



Facility Name & ID Number Providence South Holland

# 0023242 Report Period Beginning: 01/01/09 Ending: 12/31/09

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>171</u>	Skilled (SNF)	<u>171</u>	<u>62,415</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>171</u>	TOTALS	<u>171</u>	<u>62,415</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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>14,372</u>	<u>10,257</u>	<u>20,927</u>	<u>45,556</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,372</u>	<u>10,257</u>	<u>20,927</u>	<u>45,556</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.99%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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 02/02/1977

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

YES  Date N/A NO

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

YES  NO  If YES, enter number of beds certified 171 and days of care provided 19,501

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: 01/01/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Providence South Holland # 0023242 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	392,765	85,745	85,749	564,259		564,259		564,259		1
2	Food Purchase		354,098		354,098		354,098	19,272	373,370		2
3	Housekeeping	203,228	88,501		291,729		291,729		291,729		3
4	Laundry	154,777	22,471		177,248		177,248	(1,575)	175,673		4
5	Heat and Other Utilities			176,158	176,158		176,158	14,932	191,090		5
6	Maintenance	218,669		297,372	516,041		516,041	4,757	520,798		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>969,439</b>	<b>550,815</b>	<b>559,279</b>	<b>2,079,533</b>		<b>2,079,533</b>	<b>37,386</b>	<b>2,116,919</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,198	17,198		17,198		17,198		9
10	Nursing and Medical Records	3,581,954	685,222	149,675	4,416,851		4,416,851		4,416,851		10
10a	Therapy		32,186	2,054,996	2,087,182		2,087,182		2,087,182		10a
11	Activities	290,879	15,286		306,165		306,165		306,165		11
12	Social Services	107,999	132	5,710	113,841		113,841		113,841		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,980,832</b>	<b>732,826</b>	<b>2,227,579</b>	<b>6,941,237</b>		<b>6,941,237</b>		<b>6,941,237</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			1,212,896	1,212,896		1,212,896	(1,079,887)	133,009		17
18	Directors Fees										18
19	Professional Services			132,774	132,774		132,774	9,734	142,508		19
20	Dues, Fees, Subscriptions & Promotions			23,799	23,799		23,799	2,338	26,137		20
21	Clerical & General Office Expenses	467,040	54,386	43,897	565,323		565,323	624,716	1,190,039		21
22	Employee Benefits & Payroll Taxes			1,084,927	1,084,927		1,084,927		1,084,927		22
23	Inservice Training & Education			9,068	9,068		9,068		9,068		23
24	Travel and Seminar			5,871	5,871		5,871	15,868	21,739		24
25	Other Admin. Staff Transportation							3,435	3,435		25
26	Insurance-Prop.Liab.Malpractice			240,403	240,403		240,403	6,835	247,238		26
27	Other (specify):* <b>Home Office Benefits</b>							178,471	178,471		27
28	<b>TOTAL General Administration</b>	<b>467,040</b>	<b>54,386</b>	<b>2,753,635</b>	<b>3,275,061</b>		<b>3,275,061</b>	<b>(238,490)</b>	<b>3,036,571</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,417,311</b>	<b>1,338,027</b>	<b>5,540,493</b>	<b>12,295,831</b>		<b>12,295,831</b>	<b>(201,104)</b>	<b>12,094,727</b>		<b>29</b>

\*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 &amp; ID Number

Providence South Holland

#0023242

Report Period Beginning:

01/01/09

Ending:

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## 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			486,110	486,110		486,110	93,236	579,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			141,491	141,491		141,491	(11,204)	130,287			32
33	Real Estate Taxes							9,708	9,708			33
34	Rent-Facility & Grounds							8,350	8,350			34
35	Rent-Equipment & Vehicles			1,321	1,321		1,321		1,321			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			628,922	628,922		628,922	100,090	729,012			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,146,888		1,146,888		1,146,888		1,146,888			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,940	94,940		94,940		94,940			42
43	Other (specify):* <b>Non-allowable cost</b>			534,416	534,416		534,416	(534,416)				43
44	<b>TOTAL Special Cost Centers</b>		1,146,888	629,356	1,776,244		1,776,244	(534,416)	1,241,828			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,417,311	2,484,915	6,798,771	14,700,997		14,700,997	(635,430)	14,065,567			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	(64)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,575)	4		8
9	Non-Straightline Depreciation	44,972	30		9
10	Interest and Other Investment Income				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	(20,000)	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	(120,000)	43		24
25	Fund Raising, Advertising and Promotional	(6,678)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,489)	43		28
29	Other-Attach Schedule See PG5A	(429,860)	Vari.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (534,694)		\$	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)	(100,736)	Vari.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (100,736)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (635,430)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Providence South Holland

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income Offset	\$ (2,789)	21	1
2	Disallow Labs - Part A	(84,702)	43	2
3	Disallow Interehab Physiatry	(14,400)	43	3
4	Disallow Resident Welfare	(7,577)	43	4
5	Disallow Marketing Allocation	(273,456)	43	5
6	Disallow Accretion Expense	(6,114)	43	6
7	Disallow Interest Swap Expense	(38,339)	32	7
8	Out-of-State Seminar	(538)	24	8
9	Non-supported Legal Exp	(1,945)	19	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
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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>	(429,860)		49

**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
<u>Rest Haven Illianna Christian Convalescent Home</u>	<u>100</u>	<u>Rest Haven Central</u>	<u>Palos Heights</u>	<u>Holland Home</u>	<u>South Holland</u>	<u>Independent Ret.</u>
		<u>Rest Haven West</u>	<u>Downers Grove</u>	<u>Village Woods</u>	<u>Crete</u>	
		<u>Haven Park</u>	<u>Zeeland,MI</u>	<u>Providence Mgmt. &amp; Development Co.</u>	<u>Tinley Park</u>	<u>Management Co.</u>
		<u>Plymouth Place</u>	<u>LaGrange Park, IL</u>	<u>Providence Home</u>		
				<u>Health Care</u>	<u>Tinley Park</u>	<u>Home Health</u>
				<u>Saratoga Grove</u>	<u>Downers Grove</u>	<u>Supportive Living</u>

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	2 <u>Food</u>	\$	<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	\$ 19,336	\$ 19,336	1
2	V	5 <u>Utilities</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	14,932	14,932	2
3	V	6 <u>Maintenance</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	4,757	4,757	3
4	V	17 <u>Administrative</u>	1,212,896	<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	133,009	(1,079,887)	4
5	V	19 <u>Professional services</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	11,679	11,679	5
6	V	20 <u>Dues, fees &amp; subscriptions</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	2,338	2,338	6
7	V	21 <u>Clerical &amp; general - salary</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	546,927	546,927	7
8	V	21 <u>Clerical &amp; General office expense</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	80,578	80,578	8
9	V	24 <u>Travel &amp; seminar</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	16,406	16,406	9
10	V	25 <u>Other admin. Staff transportation</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	3,435	3,435	10
11	V	26 <u>Insurance-prop., liab. &amp; malpractice</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	6,835	6,835	11
12	V	27 <u>Management allocation of employee benefits</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	178,471	178,471	12
13	V	30 <u>Depreciation</u>		<u>Rest Haven Illiana Christian D/B/A Providence Life Services</u>	100.00%	48,264	48,264	13
14	Total		\$ 1,212,896			\$ 1,066,967	\$ * (145,929)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest expense	\$	Rest Haven Illiana Christian	100.00%	\$ 27,135	\$	27,135	15
16	V	33 Real estate taxes		Rest Haven Illiana Christian	100.00%	9,708		9,708	16
17	V	34 Rent - facility & grounds		Rest Haven Illiana Christian	100.00%	8,350		8,350	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		\$			\$ 45,193	\$ *	45,193	39

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

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# 0023242

Report Period Beginning:

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## 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	N/A - Voluntary Board with no compensation. See attached Schedule 7A										2
3	The board members do not conduct business with the organization.										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence South Holland

# 0023242

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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 R.H. Illiana Christ. D/B/A Providence Life Svcs  
 Street Address 18601 North Creek Drive  
 City / State / Zip Code Tinsley 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	\$ 12,854,387	\$ 19,336	1
2	5	Utilities	Accumulated Cost B	86,768,654	17	100,790	12,854,387	14,932	2
3	6	Maintenance	Accumulated Cost B	86,768,654	17	32,112	12,854,387	4,757	3
4	17	Administrative	Direct Cost A	1	17	1,219,555	1,219,555	1	133,009
5	19	Professional services	Accumulated Cost B	86,768,654	17	78,837	12,854,387	11,679	5
6	20	Dues, fees & subscriptions	Accumulated Cost B	86,768,654	1	15,780	12,854,387	2,338	6
7	21	Clerical & general - salary	Accumulated Cost B	86,768,654	17	3,691,821	3,691,821	546,927	7
8	21	Clerical & General office expense	Accumulated Cost B	86,768,654	17	543,911	12,854,387	80,578	8
9	24	Travel & seminar	Accumulated Cost B	86,768,654	17	110,742	12,854,387	16,406	9
10	25	Other admin. Staff transportation	Accumulated Cost B	86,768,654	17	23,189	12,854,387	3,435	10
11	26	Insurance-prop., liab. & malpracti	Accumulated Cost B	86,768,654	17	46,139	12,854,387	6,835	11
12	27	Management allocation of employ	Accumulated Cost B	86,768,654	17	1,204,704	12,854,387	178,471	12
13	30	Depreciation	Accumulated Cost B	86,768,654	17	325,788	12,854,387	48,264	13
14	32	Interest expense	Accumulated Cost B	86,768,654	17	183,166	12,854,387	27,135	14
15	33	Real estate taxes	Accumulated Cost B	86,768,654	17	65,528	12,854,387	9,708	15
16	34	Rent - facility & grounds	Accumulated Cost B	86,768,654	17	56,363	12,854,387	8,350	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	\$ 1,112,160	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

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# 0023242

Report Period Beginning:

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Ending:

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**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Individual Notes		X	Building Improvements	Varies	Varies	\$ 70,321	\$ 25,321	Varies	Varies	\$ 1,279	1							
2	Tax Exempt Bonds		X	Building	Varies	11/01/04	4,200,000	2,325,945	10/31/2034	Varies	140,212	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 4,270,321	\$ 2,351,266			\$ 141,491	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11									Less Interest swap expense		(38,339)	11							
12									Allocation from Home Office		27,135	12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (11,204)	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 4,270,321	\$ 2,351,266			\$ 130,287	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.)





Facility Name & ID Number Providence South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 65,000 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: \_\_\_\_\_  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>Not Available</u>	<u>1976</u>	<u>\$ 31,305</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 31,305</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**Rest Haven South Christian Nursing Home**

**Provider #: 0023242**

**1/1/2009 to 12/31/2009**

**Schedule 11A**

**Disclosure:**

Transferred building to a single member LLC, Christian Living Campus, NFP.  
All intercompany income and expenses have been eliminated.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name &amp; ID Number Providence South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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	171		1977	1977	\$ 2,657,266	\$	40	\$ 66,432	\$ 66,432	\$ 2,123,135	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Landscaping Improvements	1977		19,723		20			19,723	9
10		Building Improvements	1978		7,401		40	185	185	3,929	10
11		Land Improvements	1981		2,535		20			2,535	11
12		Building Improvements	1982		8,179		40	204	204	5,533	12
13		Building Improvements	1983		4,035		40	101	101	2,636	13
14		Land Improvements	1984		7,625		20			7,625	14
15		Building Improvements	1985		2,029		40	51	51	1,229	15
16		Building Improvements	1986		49,092		40	1,227	1,227	28,452	16
17		Building Improvements	1987		48,670		40	1,217	1,217	27,028	17
18		Land Improvements	1987		4,898		20			4,898	18
19		Building Improvements	1988		21,602		40	540	540	11,468	19
20		Land Improvements	1988		1,600		20			1,600	20
21		Building Improvements	1898		561,415		40	14,035	14,035	285,931	21
22		Land Improvements	1898		9,437		20	331	331	9,437	22
23		Building Improvements	1990		98,412		40	2,460	2,460	47,448	23
24		Building Improvements	1991		74,357		40	1,859	1,859	34,041	24
25		Building Improvements	1992		168,370		40	4,209	4,209	72,971	25
26		Land Improvements	1992		13,785		20	689	689	11,963	26
27		Building Improvements	1994		24,717		40	618	618	9,509	27
28		Building Improvements	1995		52,042		40	1,301	1,301	18,864	28
29		Land Improvements	1995		10,722		20	536	536	7,772	29
30		Landscaping	1996		20,214		20	1,010	1,010	13,333	30
31		Building Redecorating	1996		15,578		40	390	390	5,405	31
32		Building Improvement - Ceiling	1996		25,000		40	625	625	8,177	32
33		Building Improvements - HVAC	1996		5,000		40	125	125	1,635	33
34		Landscaping	1997		27,690		20	1,349	1,349	17,038	34
35		Building Resident Room Redecorating	1997		64,348		40	1,609	1,609	19,919	35
36		Building - Ceiling & Lighting	1997		62,447		40	1,561	1,561	18,379	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 South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	Building Fire Alarm System	1997	\$ 4,483	\$	40	\$ 112	\$ 112	\$ 1,437	37
38	Building - HVAC	1997	43,720		40	1,093	1,093	13,936	38
39	Building Improvement Resident Rooms in Gilead Area	1997	44,208		40	1,105	1,105	13,322	39
40	Building - Elevator Repair	1997	12,780		40	320	320	4,073	40
41	Building - Beauty Shop Renovation	1997	1,800		40	45	45	548	41
42	Land Improvement - Parking Lot	1998	46,302		20	2,316	2,316	26,634	42
43	Building Improvement Resident Rooms in Gilead Area	1998	34,374		40	859	859	9,879	43
44	Building - HVAC	1998	40,850		40	1,021	1,021	11,742	44
45	Building Rehab. Area	1998	68,738		40	1,718	1,718	19,757	45
46	Building - Kitchen Fan	1999	1,400		40	35	35	368	46
47	Building Therapy Room Renovation	1999	2,083		40	52	52	546	47
48	Building Improvement HVAC	2000	801,268		40	20,032	20,032	200,320	48
49	Building Improvement Social Service Office	2000	1,683		7			1,683	49
50	Land Improvement - Lighting	2000	30,000		15	2,000	2,000	19,000	50
51	Land Improvement - Fencing	2000	8,071		15	538	538	5,111	51
52	Building Improvement HVAC	2000	663,243		40	16,581	16,581	157,520	52
53	Building - Garage	2000	3,820		20	191	191	1,815	53
54	Building Improvement - Pipe Enclosure	2000	82,716		40	2,068	2,068	19,646	54
55	Building Improvement - Tile in Kitchen place into service 2001	2001	6,800		7			6,800	55
56	Land Improvement - Light Poles	2001	1,878		15	125	125	1,062	56
57	Building Improvements - HVAC	2001	19,808		40	495	495	4,208	57
58	Building Improvements - Kitchen Floor	2001	35,884		15	2,392	2,392	20,332	58
59	Building Improvements - Fire Protection System	2001	16,000		15	1,067	1,067	9,069	59
60	Building Improvements - Code Alert	2002	12,767		10	1,276	1,276	9,570	60
61	Building Improvements - Renovations- plumbing work	2002	4,712		15	314	314	2,355	61
62	Building Improvements - Renovations-plumbing and heating	2002	3,275		40	82	82	615	62
63	Building Improvements - painting, flooring, wallcoverings	2002	434,395		7	32,152	32,152	241,140	63
64	Building Improvements- walls, electrical,lighting	2002	431,434		40	6,206	6,206	46,545	64
65	Building Improvements- HVAC	2002	17,600		40	920	920	6,900	65
66	BI-Fire dampers	2003	62,407		15	4,161	4,161	27,046	66
67	BI-Door panels	2003	6,193		10	620	620	4,030	67
68	BI-Ceiling project	2003	21,725		40	543	543	3,530	68
69	BI-Alarm system	2003	35,502		20	1,775	1,775	11,538	69
70	TOTAL (lines 4 thru 69)		\$ 7,070,108	\$		\$ 204,878	\$ 204,878	\$ 3,723,690	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 South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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 12A, Carried Forward</b>		\$ 7,070,108	\$		\$ 204,878	\$ 204,878	\$ 3,723,690	1
2	LI-Heated sidewalk	2003	32,012		15	2,134	2,134	13,871	2
3	LI-Sign	2003	784		10	78	78	507	3
4	BI-Thermostats, heaters, pump motor, valves	2003	10,902		20	545	545	3,542	4
5	BI-Gate	2003	3,050		20	153	153	994	5
6	BI-Dental office	2004	15,500		40	388	388	2,134	6
7	BI-Alarm system	2004	2,860		7	409	409	2,249	7
8	BI-Fire protection system	2004	3,500		10	350	350	1,925	8
9	BI-Activity room	2004	967		7	138	138	759	9
10	BI-Fire protection cabinet	2004	2,850		7	407	407	2,239	10
11									11
12	BI - Generator	2005	92,610		20	4,630	4,630	20,835	12
13	BI - HVAC	2005	6,932		20	346	346	1,557	13
14	BI - Sprinklers	2005	3,815		20	190	190	855	14
15	BI - Generator	2005	3,668		20	184	184	828	15
16	BI - Outside Lights	2005	1,328		20	66	66	297	16
17	BI - Drywall	2005	880		20	44	44	198	17
18	BI - Elevator	2005	2,007		20	100	100	450	18
19	BI - Doors	2005	9,220		20	462	462	2,079	19
20	BI - Plumbing	2005	3,276		20	164	164	738	20
21	BI - Fire Alarm System	2005	6,975		20	348	348	1,566	21
22	BI - Master Station (Nurse Call)	2005	1,705		20	86	86	387	22
23	BI - Conveyor Warewashers	2005	1,772		20	88	88	396	23
24									24
25	BI - HVAC	2006	8,729		20	218	218	1,090	25
26	BI - Fire Doors	2006	4,635		20	116	116	580	26
27	BI - Elevator Repair	2006	4,031		20	101	101	505	27
28	LI - Landscaping	2006	3,189		20	80	80	400	28
29									29
30	SO-Asbestos Retirement Obligation	2006	118,956		20	5,948	5,948	20,818	30
31	South-roof replacmt.	2006	76,485		10	7,649	7,649	26,771	31
32	Roof replace middle	2006	34,668		10	3,467	3,467	12,134	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,527,414	\$		\$ 233,767	\$ 233,767	\$ 3,844,394	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 South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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>		\$ 7,527,414	\$		\$ 233,767	\$ 233,767	\$ 3,844,394	1
2	Boiler repair	2006	1,672		15	111	111	389	2
3	2 Condensers	2006	15,590		15	1,039	1,039	3,637	3
4	HVAC Controls	2006	8,150		15	543	543	1,901	4
5	Whirlpool flush	2006	395		15	26	26	91	5
6	Grease trap	2006	7,120		15	475	475	1,661	6
7	Elevator rebuild	2006	61,940		20	3,097	3,097	10,841	7
8	Whirlpool remodel	2006	51,113		20	2,556	2,556	8,946	8
9	Analog Msg Waiting Card	2006	6,871		7	982	982	3,437	9
10	Phone Cables	2006	17,500		7	2,500	2,500	8,750	10
11	Landscape	2006	1,950		10	195	195	684	11
12	Driveway Lights	2006	18,400		15	1,227	1,227	4,293	12
13									13
14	Sign painting & Maint	2007	5,472		5	1,094	1,094	2,736	14
15	Remove 377 Sq Ft of Asphalt & Construct 2 Speed Bumps	2007	2,975		8	372	372	930	15
16	Canopy repairs	2007	3,285		15	219	219	548	16
17	Phone System	2007	91,454		10	9,145	9,145	22,907	17
18	Roofing	2007	60,268		10	6,027	6,027	15,067	18
19	Sewer repairs	2007	28,997		15	1,933	1,933	4,833	19
20	Driveway Land Improvements	2007	6,900		15	460	460	1,150	20
21	Repair, test, & Certify failed backflow systems	2007	2,600		5	520	520	1,300	21
22	Elevator Repair	2007	2,899		10	290	290	675	22
23	Fire Alarm Repairs	2007	4,470		10	447	447	1,118	23
24	Paging System	2008	24,900		10	2,490	2,490	4,980	24
25	Rooftop H-Vac	2008	102,663		15	6,844	6,844	10,266	25
26	Carpeting	2008	99,195		15	6,613	6,613	9,920	26
27	Waterline	2008	63,629		7	9,090	9,090	13,635	27
28	Dining Room Smoke Doors	2008	5,830		20	292	292	437	28
29	Install Controls for Admin VVT	2008	21,950		15	1,463	1,463	2,195	29
30	Facility Signs	2008	13,351		10	1,335	1,335	2,003	30
31									31
32	Current Booked Depre for Building & Improvements	2009		364,697			(364,697)		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,258,953	\$ 364,697		\$ 295,152	\$ (69,545)	\$ 3,983,723	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 12C, Carried Forward		\$ 8,258,953	\$ 364,697		\$ 295,152	\$ (69,545)	\$ 3,983,723	1
2	Dining Floor Replaces	2009	30,329		10	1,516	1,516	1,516	2
3	Bath Rooms Remodel - Replace Flooring and Tile	2009	138,037		20	3,451	3,451	3,451	3
4	Tub Room Remodel - Replace Flooring and Tile	2009	53,790		40	672	672	672	4
5									5
6									6
7	Allocated from Home Office 2009	2009	623,655		20	27,772	27,772	119,197	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,104,764	\$ 364,697		\$ 328,564	\$ (36,133)	\$ 4,108,559	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	\$ 2,262,355	\$ 121,413	\$ 220,113	\$ 98,700	3-15	\$ 1,980,408	71
72	Current Year Purchases	104,269		10,177	10,177	3-10	10,177	72
73	Fully Depreciated Assets	1,508,733				3-15	1,508,733	73
74	Allocation from Home Office	625,841		19,958	19,958	3-15	524,984	74
75	TOTALS	\$ 4,501,198	\$ 121,413	\$ 250,248	\$ 128,835		\$ 4,024,302	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				\$	\$	\$	\$		\$	76
77	Allocation from Home Office			8,469		534	534	5	6,445	77
78										78
79										79
80	TOTALS			\$ 8,469	\$	\$ 534	\$ 534		\$ 6,445	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)	\$ 13,645,736	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 486,110	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 579,346	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 93,236	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,139,306	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6		<u>Allocation from Home Office</u>			<u>8,350</u>			6
7	TOTAL				\$ <u>8,350</u>			7

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

This amount was calculated by dividing the total amount to be amortized N/A  
 by the length of the lease 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: \$ 1,321 Description: Dietary Equipment 1,321

(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

<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	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	\$	14,141	848,472	\$	14,141	\$ 848,472	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,416	324,979		5,416	324,979	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2&3)	hrs		14,692	881,544	32,186	14,692	913,730	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				1,146,888		1,146,888	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>			\$	34,250	\$ 2,054,996	\$ 1,179,074	34,250	\$ 3,234,070	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 &amp; ID Number Providence South Holland

# 0023242

Report Period Beginning: 01/01/09

Ending:

12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 850	\$ 850	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 534,440 )	3,048,417	3,048,417	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,865	12,865	7
8	Accounts Receivable (owners or related parties)	562,410	2,888,355	8
9	Other(specify): BC/BS Excess	1,308	1,308	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,625,850	\$ 5,951,795	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,305	31,305	13
14	Buildings, at Historical Cost	8,546,664	9,104,764	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,652,053	4,509,667	16
17	Accumulated Depreciation (book methods)	(8,352,502)	(8,139,306)	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>	\$ 3,877,520	\$ 5,506,430	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,503,370	\$ 11,458,225	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 360,269	\$ 360,269	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,021	9,021	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,911	73,911	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>TDA Match - South</u>	28,290	28,290	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 471,491	\$ 471,491	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	25,321	25,321	39
40	Mortgage Payable			40
41	Bonds Payable		2,325,945	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Long-Term Liabilities</u>	209,918	209,918	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 235,239	\$ 2,561,184	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 706,730	\$ 3,032,675	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,796,640	\$ 8,425,550	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,503,370	\$ 11,458,225	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>7,060,817</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(45,653)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>7,015,164</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(218,526)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>2</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(218,524)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,796,640</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Providence South Holland

# 0023242

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 14,482,208	1
2	Discounts and Allowances for all Levels	(2,262,082)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,220,126	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	473,478	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 473,478	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,089	13
14	Non-Patient Meals	64	14
15	Telephone, Television and Radio	16,464	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,133,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	77,357	19
20	Radiology and X-Ray	66,541	20
21	Other Medical Services	419,658	21
22	Laundry	1,575	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,734,358	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	33,400	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 33,400	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc. Charges	18,320	28
28a	Other Income	2,789	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 21,109	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,482,471	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,079,533	31
32	Health Care	6,941,237	32
33	General Administration	3,275,061	33
<b>B. Capital Expense</b>			
34	Ownership	628,922	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,681,304	35
36	Provider Participation Fee	94,940	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,700,997	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(218,526)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (218,526)	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 South Holland

# 0023242

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 86,678	\$ 41.67	1
2	Assistant Director of Nursing	1,952	2,080	62,630	30.11	2
3	Registered Nurses	18,619	19,893	559,926	28.15	3
4	Licensed Practical Nurses	47,870	50,388	1,232,128	24.45	4
5	CNAs & Orderlies	107,607	116,078	1,607,409	13.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,976	2,131	44,620	20.94	9
10	Activity Assistants	15,007	16,701	246,259	14.75	10
11	Social Service Workers	6,252	6,440	107,999	16.77	11
12	Dietician	2,885	2,885	60,127	20.84	12
13	Food Service Supervisor	1,594	1,657	36,258	21.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,938	26,858	296,380	11.04	15
16	Dishwashers					16
17	Maintenance Workers	14,429	15,618	218,669	14.00	17
18	Housekeepers	14,727	16,130	203,228	12.60	18
19	Laundry	12,136	12,999	154,777	11.91	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,091	2,315	51,324	22.17	23
24	Clerical	28,530	30,465	415,716	13.65	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	1,924	2,215	33,182	14.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	305,465	326,933	\$ 5,417,311 *	\$ 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	\$ 12,788	1(3)	35
36	Medical Director	Monthly	17,198	9(3)	36
37	Medical Records Consultant	Monthly	4,290	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	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				44
45	Social Service Consultant	Monthly	3,120	12(3)	45
46	Other(specify)				46
47	Chaplain		2,590	12(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,786		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,090	\$ 65,402	10(3)	50
51	Licensed Practical Nurses	1,259	44,055	10(3)	51
52	Certified Nurse Assistants/Aides	1,625	34,128	10(3)	52
53	TOTAL (lines 50 - 52)	3,974	\$ 143,585		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	
Richard Nolden	Administrator	0	\$ 133,009	Workers' Compensation Insurance	\$ 266,276	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	26,348	Advertising: Employee Recruitment	3,135	
Amount paid out of Home Office in column 7				FICA Taxes	395,130	Health Care Worker Background Check		
				Employee Health Insurance	268,400	(Indicate # of checks performed 625 )	7,500	
				Uniforms	4,003	Patient Background Checks	99 1,192	
				TDA Expense	54,173	Life Services Newtwok of Illinois	8,091	
				Drug Testing	18,194			
				Employee Welfare	50,933	Miscellaneous Subscriptions	739	
				Employee Medical	299	Allocated from Home Office	2,338	
				Other Emp Benefits	1,171	Miscellaneous Lisc & Fees	2,147	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 133,009	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,084,927	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,137	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee (Eliminated in Col 7)			\$ 1,212,896	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)			\$ 1,212,896				Seminar Expense	5,333
							Allocated from Home Office	16,406
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
<b>C. Professional Services</b>				TOTAL		\$	TOTAL	\$ 21,739
Vendor/Payee	Type		Amount					
RSM McGladrey, Inc.	Accounting		\$ 10,146					
KPMG, LLP	Accounting		4,680					
Achieve Accreditation	Acceditation		9,675					
Jackson Wabash	Clinical Consulting		33,113					
Pam Van Austin	Clinical Consulting		514					
Method Management	Consulting		5,050					
Laner Muchin Dombrow Becker Lev	Legal Fees		13,256					
Much Shelist	Legal Fees		14,240					
Myers, Miller & Krauskopf	Legal Fees		2,517					
Reed Smith LLP	Legal Fees		33,706					
John R. Russell	Legal Fees		5,877					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 132,774					

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

\*\*See instructions.

**Rest Haven South**  
**Provider #: 0023242**  
**01/01/09 to 12/31/09**

**Schedule 21A**

XIX. SUPPORT SCHEDULE  
C. Professional Services

Total (agree to Schedule V, line 19, column 3)

132,774

Allocated from Home Office

Legal

-

Other

11,679

11,679

Non-Allowable Legal

(1,945)

Total (agree to Schedule V, line 19, column 8)

142,508

142,508

**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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
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 South Holland

# 0023242

Report Period Beginning: 01/01/09

Ending: 12/31/09

**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. LSN \$8,091
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 171,799 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. \$ 94,940  
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. \$ 64
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**