	Dining Room Renovation	2003	17,358	2,480	7	2,480		15,985	28
29	Lights	2003	20,442	1,022	20	1,022		6,643	29
30	Roof renovation	2003	152,000	15,200	10	15,200		98,800	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,544,947	\$ 179,404		\$ 179,797	\$ 393	\$ 4,101,715	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	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	Totals from Page 12C, Carried Forward		\$ 6,544,947	\$ 179,404		\$ 179,797	\$ 393	\$ 4,101,715	1
2	Menu boards	2003	2,160	216	10	216		1,404	2
3	Carpeting	2003	5,957	851	7	851		5,532	3
4	Sliding doors	2003	2,100	210	10	210		1,365	4
5	Wander system	2003	21,630	1,082	20	1,082		7,543	5
6									6
7	Tile	2004	24,492	2,450	10	2,450		13,475	7
8	Door	2004	4,579	458	10	458		2,519	8
9	Basement restroom	2004	37,076	927	40	927		6,489	9
10	Lights/shades	2004	3,562	178	20	178		1,246	10
11	Awning	2004	10,790	1,079	10	1,079		5,935	11
12	Shades	2004	1,960	280	7	280		1,540	12
13	Exit ramps	2004	5,450	363	15	363		1,997	13
14									14
15	Fire Door	2005	5,637	564	10	564		2,538	15
16	Storm Sewer improvements	2005	42,800	2,140	20	2,140		9,630	16
17	Water Heaters	2005	8,808	588	15	588		2,646	17
18	Patio and Major Landscaping Improvements	2005	16,805	1,120	15	1,120		5,040	18
19	Lights	2005	16,708	836	20	836		3,762	19
20	Unit 1 basement Improvements	2005	4,165	208	20	208		936	20
21	Elevator	2005	28,163	1,408	20	1,408		6,336	21
22	Unit 1 basement windows	2005	7,750	194	40	194		873	22
23	Wallpaper	2005	8,185	1,170	7	1,170		5,265	23
24	Baseboards	2005	1,078	154	7	154		693	24
25	Dock flooring	2005	2,000	286	7	286		1,287	25
26	Window Coverings	2005	13,162	1,880	7	1,880		8,460	26
27	5 Ton 3 Phase Condensing Unit	2005	2,696	135	20	135		607	27
28	Carpeting	2005	1,254	63	20	63		283	28
29	Electric Door Unit	2005	1,087	54	20	54		243	29
30	PC Disposer	2005	2,699	135	20	135		607	30
31	Electric Door Unit	2005	1,529	76	20	76		342	31
32	Nurse Call System	2005	7,749	387	20	387		1,742	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,836,978	\$ 198,896		\$ 199,289	\$ 393	\$ 4,202,050	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	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	Totals from Page 12D, Carried Forward		\$ 6,836,978	\$ 198,896		\$ 199,289	\$ 393	\$ 4,202,050	1
2	Parking Lot Lights	2005	2,940	196	15	196		882	2
3	Patio & Drainage Improvements	2005	10,958	731	15	731		3,289	3
4	Driveway	2005	29,377	1,469	20	1,469		6,610	4
5	Elevator	2006	18,897	472	20	472		1,888	5
6	Security Alarm System	2006	115,751	5,788	10	5,788		23,152	6
7	Nurse Call System	2006	123,550	8,825	7	8,825		35,300	7
8	5 Ton Rooftop Water Heater/Circulation Pump	2006	10,954	365	15	365		1,460	8
9	Asbestos Retirement Obligation	2006	97,309	6,951	7	6,951		27,804	9
10	Whirlpool Tub	2006	41,350	1,378	15	1,378		5,512	10
11	CSH Heating Unit	2006	3,750	125	15	125		500	11
12	Dock Door	2006	3,959	99	20	99		396	12
13	Central Air Unit	2006	5,677	189	15	189		756	13
14	Auto Door Opener	2006	2,200	110	10	110		440	14
15	New Phone System	2007	99,032	9,903	10	9,903		24,758	15
16	Cabnets Remodel	2007	4,686	312	15	312		780	16
17	Front Desk Cabinets	2007	13,428	671	20	671		1,678	17
18	Sump Pump	2007	9,240	616	15	616		1,540	18
19	Fire Panel	2007	16,950	1,695	10	1,695		4,238	19
20	HVAC Fixed	2007	11,325	755	15	755		1,888	20
21	Door Installed	2007	3,320	221	15	221		553	21
22	Outlets	2007	10,620	2,655	2	2,655		10,620	22
23	Foyer Windows and Cabinets	2007	5,530	277	20	277		692	23
24	Boiler Repairs	2007	114,664	7,644	15	7,644		19,110	24
25	Dinning Windows & Kickplates	2007	4,894	245	20	245		612	25
26	Waterproof Basement	2007	3,300	220	15	220		550	26
27	Doors and Cabinets Installed	2007	6,572	329	20	329		822	27
28	HVAC C&D Wing Piping	2007	85,642	2,141	40	2,141		5,353	28
29	Audio Station, Shades, Control Box	2007	3,168	453	7	453		1,132	29
30	Sign Repair	2007	2,840		20	142	142	355	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,698,861	\$ 253,731		\$ 254,266	\$ 535	\$ 4,384,720	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	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	Totals from Page 12E, Carried Forward		\$ 7,698,861	\$ 253,731		\$ 254,266	\$ 535	\$ 4,384,720	1
2									2
3	Unit 2 lobby - remove wall & replace flooring	2008	19,750	495	40	495		742	3
4	Install sprinkler system in Chapel	2008	23,175	580	40	580		870	4
5	Elec. Units - 2 carts	2008	5,240	262	20	262		393	5
6	HVAC - fan coils	2008	42,386	2,120	20	2,120		3,180	6
7	A/C unit	2008	5,292	264	20	264		396	7
8									8
9	Pipe railings	2008	5,298	354	15	354		531	9
10	Insulate hot water piping	2008	4,348	290	15	290		435	10
11	Commercial doors	2008	9,360	624	15	624		936	11
12	Reconnect new RTU and replace air handlers	2008	39,719	2,648	15	2,648		3,972	12
13	5 ton HVAC - rooftop unit	2008	9,788	652	15	652		978	13
14									14
15	Unit 2 lobby - carpeting	2008	14,161	2,024	7	2,024		3,036	15
16	Wallpaper	2008	9,000	1,286	7	1,286		1,929	16
17									17
18	Central-Wander alarm	2009	131,334	6,567	10	6,567		6,567	18
19	Unit 2 Waterproofing	2009	4,365	146	15	146		146	19
20	Central Egress doors	2009	10,735	268	20	268		268	20
21	Chimmney Tuckpointing	2009	7,000	175	20	175		175	21
22	Dining Room Lighting	2009	6,777	169	20	169		169	22
23	Emergency Phone	2009	3,168	226	7	226		226	23
24	Facility Signage	2009	3,628	181	10	181		181	24
25	Facility Signage	2009	13,033	652	10	652		652	25
26	Tile Flooring	2009	10,785	270	20	270		270	26
27	Signage	2009	8,059	403	10	403		403	27
28	Painting-Lobby	2009	15,100	1,079	7	1,079		1,079	28
29	Asbestos removal	2009	3,520		7	251	251	251	29
30									30
31									31
32									32
33	Allocation from Home Office	2009	687,878			30,631	30,631	131,471	33
34	TOTAL (lines 1 thru 33)		\$ 8,791,760	\$ 275,466		\$ 306,883	\$ 31,417	\$ 4,543,976	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	\$ 2,101,304	\$ 135,602	\$ 171,883	\$ 36,281	Various	\$ 1,743,901	71
72	Current Year Purchases	143,752	13,629	13,629		3-10	13,629	72
73	Fully Depreciated Assets	2,493,580					2,493,580	73
74	Allocation from Home Office	690,288		22,014	22,014		577,324	74
75	TOTALS	\$ 5,428,924	\$ 149,231	\$ 207,526	\$ 58,295		\$ 4,828,434	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	Allocation from Home Office			\$ 9,341	\$	\$ 589	\$ 589		\$ 7,109	76
77										77
78										78
79										79
80	TOTALS			\$ 9,341	\$	\$ 589	\$ 589		\$ 7,109	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)	\$ 14,260,025	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 424,697	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 514,998	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 90,301	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,379,519	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			93
94			94
95		\$	95

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

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

Facility Name & ID Number Providence Palos Heights

0007534

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Home Office</u>				<u>9,210</u>			6
7	TOTAL				\$ <u>9,210</u>			7

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

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

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

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: \$ 3,072

Description: Dietary Eqpt - \$3.072

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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	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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	15,014	\$ 900,830	\$	15,014	\$ 900,830	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,279	256,748		4,279	256,748	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,510	750,590		12,510	750,590	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 prescripts				1,244,536		1,244,536	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			\$	31,803	\$ 1,908,168	\$ 1,244,536	31,803	\$ 3,152,704	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 Palos Heights

0007534

Report 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,500	\$ 1,500	1
2	Cash-Patient Deposits	6,550	6,550	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,278,956	3,278,956	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,355	7,355	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,294,361	\$ 3,294,361	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	30,000	13
14	Buildings, at Historical Cost	8,104,278	8,791,760	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,831,204	5,438,265	16
17	Accumulated Depreciation (book methods)	(10,321,535)	(9,379,519)	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)	\$ 2,643,947	\$ 4,880,506	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,938,308	\$ 8,174,867	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,154,784	\$ 1,154,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,550	6,550	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,934	84,934	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,047	33,047	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/from Related Entities	4,803,801	4,803,801	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,083,116	\$ 6,083,116	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,658,223	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Long-Term Liabilities	139,889	139,889	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 139,889	\$ 2,798,112	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,223,005	\$ 8,881,228	46
47	TOTAL EQUITY(page 18, line 24)	\$ (284,697)	\$ (706,361)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,938,308	\$ 8,174,867	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 243,767	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(52,171)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 191,596	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(476,293)	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)	\$ (476,293)	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)	\$ (284,697)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights

0007534

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,974,329	1
2	Discounts and Allowances for all Levels	(2,793,499)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,180,830	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,886,740	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,886,740	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,036	14
15	Telephone, Television and Radio	17,008	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,173,947	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,466	19
20	Radiology and X-Ray	46,265	20
21	Other Medical Services	118,691	21
22	Laundry	2,629	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,467,042	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	27,185	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,185	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,561,797	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,467,694	31
32	Health Care	7,174,989	32
33	General Administration	3,695,631	33
B. Capital Expense			
34	Ownership	595,471	34
C. Ancillary Expense			
35	Special Cost Centers	1,998,637	35
36	Provider Participation Fee	105,668	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,038,090	40
41	Income before Income Taxes (line 30 minus line 40)**	(476,293)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (476,293)	43

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

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

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

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

Facility Name & ID Number Providence Palos Heights

0007534

Report Period Beginning:

01/01/2009

Ending:

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	1,928	2,080	\$ 95,232	\$ 45.78	1
2	Assistant Director of Nursing	1,984	2,112	63,564	30.10	2
3	Registered Nurses	34,766	36,453	1,047,403	28.73	3
4	Licensed Practical Nurses	45,116	46,546	1,064,917	22.88	4
5	CNAs & Orderlies	117,137	127,726	1,764,410	13.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,080	36,173	17.39	9
10	Activity Assistants	13,026	13,881	172,753	12.45	10
11	Social Service Workers	9,503	9,884	181,325	18.35	11
12	Dietician	2,492	2,549	62,105	24.36	12
13	Food Service Supervisor	1,383	2,882	86,649	30.07	13
14	Head Cook	7,051	7,446	94,545	12.70	14
15	Cook Helpers/Assistants	34,739	35,995	357,028	9.92	15
16	Dishwashers					16
17	Maintenance Workers	11,695	12,474	219,841	17.62	17
18	Housekeepers	24,110	25,755	308,839	11.99	18
19	Laundry	8,064	8,609	104,009	12.08	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,400	1,400	33,811	24.15	23
24	Clerical	29,006	30,517	425,824	13.95	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	4,023	4,224	60,053	14.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beautician</u>	585	639	7,899	12.36	33
34	TOTAL (lines 1 - 33)	350,000	373,252	\$ 6,186,380 *	\$ 16.57	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	\$ 128,831	1(3)	35
36	Medical Director	Monthly	16,080	9(3)	36
37	Medical Records Consultant	Monthly	5,070	10(3)	37
38	Nurse Consultant	Monthly	264	10(3)	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	Monthly	2,793	12(2)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 153,038		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9	\$ 468	10(3)	50
51	Licensed Practical Nurses	8	336	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	17	\$ 804		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	
Carol Shaw Burns	Administrator	0	\$ 151,357	Workers' Compensation Insurance	\$ 336,541	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	93,368	Advertising: Employee Recruitment	1,676	
				FICA Taxes	449,344	Health Care Worker Background Check		
				Employee Health Insurance	264,396	(Indicate # of checks performed 98)	1,170	
				Employee Meals		Patient Background Checks	61 733	
				Illinois Municipal Retirement Fund (IMRF)*		JCAHO Expense	18,120	
				Employee Education	1,901	Life Services Network Dues	10,532	
				Employee Welfare	51,776	Miscellaneous Dues	1,349	
				Drug Testing	7,186	Miscellaneous Subscriptions	5,377	
				TDA Expense	68,881	Allocated from Home Office	2,578	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
Amount paid out of home office, allocated in column 7								
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 151,357	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,273,393		\$ 42,530		
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)			\$ 1,261,958	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	3,011
							Allocated from Home Office	18,095
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,261,958	TOTAL			(agree to Sch. V, line 24, col. 8)	
				\$		\$ 21,106		
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21A			\$ 172,071					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 172,071					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Rest Haven Illiana Christian
Provider #: 0007534
1/1/2008 to 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Laner, Muchin, Dombrow, Becker, Levin & Tominberg, LTD	Legal	46,370
Ed Fox & Associates	Legal	30,288
Michelle Woodard	Legal	29,712
Myers, Miller & Krauskopf	Legal	5,288
Reed Smith LLP	Legal	10,088
Reverse Prior Year Accrual	Legal	(7,108)
McGladrey & Pullen LLP	Accounting	14,827
Life Services Network	Surveys	2,075
Method Management	Surveys	3,250
Jackson Wabash	Employee Recruitment	24,079
Environmental System Designs	Computer Services	83
Arlington Resources	Employee Recruitment	13,119
Total (agree to Schedule V, line 19, column 3)		<u>172,071</u>
Plus: Allocated from Home Office		12,882
Total (agree to Schedule V, line 19, column 8)		<u><u>184,953</u></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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					5 FY2006	6 FY2007	7 FY2008	8 FY2009	9 FY2010	10 FY2011	11 FY2012	12 FY2013	13 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights

0007534

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 - \$10,532
- (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? 6.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 169,865 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. \$ 105,668
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,036
- (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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (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