

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0007534

Facility Name: Providence Palos Heights

Address: 13259 South Central Avenue Palos Heights 60463
Number City Zip Code

County: Cook

Telephone Number: (708)597-1000 Fax # (708)389-9990

HFS ID Number:

Date of Initial License for Current Owners: 02/10/60

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (C) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Providence Palos Heights# 0007534 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 bedsN/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>34,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>98</u>	Intermediate (ICF)	<u>98</u>	<u>35,868</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,638	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,327</u>	<u>4,041</u>	<u>20,669</u>	<u>32,037</u>	8
9	SNF/PED					9
10	ICF	<u>7,812</u>	<u>5,814</u>	<u>3,620</u>	<u>17,246</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,139	9,855	24,289	49,283	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.77%

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?

YesG. 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 20,585Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	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	684,257	51,383		735,640		735,640		735,640			1
2	Food Purchase		424,920		424,920		424,920	6,654	431,574			2
3	Housekeeping	281,295	73,667		354,961		354,961		354,961			3
4	Laundry	75,787	26,812		102,599		102,599	(702)	101,897			4
5	Heat and Other Utilities			181,493	181,493		181,493	18,708	200,201			5
6	Maintenance	305,216		331,225	636,441		636,441	(39,637)	596,804			6
7	Other (specify):*											7
8	TOTAL General Services	1,346,555	576,782	512,718	2,436,055		2,436,055	(14,977)	2,421,078			8
	B. Health Care and Programs											
9	Medical Director			52,000	52,000		52,000		52,000			9
10	Nursing and Medical Records	3,838,868	659,037	19,647	4,517,552		4,517,552		4,517,552			10
10a	Therapy											10a
11	Activities	131,278	10,114	848	142,240		142,240		142,240			11
12	Social Services	177,820			177,820		177,820		177,820			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,147,965	669,152	72,495	4,889,612		4,889,612		4,889,612			16
	C. General Administration											
17	Administrative			1,362,672	1,362,672		1,362,672	(1,198,870)	163,802			17
18	Directors Fees											18
19	Professional Services			34,743	34,743		34,743	10,939	45,682			19
20	Dues, Fees, Subscriptions & Promotions			44,466	44,466		44,466	3,088	47,554			20
21	Clerical & General Office Expenses	759,557	103,228	49,515	912,299		912,299	633,280	1,545,579			21
22	Employee Benefits & Payroll Taxes			1,437,921	1,437,921		1,437,921		1,437,921			22
23	Inservice Training & Education			4,223	4,223		4,223		4,223			23
24	Travel and Seminar			233	233		233	10,555	10,788			24
25	Other Admin. Staff Transportation			14,894	14,894		14,894	5,425	20,319			25
26	Insurance-Prop.Liab.Malpractice			157,679	157,679		157,679	4,804	162,483			26
27	Other (specify):* Home Office Benefits							188,007	188,007			27
28	TOTAL General Administration	759,557	103,228	3,106,346	3,969,131		3,969,131	(342,772)	3,626,359			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,254,077	1,349,161	3,691,559	11,294,797		11,294,797	(357,749)	10,937,048			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			411,279	411,279		411,279	161,311	572,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			175,450	175,450		175,450	(45,176)	130,274			32
33	Real Estate Taxes							7,469	7,469			33
34	Rent-Facility & Grounds							10,815	10,815			34
35	Rent-Equipment & Vehicles			4,801	4,801		4,801		4,801			35
36	Other (specify):*											36
37	TOTAL Ownership			591,530	591,530		591,530	134,419	725,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,268,944	1,666,502	2,935,446		2,935,446		2,935,446			39
40	Barber and Beauty Shops		2,017		2,017		2,017		2,017			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			322,124	322,124		322,124		322,124			42
43	Other (specify):* Non-Allowable Co			727,556	727,556		727,556	(727,556)	(0)			43
44	TOTAL Special Cost Centers		1,270,960	2,716,182	3,987,142		3,987,142	(727,556)	3,259,586			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,254,077	2,620,122	6,999,270	15,873,469		15,873,469	(950,886)	14,922,583			45

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

		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	(281)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,294)	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	115,199	30		9
10	Interest and Other Investment Income	(65,972)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,000)	43		24
25	Fund Raising, Advertising and Promotional	(7,401)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,513)	43		28
29	Other-Attach Schedule See Pg 5A	(539,246)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (733,508)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(217,378)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,378)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (950,886)		37

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

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

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

Providence Palos Heights

ID# 0007534

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow non-allowable Lab Expense	\$ (92,240)	43	1
2	Disallow non-allowable X-Ray Expense	(85,440)	43	2
3	Disallow Laundry Income	(702)	4	3
4	Disallow Interehab Physiatry	(72,000)	43	4
5	Disallow non-allowable residents welfare	(80,284)	43	5
6	Disallow non-allowable marketing expense	(156,379)	43	6
7	Disallow non-allowable accretion expense	(4,390)	43	7
8	Offset miscellaneous income	(2,570)	21	8
9	Remove Capitalized Repair Expenses	(43,333)	6	9
10	Disallow non-allowable newspapers ads	(1,908)	43	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	(539,246)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	
		Haven Park	Zeeland, MI	Providence Home		Management Co.
				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%	\$ 6,935	\$ 6,935	1
2	V	5	Utilities		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	18,708	18,708	2
3	V	6	Maintenance-Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	3,696	3,696	3
4	V	17	Administrative	1,362,672	Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	163,802	(1,198,870)	4
5	V	19	Professional Services		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	10,939	10,939	5
6	V	20	Dues,fees & subscriptions		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	3,088	3,088	6
7	V	21	Clerical & General-Salary		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	533,008	533,008	7
8	V	21	Clerical & General-Other		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	111,136	111,136	8
9	V	24	Travel & Seminar		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	10,555	10,555	9
10	V	25	Other admin. Staff transporation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	5,425	5,425	10
11	V	26	Insurance-prop,liab. & malpractice		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	4,804	4,804	11
12	V	27	Mgmt allocation of EE benefits		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	188,007	188,007	12
13	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	46,111	46,111	13
14	Total			\$ 1,362,672			\$ 1,106,214	\$ * (256,458)	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.

☒ X

 YES

☐ NO

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

1		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 Convalescent Home d/b/a Providenc	100.00%	\$ 20,796	\$ 20,796	15
16	V	33	Real Estate taxes		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	7,469	7,469	16
17	V	34	Rent-facility & grounds		Rest Haven Illiana Christian Convalescent Home d/b/a Providenc	100.00%	10,815	10,815	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			\$			\$ 39,080	\$ * 39,080	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Providence Palos Heights# 0007534

Report Period Beginning:

01/01/2012Ending: 2/31/2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated Cost B	93,836,258	17	\$ 46,759	\$	13,917,663	\$ 6,935	1
2	5	Utilities	Accumulated Cost B	93,836,258	17	126,133		13,917,663	18,708	2
3	6	Maintenance	Accumulated Cost B	93,836,258	17	24,916		13,917,663	3,696	3
4	17	Administrative	Direct Cost A	1	1	1,324,456	1,324,456	1	163,802	4
5	19	Professional services	Accumulated Cost B	93,836,258	17	73,753		13,917,663	10,939	5
6	20	Dues, fees & subscriptions	Accumulated Cost B	93,836,258	17	20,821		13,917,663	3,088	6
7	21	Clerical & general - salary	Accumulated Cost B	93,836,258	17	3,593,671	3,593,671	13,917,663	533,008	7
8	21	Clerical & general - Other	Accumulated Cost B	93,836,258	17	749,309		13,917,663	111,136	8
9	24	Travel & seminar	Accumulated Cost B	93,836,258	17	71,167		13,917,663	10,555	9
10	25	Other Admin. Staff transportation	Accumulated Cost B	93,836,258	17	36,574		13,917,663	5,425	10
11	26	Insurance-prop.,liab. & malpract	Accumulated Cost B	93,836,258	17	32,387		13,917,663	4,804	11
12	27	Mgmt allocation of ee benefits	Accumulated Cost B	93,836,258	17	1,267,588		13,917,663	188,007	12
13	30	Depreciation	Accumulated Cost B	93,836,258	17	310,891		13,917,663	46,111	13
14	32	Interest expense	Accumulated Cost B	93,836,258	17	140,210		13,917,663	20,796	14
15	33	Real Estate taxes	Accumulated Cost B	93,836,258	17	50,359		13,917,663	7,469	15
16	34	Rent-facility & grounds	Accumulated Cost B	93,836,258	17	72,918		13,917,663	10,815	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,941,912	\$ 4,918,127		\$ 1,145,294	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Tax Exempt Bonds		X	Mortgage & Additions	Varies	11/01/04	\$ 4,800,000	\$ 2,463,523	10/31/34	Variable	\$ 175,450	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,800,000	\$ 2,463,523			\$ 175,450	9	
	B. Non-Facility Related*												
10								Disallow non-care interest			(65,972)	10	
11								Allocated from Home Office			20,796	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (45,176)	14	
15	TOTALS (line 9+line14)						\$ 4,800,000	\$ 2,463,523			\$ 130,274	15	

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Allocated from Home Office	\$	7,469 6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7,469 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007		8	
	2008		9	
	2009		10	
	2010		11	
	2011		12	
Real Estate taxes are allocated from a for-profit management entity				
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
		14	PLUS APPEAL COST FROM LINE 5 \$	14
		15	LESS REFUND FROM LINE 6 \$	15
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Providence Palos Heights

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0007534

CONTACT PERSON REGARDING THIS REPORT

Bill DeYoung

TELEPHONE

(708) 342-8100

FAX #:

(708) 348-8006

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	19-09-01-203-007-1007	Home Office Building	\$ 20,375.04	\$ 7,469.00
2.	19-09-01-203-007-1001	Home Office Building	\$ 13,604.00	\$
3.	19-09-01-203-007-1006	Home Office Building	\$ 16,380.30	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 50,359.34	\$ 7,469.00

B.
Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	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:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	441,662	1960	\$ 30,000	1
2					2
3	TOTALS	441,662		\$ 30,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		40	3,683	3,683	139,933	8	
	Improvement Type**											
9	Improvements			1967	312,475		40			312,475	9	
10	Improvements			1970	74,824		40			74,824	10	
11	Improvements			1971	10,740		40			10,740	11	
12	Improvements			1972	3,992		40			3,992	12	
13	Improvements			1973	2,002		40	50	50	1,967	13	
14	Improvements			1974	1,001		40	25	25	955	14	
15	Improvements			1976	8,418		40	210	210	7,660	15	
16	Improvements			1977	1,073		40	27	27	954	16	
17	Improvements			1979	450		40	11	11	374	17	
18	Improvements			1980	629		40	16	16	528	18	
19	Improvements			1982	3,077		40	77	77	2,387	19	
20	Improvements			1983	4,063		40	102	102	3,060	20	
21	Improvements			1984	11,366		40	284	284	8,236	21	
22	Improvements			1985	5,552		40	139	139	3,892	22	
23	Improvements			1986	308,545		40	7,714	7,714	208,278	23	
24	Improvements			1987	242,285		40	6,057	6,057	157,482	24	
25	Improvements			1988	144,720		40	3,618	3,618	79,118	25	
26	Improvements			1989	75,090		40	1,877	1,877	45,039	26	
27	Improvements			1990	258,016		40	6,450	6,450	151,730	27	
28	Improvements			1991	88,476		40	2,212	2,212	50,396	28	
29	Improvements			1992	51,572		40	1,289	1,289	27,069	29	
30	Improvements			1993	283,946		40	7,099	7,099	142,569	30	
31	Improvements			1994	396,618		40	9,915	9,915	189,399	31	
32	Improvements			1995	207,113		40	5,526	5,526	95,974	32	
33	Improvements			1995	13,913		15			13,913	33	
34	Parking Lot Expansion			1996	74,714		40	1,868	1,868	30,822	34	
35	Wing C & D Renovations			1996	226,501		40	5,662	5,662	93,423	35	
36	Improvements			1996	279,308		40	6,982	6,982	115,203	36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Providence Palos Heights

0007534

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	15	\$ 147	\$ 147	\$ 4,789	37
38	Lighting System	1996	49,263		40	1,232	1,232	20,328	38
39	Architect Fees	1996	13,512		40	338	338	5,577	39
40	Alarm System	1996	4,704		15	151	151	4,855	40
41	Whirlpool Renovation	1996	11,914		15	401	401	12,315	41
42	Door	1996	656		15			656	42
43	Unit I & II Renovation	1996	22,981		40	574	574	9,471	43
44	Landscaping	1997	5,984		15	213	213	5,984	44
45	Unit I A & B remodel:Carpentry, elec. Plumb	1997	236,778		25	9,472	9,472	146,817	45
46	Unit I C & D remodel:Carpentry, elec. plumb.	1997	211,804		25	8,472	8,472	131,316	46
47	Unit I Whirlpool Renovation	1997	3,264		25	130	130	2,015	47
48	Unit II Whirlpool Renovation	1997	3,910		25	156	156	2,418	48
49	Plumbing	1997	1,595		25	64	64	992	49
50	Unit II Laundry Room Cabinets	1997	729		25	30	30	465	50
51	Chapel Roof	1997	8,750		25	350	350	5,425	51
52	Ramp Entrance	1997	32,456		25	1,298	1,298	20,119	52
53	Employee Patio	1997	3,975		25	159	159	2,465	53
54	Ramp Curbing	1997	1,396		25	56	56	868	54
55	Stairwell Doors	1997	1,833		25	74	74	1,147	55
56	Handicap Ramp	1997	12,166		25	486	486	7,533	56
57	Medical Supply Room Renovation	1997	20,773		25	830	830	12,865	57
58	Unit II A & B remodel:Carpentry, fire protection	1997	78,500		25	3,140	3,140	48,670	58
59	A & B Basement Remodeling	1997	2,331		25	94	94	1,457	59
60	Unit II Storage Room	1997	3,458		25	138	138	2,139	60
61	Unit I A & B remodel:Carpentry, elec., tile	1998	18,389		25			18,389	61
62	Unit II Handicap Ramp	1998	2,002		25	80	80	1,160	62
63	Unit II Storage Room	1998	8,807		25	352	352	5,104	63
64	Unit II A & B Bsmnt remodel:Carpty, elec, plumb.	1998	83,634		25	3,345	3,345	48,503	64
65	Unit I A & B remodel:Carpty,plmg, elec.	1998	19,906		25	796	796	11,542	65
66	Unit II A & B Bsmt remodel:Carpty & fire prot.	1998	10,676		25	427	427	6,192	66
67	Design Plan for Renovation	1998	706		25	28	28	406	67
68	Unit II A & B Bsmt remodel:Carpentry & fee	1998	2,314		25	93	93	1,348	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,257,156	\$		\$ 104,019	\$ 104,019	\$ 3,651,290	70

**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:

01/01/2012

Ending:

12/31/2012

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,257,156	\$		\$ 104,019	\$ 104,019	\$ 3,651,290	1
2	Painting for Renovation	1998	3,873		25	154	154	2,233	2
3	Unit I A & B remodel:Carpty,& finishing	1998	20,171		25	806	806	11,687	3
4	Carpeting	1998	13,997		5			13,997	4
5	Unit I A & B remodel:Carpty, plmg, fire	1998	8,026		25	322	322	4,669	5
6	Unit II Patio /Alzheimer's Garden	1998	49,519		25	1,980	1,980	28,710	6
7	Hot Water Heater	1998	831		15	56	56	812	7
8	Roof	1998	991		10			991	8
9	A/C Circulator	1998	1,115		15	74	74	1,073	9
10	Chimney Vent	1998	519		25	20	20	290	10
11	Fascia	1998	789		25	32	32	464	11
12	Smoke Detectors	1998	1,081		15	72	72	1,044	12
13	Speed Bumps for Parking Lot	1998	781		5			781	13
14	Heating & Cooling System	1998	34,826		25	1,394	1,394	20,213	14
15	Nurses' Alarm System	1998	13,917		25	556	556	8,062	15
16	Piping	1998	682		25	28	28	406	16
17	Patio	1999	10,472		40	262	262	3,537	17
18	Carpeting	1999	6,283		10			6,283	18
19	Electrical Generator	1999	66,394		10			66,394	19
20	Wall Firestopping	1999	15,000		10			15,000	20
21	Interior design fee	1999	228		10			228	21
22	Electrical	1999	4,383		10			4,383	22
23	Wall Firestopping	1999	35,000		10			35,000	23
24	Switchboard	1999	5,696		10			5,696	24
25	Landscaping	1999	48,376		40	1,210	1,210	16,335	25
26	Parking Lot	1999	8,610		40	216	216	2,916	26
27	Air Conditioners	1999	80,030		40			80,030	27
28	Boiler Repairs	1999	9,060		10			9,060	28
29	Landscaping	2000	10,704		15	712	712	8,900	29
30	Patio Shelter	2000	5,150		20	256	256	3,200	30
31	Garden	2000	7,768		15	516	516	6,450	31
32	Benches	2000	958		10			958	32
33	Lobby remodel	2000	102,660		10			102,660	33
34	TOTAL (lines 1 thru 33)		\$ 5,825,046	\$		\$ 112,685	\$ 112,685	\$ 4,113,752	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,825,046	\$		\$ 112,685	\$ 112,685	\$ 4,113,752	1
2	Dining Room Renovation	2000	6,269		15	416	416	5,200	2
3	Wing Renovation	2000	102,095		40	2,552	2,552	31,900	3
4	Boiler and Pump	2000	10,450		15	696	696	8,700	4
5	Ansul	2000	3,728		15	248	248	3,100	5
6	Generator	2000	8,629		20	430	430	5,375	6
7	Fire Alarm System	2000	10,135		40	252	252	3,150	7
8	Exhaust Fan	2000	2,780		15	184	184	2,300	8
9	Landscaping	2001	5,680		5			5,680	9
10	Lobby remodel	2001	41,806		40	1,045	1,045	12,018	10
11	A-Wing remodel	2001	51,393		40	1,285	1,285	14,778	11
12	Sinks	2001	5,165		15	344	344	3,956	12
13	Doors	2001	5,278		15	352	352	4,048	13
14	Ejector Pump	2001	9,674		15	645	645	7,418	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		15	48	48	504	18
19	Whirlpool renovation	2002	2,177		15	145	145	1,523	19
20	Roof renovation	2002	90,250		10	4,512	4,512	90,250	20
21	Code Alert	2002	3,164		10	162	162	3,164	21
22	Firestopping work	2002	3,108		40	78	78	819	22
23	Dining Room Renovation	2002	135,527		40	3,388	3,388	35,574	23
24	Cabinets	2002	4,928		7			4,928	24
25	Blinds	2002	1,045		7			1,045	25
26	File cabinets	2002	2,327		7			2,327	26
27	Furniture	2002	1,814		7			1,814	27
28	Dining Room Renovation	2003	17,358		7			17,358	28
29	Lights	2003	20,442		20	1,022	1,022	9,709	29
30	Roof renovation	2003	152,000		10	15,200	15,200	144,400	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,544,947	\$		\$ 145,689	\$ 145,689	\$ 4,556,751	34

**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:

01/01/2012

Ending:

12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,544,947	\$		\$ 145,689	\$ 145,689	\$ 4,556,751	1
2	Menu boards	2003	2,160		10	216	216	2,052	2
3	Carpeting	2003	5,957		7			5,957	3
4	Sliding doors	2003	2,100		10	210	210	1,995	4
5	Wander system	2003	21,630		20	1,082	1,082	10,789	5
6									6
7	Tile	2004	24,492		10	2,450	2,450	20,825	7
8	Door	2004	4,579		10	458	458	3,893	8
9	Basement restroom	2004	37,076		40	927	927	9,270	9
10	Lights/shades	2004	3,562		20	178	178	1,780	10
11	Awning	2004	10,790		10	1,079	1,079	9,172	11
12	Shades	2004	1,960		7			1,960	12
13	Exit ramps	2004	5,450		15	363	363	3,086	13
14									14
15	Fire Door	2005	5,637		10	564	564	4,230	15
16	Storm Sewer improvements	2005	42,800		20	2,140	2,140	16,050	16
17	Water Heaters	2005	8,808		15	588	588	4,410	17
18	Patio and Major Landscaping Improvements	2005	16,805		15	1,120	1,120	8,400	18
19	Lights	2005	16,708		20	836	836	6,270	19
20	Unit 1 basement Improvements	2005	4,165		20	208	208	1,560	20
21	Elevator	2005	28,163		20	1,408	1,408	10,560	21
22	Unit 1 basement windows	2005	7,750		40	194	194	1,455	22
23	Wallpaper	2005	8,185		7	580	580	8,185	23
24	Baseboards	2005	1,078		7	77	77	1,078	24
25	Dock flooring	2005	2,000		7	141	141	2,000	25
26	Window Coverings	2005	13,162		7	942	942	13,162	26
27	5 Ton 3 Phase Condensing Unit	2005	2,696		20	135	135	1,012	27
28	Carpeting	2005	1,254		20	63	63	472	28
29	Electric Door Unit	2005	1,087		20	54	54	405	29
30	PC Disposer	2005	2,699		20	135	135	1,012	30
31	Electric Door Unit	2005	1,529		20	76	76	570	31
32	Nurse Call System	2005	7,749		20	387	387	2,903	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,836,978	\$		\$ 162,300	\$ 162,300	\$ 4,711,264	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,836,978	\$		\$ 162,300	\$ 162,300	\$ 4,711,264	1
2	Parking Lot Lights	2005	2,940		15	196	196	1,470	2
3	Patio & Drainage Improvements	2005	10,958		15	731	731	5,482	3
4	Driveway	2005	29,377		20	1,469	1,469	11,017	4
5	Elevator	2006	18,897		20	472	472	3,304	5
6	Security Alarm System	2006	115,751		10	5,788	5,788	40,516	6
7	Nurse Call System	2006	123,550		7	8,825	8,825	61,775	7
8	5 Ton Rooftop Water Heater/Circulation Pump	2006	10,954		15	365	365	2,555	8
9	Asbestos Retirement Obligation	2006	97,309		7	6,951	6,951	48,657	9
10	Whirlpool Tub	2006	41,350		15	1,378	1,378	9,646	10
11	CSH Heating Unit	2006	3,750		15	125	125	875	11
12	Dock Door	2006	3,959		20	99	99	693	12
13	Central Air Unit	2006	5,677		15	189	189	1,323	13
14	Auto Door Opener	2006	2,200		10	110	110	770	14
15	New Phone System	2007	99,032		10	9,903	9,903	54,467	15
16	Cabnets Remodel	2007	4,686		15	312	312	1,716	16
17	Front Desk Cabinets	2007	13,428		20	671	671	3,691	17
18	Sump Pump	2007	9,240		15	616	616	3,388	18
19	Fire Panel	2007	16,950		10	1,695	1,695	9,323	19
20	HVAC Fixed	2007	11,325		15	755	755	4,153	20
21	Door Installed	2007	3,320		15	221	221	1,216	21
22	Outlets	2007	10,620		2			10,620	22
23	Foyer Windows and Cabinets	2007	5,530		20	277	277	1,523	23
24	Boiler Repairs	2007	114,664		15	7,644	7,644	42,042	24
25	Dinning Windows & Kickplates	2007	4,894		20	245	245	1,347	25
26	Waterproof Basement	2007	3,300		15	220	220	1,210	26
27	Doors and Cabinets Installed	2007	6,572		20	329	329	1,809	27
28	HVAC C&D Wing Piping	2007	85,642		40	2,141	2,141	11,776	28
29	Audio Station, Shades, Control Box	2007	3,168		7	453	453	2,491	29
30	Sign Repair	2007	2,840		20	142	142	781	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,698,861	\$		\$ 214,622	\$ 214,622	\$ 5,050,900	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,698,861	\$		\$ 214,622	\$ 214,622	\$ 5,050,900	1
2	Unit 2 lobby - remove wall & replace flooring	2008	19,750		40	495	495	2,227	2
3	Install sprinkler system in Chapel	2008	23,175		40	580	580	2,610	3
4	Elec. Units - 2 carts	2008	5,240		20	262	262	1,179	4
5	HVAC - fan coils	2008	42,386		20	2,120	2,120	9,540	5
6	A/C unit	2008	5,292		20	264	264	1,188	6
7									7
8	Pipe railings	2008	5,298		15	354	354	1,593	8
9	Insulate hot water piping	2008	4,348		15	290	290	1,305	9
10	Commercial doors	2008	9,360		15	624	624	2,808	10
11	Reconnect new RTU and replace air handlers	2008	39,719		15	2,648	2,648	11,916	11
12	5 ton HVAC - rooftop unit	2008	9,788		15	652	652	2,934	12
13									13
14	Unit 2 lobby - carpeting	2008	14,161		7	2,024	2,024	9,108	14
15	Wallpaper	2008	9,000		7	1,286	1,286	5,787	15
16									16
17	Central-Wander alarm	2009	131,334		10	13,133	13,133	45,967	17
18	Unit 2 Waterproofing	2009	4,365		15	291	291	1,019	18
19	Central Egress doors	2009	10,735		20	537	537	1,879	19
20	Chimmney Tuckpointing	2009	7,000		20	350	350	1,225	20
21	Dining Room Lighting	2009	6,777		20	339	339	1,186	21
22	Emergency Phone	2009	3,168		7	453	453	1,584	22
23	Facility Signage	2009	3,628		10	363	363	1,270	23
24	Facility Signage	2009	13,033		10	1,303	1,303	4,562	24
25	Tile Flooring	2009	10,785		20	539	539	1,888	25
26	Signage	2009	8,059		10	806	806	2,821	26
27	Painting-Lobby	2009	15,100		7	2,157	2,157	7,550	27
28	Asbestos removal	2009	3,520		7	503	503	1,760	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,103,882	\$		\$ 246,995	\$ 246,995	\$ 5,175,804	34

**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:

01/01/2012

Ending:

12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,103,882	\$		\$ 246,995	\$ 246,995	\$ 5,175,804	1
2	Nurse Call Station	2010	156,023		10	15,602	15,602	39,005	2
3	H-Vac Roof Unit	2010	9,222		15	615	615	1,537	3
4	Drain lines	2010	43,579		20	2,179	2,179	5,447	4
5	Unit 1 Boiler	2010	116,668		15	7,778	7,778	19,445	5
6	Gas Line Repair & Replacement	2010	11,879		20	594	594	1,485	6
7	Repair & Replace Alarm & Smoke Detectors	2010	12,583		20	629	629	1,573	7
8	Kitchen Water Heater, Exhaust Fan, and Water Pump	2010	9,133		20	457	457	1,142	8
9	Heater Exchange Unit Installed	2010	3,592		20	180	180	449	9
10	Repair Cost Non-Depre	2010			20				10
11									11
12	PH repeaters	2011	27,545		10	2,754	2,754	4,131	12
13	Wireless project	2011	9,793		10	980	980	1,470	13
14	Gas piping	2011	30,174		40	754	754	1,131	14
15	Nursecall station	2011	9,477		10	948	948	1,422	15
16	Valve	2011	7,850		15	524	524	786	16
17	PH drapes	2011	19,764		7	2,824	2,824	4,236	17
18	Ph asphalt	2011	91,376		10	9,138	9,138	13,707	18
19	U2 A&D flooring	2011	5,896		7	842	842	1,263	19
20	DR Hvac	2011	15,563		15	1,038	1,038	1,557	20
21	Seal Coat drive and U shape drive	2011	5,600		20	280	280	420	21
22	Sheet dampers	2011	2,572		20	128	128	192	22
23	Electrical installation	2011	3,300		20	166	166	249	23
24	Glass and mirror	2011	5,831		20	292	292	438	24
25	Installation of new Valve	2011	3,353		20	168	168	252	25
26	Kitchen remodelling	2011	8,069		20	404	404	606	26
27	Shower Project	2011	10,713		20	536	536	801	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,723,437	\$		\$ 296,804	\$ 296,804	\$ 5,278,548	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,723,437	\$		\$ 296,804	\$ 296,804	\$ 5,278,548	1
2	Flooring/Tile Work: Lobby & Dinning Area	2012	21,812		7	1,558	1,558	1,558	2
3	Install Drywall/Ceiling: 2 Commons Unit	2012	144,203		40	1,803	1,803	1,803	3
4	Automatic Front Door	2012	2,730		10	137	137	137	4
5	Duct Work/Circulating Pump	2012	3,397		15	113	113	113	5
6	PVC Piping/Sewer Drain - Basement Hallway	2012	3,753		15	125	125	125	6
7	Paving - Remove & Install Concrete Pad, Wire Mesh & Asphalt	2012	4,675		20	117	117	117	7
8	Stainless Steel Fire Door - Kitchen	2012	4,840		15	161	161	161	8
9	Thermostat & Guards: Dining, Chapel, Wicker,& Garden	2012	5,057		10	253	253	253	9
10	Hallways; Resident Rooms 71-73, 97-100,84,86 & 88 & Lounge								10
11	Spindles & Fabrication - NE Stairwell & Laundry Area	2012	6,155		10	308	308	308	11
12	Add & Replace Smoke Detectors	2012	7,332		10	367	367	367	12
13	HVAC	2012	10,803		15	360	360	360	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Current Year Building Depreciation	2012		245,219			(245,219)		21
22	Current Year Land Improvement Depreciation	2012		35,694			(35,694)		22
23	Allocation from Home Office	2012	625,584		20	27,940	27,940	167,239	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)		\$ 9,563,778	\$ 280,913		\$ 330,045	\$ 49,132	\$ 5,451,088	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,519,208	\$ 126,090	\$ 220,097	\$ 94,007	3-10	\$ 2,368,545	71
72	Current Year Purchases	60,083	4,276	4,276		5-10	4,276	72
73	Fully Depreciated Assets	2,493,580					2,493,580	73
74	Allocation from Home Office	660,128		17,637	17,637		621,689	74
75	TOTALS	\$ 5,732,999	\$ 130,366	\$ 242,010	\$ 111,644		\$ 5,488,090	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Home Office			\$ 8,479	\$	\$ 535	\$ 535		\$ 8,057	76
77										77
78										78
79										79
80	TOTALS			\$ 8,479	\$	\$ 535	\$ 535		\$ 8,057	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)	\$ 15,335,256	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 411,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 572,590	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 161,311	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,947,235	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: 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	Allocated from home office				10,815			6
7	TOTAL				\$ 10,815			7

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending

Annual Rent

12. /2013 \$
13. /2014 \$
14. /2015 \$

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: \$ 4,801

Description: Dietary Equip - 4,801

(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			\$ N/A	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

COMPLETED

1. From this facility

2. From other facilities (f)

DROP-OUTS

1. From this facility

2. From other facilities (f)

TOTAL TRAINED

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	39(3)	hrs	\$	10,658	\$ 767,350	\$	10,658	\$ 767,350	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,399	244,695		3,399	244,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		9,090	654,457		9,090	654,457	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				1,268,944		1,268,944	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			\$	23,147	\$ 1,666,502	\$ 1,268,944	23,147	\$ 2,935,446	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.

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	7,017	7,017	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 257,434)	2,901,175	2,901,175	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,528	12,528	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,922,220	\$ 2,922,220	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	8,790,911	9,563,778	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,184,211	5,741,478	16
17	Accumulated Depreciation (book methods)	(11,576,651)	(10,947,235)	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)	\$ 2,428,471	\$ 4,388,021	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,350,691	\$ 7,310,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 696,355	\$ 696,355	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,017	7,017	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,788	63,788	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,397	69,397	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	<u>Due In/From Related Entities</u>	5,316,026	5,316,026	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,152,585	\$ 6,152,585	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		2,463,523	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Long-Term Liabilities</u>	150,711	150,711	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 150,711	\$ 2,614,234	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,303,296	\$ 8,766,819	46
47	TOTAL EQUITY(page 18, line 24)	\$ (952,604)	\$ (1,456,578)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,350,691	\$ 7,310,241	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (781,430)	1
2	Restatements (describe):		2
3	Prior Period adjustment	58,096	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (723,334)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(229,270)	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)	\$ (229,270)	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)	\$ (952,604)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Providence Palos Heights**# **0007534**Report Period Beginning: **01/01/2012**Ending: **12/31/2012****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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,253,489	1
2	Discounts and Allowances for all Levels	(5,321,465)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,932,024	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,190,711	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,190,711	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	281	14
15	Telephone, Television and Radio	8,294	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,227,369	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	163,279	19
20	Radiology and X-Ray	50,804	20
21	Other Medical Services	68,163	21
22	Laundry	702	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,518,894	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	Miscellaneous Revenue	2,570	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,570	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,644,199	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,436,055	31
32	Health Care	4,889,612	32
33	General Administration	3,969,131	33
	B. Capital Expense		
34	Ownership	591,530	34
	C. Ancillary Expense		
35	Special Cost Centers	3,665,018	35
36	Provider Participation Fee	322,124	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,873,469	40
41	Income before Income Taxes (line 30 minus line 40)**	(229,270)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (229,270)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,957,785	44
45	Private Pay - Net Inpatient Revenue	2,171,238	45
46	Medicare - Net Inpatient Revenue	4,252,392	46
47	Other-(specify) Managed Care	550,609	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,932,024	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? **Yes** If not, please attach a reconciliation.

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

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

Facility Name & ID Number Providence Palos Heights# 0007534Report Period Beginning: 01/01/2012Ending: 12/31/2012

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	840	960	\$ 44,968	\$ 46.84	1
2	Assistant Director of Nursing	1,553	1,680	63,297	37.68	2
3	Registered Nurses	38,056	39,706	1,200,317	30.23	3
4	Licensed Practical Nurses	30,716	32,913	833,733	25.33	4
5	CNAs & Orderlies	120,362	127,065	1,669,544	13.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,395	10,894	131,278	12.05	10
11	Social Service Workers	9,625	10,475	177,820	16.98	11
12	Dietician	3,130	3,210	81,077	25.26	12
13	Food Service Supervisor	1,222	1,468	49,074	33.43	13
14	Head Cook	16,950	18,227	264,546	14.51	14
15	Cook Helpers/Assistants	27,058	28,270	289,560	10.24	15
16	Dishwashers					16
17	Maintenance Workers	20,445	21,756	305,216	14.03	17
18	Housekeepers	23,170	24,480	281,295	11.49	18
19	Laundry	6,239	6,588	75,787	11.50	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	37,894	41,956	759,557	18.10	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	1,742	1,954	27,008	13.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	349,397	371,602	\$ 6,254,077 *	\$ 16.83	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	52,000	9(3)	36
37	Medical Records Consultant	Monthly	2,147	10(3)	37
38	Nurse Consultant	Monthly	17,500	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	Monthly	848	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 72,495		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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	
Timothy Abbring	Administrator		\$ 163,802	Workers' Compensation Insurance		\$ 377,538	IDPH License Fee	\$ 1,990	
Amount paid out of home office, allocated in column 7				Unemployment Compensation Insurance		44,155	Advertising: Employee Recruitment	879	
				FICA Taxes		452,078	Health Care Worker Background Check		
				Employee Health Insurance		398,429	(Indicate # of checks performed 322)	9,028	
				Employee Meals			Patient Background Checks	348 4,175	
				Illinois Municipal Retirement Fund (IMRF)*			JCAHO Expense	12,798	
				Employee Education		12,496	Life Services Network Dues	10,735	
				Employee Welfare		53,508	Miscellaneous Dues	249	
				Drug Testing		8,457	Miscellaneous Subscriptions	4,612	
				TDA Expense		72,584	Allocated from Home Office	3,088	
				Uniform		6,000	Less: Public Relations Expense	()	
				Employee Medical		12,676	Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 1,437,921	\$ 47,554		
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)			\$ 1,362,672	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)							Seminar Expense	233	
C. Professional Services							Allocated from Home Office	10,555	
Vendor/Payee	Type		Amount				Entertainment Expense	()	
See Schedule 21A			\$				(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 10,788	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL					

*** Attach copy of IMRF notifications**

****See instructions.**

Providence Palos Heights

Provider #: 0007534

1/1/2012 to 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Laner Muchin Dombrow Becker Levin & Tominberg, LTD	Legal	9,956
KPMG	Accounting	6,030
McGladrey LLP	Accounting	10,499
Joanne Miaczynski	Consulting	7,063
Mary Jane Impoy	Consulting	1,196
Total (agree to Schedule V, line 19, column 3)		34,744
Plus: Allocated from Home Office		10,939
Total (agree to Schedule V, line 19, column 8)		45,683

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - 10,735
- (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. \$ 127,240 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. \$ 322,124
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. \$ 562
- (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.