

		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: 0023242

Facility Name: Providence South Holland

Address: 16300 Wausau Street South Holland 60473
Number City Zip Code

County: Cook

Telephone Number: (708) 596-5500 Fax # (708) 877-4827

HFS ID Number:

Date of Initial License for Current Owners: 02/02/1977

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

Paid Preparer

(Signed) _____ (Date) _____
(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 South Holland# 0023242 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>171</u>	Skilled (SNF)	<u>171</u>	<u>62,586</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>62,586</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,942</u>	<u>7,834</u>	<u>22,879</u>	<u>40,655</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>9,942</u>	<u>7,834</u>	<u>22,879</u>	<u>40,655</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 64.96%

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 02/02/1977

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

YES ☐Date N/ANO ☒

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 20,833Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

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

* 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	406,826	119,891		526,717		526,717		526,717		1
2	Food Purchase		313,822		313,822		313,822	5,595	319,417		2
3	Housekeeping	226,888	105,191		332,079		332,079		332,079		3
4	Laundry	165,148	39,109		204,257		204,257	(650)	203,607		4
5	Heat and Other Utilities			191,029	191,029		191,029	17,937	208,966		5
6	Maintenance	225,652		255,737	481,389		481,389	(4,206)	477,183		6
7	Other (specify):*										7
8	TOTAL General Services	1,024,514	578,013	446,766	2,049,293		2,049,293	18,676	2,067,969		8
	B. Health Care and Programs										
9	Medical Director			18,988	18,988		18,988		18,988		9
10	Nursing and Medical Records	3,151,406	582,048	10,983	3,744,437		3,744,437		3,744,437		10
10a	Therapy										10a
11	Activities	243,183	27,897	520	271,600		271,600		271,600		11
12	Social Services	164,210	75	5,527	169,812		169,812		169,812		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,558,799	610,020	36,018	4,204,837		4,204,837		4,204,837		16
	C. General Administration										
17	Administrative			1,291,008	1,291,008		1,291,008	(1,172,572)	118,436		17
18	Directors Fees										18
19	Professional Services			82,029	82,029		82,029	7,734	89,763		19
20	Dues, Fees, Subscriptions & Promotions			29,009	29,009		29,009	2,961	31,970		20
21	Clerical & General Office Expenses	721,142	63,610	37,559	822,311		822,311	612,585	1,434,896		21
22	Employee Benefits & Payroll Taxes			1,265,064	1,265,064		1,265,064		1,265,064		22
23	Inservice Training & Education			4,135	4,135		4,135		4,135		23
24	Travel and Seminar			4,704	4,704		4,704	10,120	14,824		24
25	Other Admin. Staff Transportation			11,809	11,809		11,809	5,201	17,010		25
26	Insurance-Prop.Liab.Malpractice			210,503	210,503		210,503	4,606	215,109		26
27	Other (specify):* Home Office Benefits							180,257	180,257		27
28	TOTAL General Administration	721,142	63,610	2,935,820	3,720,572		3,720,572	(349,108)	3,371,464		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,304,455	1,251,643	3,418,604	9,974,702		9,974,702	(330,432)	9,644,270		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			495,491	495,491		495,491	141,081	636,572			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,706	154,706		154,706	(37,787)	116,919			32
33	Real Estate Taxes							7,161	7,161			33
34	Rent-Facility & Grounds							10,369	10,369			34
35	Rent-Equipment & Vehicles			2,269	2,269		2,269		2,269			35
36	Other (specify):*											36
37	TOTAL Ownership			652,466	652,466		652,466	120,824	773,290			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,302,921	2,129,855	3,432,776		3,432,776		3,432,776			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,397	248,397		248,397		248,397			42
43	Other (specify):* Non-Allowable Co			983,524	983,524		983,524	(983,524)				43
44	TOTAL Special Cost Centers		1,302,921	3,361,776	4,664,697		4,664,697	(983,524)	3,681,173			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,304,455	2,554,564	7,432,846	15,291,865		15,291,865	(1,193,132)	14,098,733			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	(1,054)	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	(650)	4		8
9	Non-Straightline Depreciation	96,871	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	(715)	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	(680,000)	43		24
25	Fund Raising, Advertising and Promotional	(3,869)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(480)	43		28
29	Other-Attach Schedule See Pg 5A	(371,697)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (961,594)		\$	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	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)	(231,538)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (231,538)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,193,132)		37

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

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

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

Providence South Holland

ID# 0023242

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Misc Income Offset	\$ (5,008)	21	1
2	Disallow Labs - Part A	(125,991)	43	2
3	Disallow Interehab Psychiatry	(14,400)	43	3
4	Disallow Resident Welfare	(8,831)	43	4
5	Disallow Marketing Allocation	(140,952)	43	5
6	Disallow Accretion Expense	(6,681)	43	6
7	Non-Allow Home Office Redemptions	(57,726)	32	7
8	Out-Period Legal Expense	(2,754)	19	8
9	Capitalized Maintenance	(7,749)	6	9
10	Non-Allowable Newspaper expense	(1,605)	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	(371,697)		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 Illianna Christian Convalescent Home	100	Rest Haven Central	Palos Heights	Holland Home	South Holland	Independent Ret.
		Rest Haven West	Downers Grove	Village Woods	Crete	
		Haven Park	Zeeland,MI	Providence Mgmt. & Development Co.	Tinley Park	Management Co.
		Plymouth Place	LaGrange Park, IL	Providence Home		
				Health Care	Tinley Park	Home Health
				Saratoga Grove	Downers Grove	Supportive Living

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	\$	Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	\$ 6,649	\$ 6,649	1
2	V	5	Utilities		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	17,937	17,937	2
3	V	6	Maintenance		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	3,543	3,543	3
4	V	17	Administrative	1,291,008	Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	118,436	(1,172,572)	4
5	V	19	Professional services		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	10,488	10,488	5
6	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	2,961	2,961	6
7	V	21	Clerical & general - salary		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	511,038	511,038	7
8	V	21	Clerical & General office expense		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	106,555	106,555	8
9	V	24	Travel & seminar		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	10,120	10,120	9
10	V	25	Other admin. Staff transportation		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	5,201	5,201	10
11	V	26	Insurance-prop., liab. & malpractice		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	4,606	4,606	11
12	V	27	Management allocation of employee benefits		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	180,257	180,257	12
13	V	30	Depreciation		Rest Haven Illiana Christian D/B/A Providence Life Services	100.00%	44,210	44,210	13
14	Total			\$ 1,291,008			\$ 1,022,001	\$ * (269,007)	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%	\$ 19,939	\$ 19,939	15
16	V	33	Real estate taxes		Rest Haven Illiana Christian	100.00%	7,161	7,161	16
17	V	34	Rent - facility & grounds		Rest Haven Illiana Christian	100.00%	10,369	10,369	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			\$			\$ 37,469	\$ * 37,469	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 compenstation. See attached Schedule 7A							\$		1	
2		The board members do not conduct business with the organization.								2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11										11	
12										12	
13								TOTAL	\$		13

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

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

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 R.H. Illiana Christ. D/B/A Providence Life Srvcs
Street Address 18601 North Creek Drive
City / State / Zip Code Tinsley Park, IL 60477
Phone Number (708) 342-8100
Fax Number (708) 342-8006

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Accumulated Cost B	93,836,258	17	\$ 46,759	\$	13,343,978	\$ 6,649	1
2	5	Utilities	Accumulated Cost B	93,836,258	17	126,133		13,343,978	17,937	2
3	6	Maintenance	Accumulated Cost B	93,836,258	17	24,916		13,343,978	3,543	3
4	17	Administrative	Direct Cost A	1	1	1,324,456	1,342,092	1	118,436	4
5	19	Professional services	Accumulated Cost B	93,836,258	17	73,753		13,343,978	10,488	5
6	20	Dues, fees & subscriptions	Accumulated Cost B	93,836,258	17	20,821		13,343,978	2,961	6
7	21	Clerical & general - salary	Accumulated Cost B	93,836,258	17	3,593,671	3,593,671	13,343,978	511,038	7
8	21	Clerical & General office expense	Accumulated Cost B	93,836,258	17	749,309		13,343,978	106,555	8
9	24	Travel & seminar	Accumulated Cost B	93,836,258	17	71,167		13,343,978	10,120	9
10	25	Other admin. Staff transportation	Accumulated Cost B	93,836,258	17	36,574		13,343,978	5,201	10
11	26	Insurance-prop., liab. & malpract	Accumulated Cost B	93,836,258	17	32,387		13,343,978	4,606	11
12	27	Management allocation of employ	Accumulated Cost B	93,836,258	17	1,267,588		13,343,978	180,257	12
13	30	Depreciation	Accumulated Cost B	93,836,258	17	310,891		13,343,978	44,210	13
14	32	Interest expense	Accumulated Cost B	93,836,258	17	140,210		13,343,978	19,939	14
15	33	Real estate taxes	Accumulated Cost B	93,836,258	17	50,359		13,343,978	7,161	15
16	34	Rent - facility & grounds	Accumulated Cost B	93,836,258	17	72,918		13,343,978	10,369	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,941,912	\$ 4,935,763		\$ 1,059,470	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	Individual Notes		X	Building Improvements	Varies	Varies	\$ 70,321	\$ 23,500	Varies	Varies	\$ 1,187	1	
2	Tax Exempt Bonds		X	Building	Varies	11/01/04	4,200,000	2,155,582	10/31/34	Varies	153,519	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,270,321	\$ 2,179,082			\$ 154,706	9	
	B. Non-Facility Related*												
10												10	
11							Non-Allow Home Office Redemptions				(57,726)	11	
12												12	
13							Allocated from Home Office				19,939	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (37,787)	14	
15	TOTALS (line 9+line14)						\$ 4,270,321	\$ 2,179,082			\$ 116,919	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.		Allocated from Home Office		7,161	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$ 7,161	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 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 South Holland COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023242

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

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

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	\$ 13,604.00	\$ 7,161.00
2.	19-09-01-203-007-1001	Home Office Building	\$ 16,380.00	\$
3.	19-09-01-203-007-1006	Home Office Building	\$ 20,375.00	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 50,359.00	\$ 7,161.00

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: 65,000

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories 1

C. Does the Operating Entity?

X(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	Not Available	1976	\$ 31,305	1
2					2
3	TOTALS			\$ 31,305	3

Facility Name & ID Number Providence South Holland

0023242

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	
	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	\$ 2,322,431
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping Improvements			1977	19,723		20			19,723
10	Building Improvements			1978	7,401		40	185	185	4,484
11	Land Improvements			1981	2,535		20			2,535
12	Building Improvements			1982	8,179		40	204	204	6,145
13	Building Improvements			1983	4,035		40	101	101	2,939
14	Land Improvements			1984	7,625		20			7,625
15	Building Improvements			1985	2,029		40	51	51	1,382
16	Building Improvements			1986	49,092		40	1,227	1,227	32,133
17	Building Improvements			1987	48,670		40	1,217	1,217	30,679
18	Land Improvements			1987	4,898		20			4,898
19	Building Improvements			1988	21,602		40	540	540	13,088
20	Land Improvements			1988	1,600		20			1,600
21	Building Improvements			1898	561,415		40	14,035	14,035	328,036
22	Land Improvements			1898	9,437		20			9,437
23	Building Improvements			1990	98,412		40	2,460	2,460	54,828
24	Building Improvements			1991	74,357		40	1,859	1,859	39,618
25	Building Improvements			1992	168,370		40	4,209	4,209	85,598
26	Land Improvements			1992	13,785		20	689	689	14,030
27	Building Improvements			1994	24,717		40	618	618	11,363
28	Building Improvements			1995	52,042		40	1,301	1,301	22,767
29	Land Improvements			1995	10,722		20	536	536	9,380
30	Landscaping			1996	20,214		20	1,010	1,010	16,363
31	Building Redecorating			1996	15,578		40	390	390	6,575
32	Building Improvement - Ceiling			1996	25,000		40	625	625	10,052
33	Building Improvements - HVAC			1996	5,000		40	125	125	2,010
34	Landscaping			1997	27,690		20	1,349	1,349	21,085
35	Building Resident Room Redecorating			1997	64,348		40	1,609	1,609	24,746
36	Building - Ceiling & Lighting			1997	62,447		40	1,561	1,561	23,062

*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 South Holland

0023242

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	Building Fire Alarm System	1997	\$ 4,483	\$	40	\$ 112	\$ 112	\$ 1,773	37
38	Building - HVAC	1997	43,720		40	1,093	1,093	17,215	38
39	Building Improvement Resident Rooms in Gilead Area	1997	44,208		40	1,105	1,105	16,637	39
40	Building - Elevator Repair	1997	12,780		40	320	320	5,033	40
41	Building - Beauty Shop Renovation	1997	1,800		40	45	45	683	41
42	Land Improvement - Parking Lot	1998	46,302		20	2,316	2,316	33,582	42
43	Building Improvement Resident Rooms in Gilead Area	1998	34,374		40	859	859	12,456	43
44	Building - HVAC	1998	40,850		40	1,021	1,021	14,805	44
45	Building Rehab. Area	1998	68,738		40	1,718	1,718	24,911	45
46	Building - Kitchen Fan	1999	1,400		40	35	35	473	46
47	Building Therapy Room Renovation	1999	2,083		40	52	52	702	47
48	Building Improvement HVAC	2000	801,268		40	20,032	20,032	260,416	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	25,000	50
51	Land Improvement - Fencing	2000	8,071		15	538	538	6,725	51
52	Building Improvement HVAC	2000	663,243		40	16,581	16,581	207,263	52
53	Building - Garage	2000	3,820		20	191	191	2,388	53
54	Building Improvement - Pipe Enclosure	2000	82,716		40	2,068	2,068	25,850	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	1,437	56
57	Building Improvements - HVAC	2001	19,808		40	495	495	5,693	57
58	Building Improvements - Kitchen Floor	2001	35,884		15	2,392	2,392	27,508	58
59	Building Improvements - Fire Protection System	2001	16,000		15	1,067	1,067	12,270	59
60	Building Improvements - Code Alert	2002	12,767		10	645	645	12,767	60
61	Building Improvements - Renovations- plumbing work	2002	4,712		15	314	314	3,297	61
62	Building Improvements - Renovations-plumbing and heating	2002	3,275		40	82	82	861	62
63	Building Improvements - painting, flooring, wallcoverings	2002	434,395		7	32,152	32,152	337,596	63
64	Building Improvements- walls, electrical,lighting	2002	431,434		40	6,206	6,206	65,163	64
65	Building Improvements- HVAC	2002	17,600		40	920	920	9,660	65
66	BI-Fire dampers	2003	62,407		15	4,161	4,161	39,529	66
67	BI-Door panels	2003	6,193		10	620	620	5,890	67
68	BI-Ceiling project	2003	21,725		40	543	543	5,159	68
69	BI-Alarm system	2003	35,502		20	1,775	1,775	16,863	69
70	TOTAL (lines 4 thru 69)		\$ 7,070,108	\$		\$ 203,916	\$ 203,916	\$ 4,336,700	70

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

Facility Name & ID Number Providence South Holland

0023242

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		\$ 7,070,108	\$		\$ 203,916	\$ 203,916	\$ 4,336,700	1
2	LI-Heated sidewalk	2003	32,012		15	2,134	2,134	20,273	2
3	LI-Sign	2003	784		10	78	78	741	3
4	BI-Thermostats, heaters, pump motor, valves	2003	10,902		20	545	545	5,177	4
5	BI-Gate	2003	3,050		20	153	153	1,453	5
6	BI-Dental office	2004	15,500		40	388	388	3,298	6
7	BI-Alarm system	2004	2,860		7			2,860	7
8	BI-Fire protection system	2004	3,500		10	350	350	2,975	8
9	BI-Activity room	2004	967		7	70	70	1,037	9
10	BI-Fire protection cabinet	2004	2,850		7			2,850	10
11									11
12	BI - Generator	2005	92,610		20	4,630	4,630	34,725	12
13	BI - HVAC	2005	6,932		20	346	346	2,595	13
14	BI - Sprinklers	2005	3,815		20	190	190	1,425	14
15	BI - Generator	2005	3,668		20	184	184	1,380	15
16	BI - Outside Lights	2005	1,328		20	66	66	495	16
17	BI - Drywall	2005	880		20	44	44	330	17
18	BI - Elevator	2005	2,007		20	100	100	750	18
19	BI - Doors	2005	9,220		20	462	462	3,465	19
20	BI - Plumbing	2005	3,276		20	164	164	1,230	20
21	BI - Fire Alarm System	2005	6,975		20	348	348	2,610	21
22	BI - Master Station (Nurse Call)	2005	1,705		20	86	86	645	22
23	BI - Conveyor Warewashers	2005	1,772		20	88	88	660	23
24									24
25	BI - HVAC	2006	8,729		20	218	218	1,744	25
26	BI - Fire Doors	2006	4,635		20	116	116	928	26
27	BI - Elevator Repair	2006	4,031		20	101	101	808	27
28	LI - Landscaping	2006	3,189		20	80	80	640	28
29									29
30	SO-Asbestos Retirement Obligation	2006	118,956		20	5,948	5,948	38,662	30
31	South-roof replacmt.	2006	76,485		10	7,649	7,649	49,718	31
32	Roof replace middle	2006	34,668		10	3,467	3,467	22,535	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,527,414	\$		\$ 231,921	\$ 231,921	\$ 4,542,709	34

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

Facility Name & ID Number Providence South Holland

0023242

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 12B, Carried Forward		\$ 7,527,414	\$		\$ 231,921	\$ 231,921	\$ 4,542,709	1
2	Boiler repair	2006	1,672		15	111	111	722	2
3	2 Condensers	2006	15,590		15	1,039	1,039	6,754	3
4	HVAC Controls	2006	8,150		15	543	543	3,530	4
5	Whirlpool flush	2006	395		15	26	26	169	5
6	Grease trap	2006	7,120		15	475	475	3,086	6
7	Elevator rebuild	2006	61,940		20	3,097	3,097	20,132	7
8	Whirlpool remodel	2006	51,113		20	2,556	2,556	16,614	8
9	Analog Msg Waiting Card	2006	6,871		7	982	982	6,383	9
10	Phone Cables	2006	17,500		7	2,500	2,500	16,250	10
11	Landscape	2006	1,950		10	195	195	1,269	11
12	Driveway Lights	2006	18,400		15	1,227	1,227	7,974	12
13									13
14	Sign painting & Maint	2007	5,472		5	547	547	5,472	14
15	Remove 377 Sq Ft of Asphalt & Construct 2 Speed Bumps	2007	2,975		8	372	372	2,046	15
16	Canopy repairs	2007	3,285		15	219	219	1,205	16
17	Phone System	2007	91,454		10	9,145	9,145	50,343	17
18	Roofing	2007	60,268		10	6,027	6,027	33,147	18
19	Sewer repairs	2007	28,997		15	1,933	1,933	10,633	19
20	Driveway Land Improvements	2007	6,900		15	460	460	2,530	20
21	Repair, test, & Certify failed backflow systems	2007	2,600		5	260	260	2,600	21
22	Elevator Repair	2007	2,899		10	290	290	1,545	22
23	Fire Alarm Repairs	2007	4,470		10	447	447	2,459	23
24	Paging System	2008	24,900		10	2,490	2,490	12,450	24
25	Rooftop H-Vac	2008	102,663		15	6,844	6,844	30,799	25
26	Carpeting	2008	99,195		15	6,613	6,613	29,759	26
27	Waterline	2008	63,629		7	9,090	9,090	40,905	27
28	Dining Room Smoke Doors	2008	5,830		20	292	292	1,312	28
29	Install Controls for Admin VVT	2008	21,950		15	1,463	1,463	6,585	29
30	Facility Signs	2008	13,351		10	1,335	1,335	6,008	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,258,953	\$		\$ 292,499	\$ 292,499	\$ 4,865,387	34

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

Facility Name & ID Number Providence South Holland

0023242

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		\$ 8,258,953	\$		\$ 292,499	\$ 292,499	\$ 4,865,387	1
2	Dining Floor Replaces	2009	30,329		10	3,033	3,033	10,615	2
3	Bath Rooms Remodel - Replace Flooring and Tile	2009	138,037		20	6,902	6,902	24,157	3
4	Tub Room Remodel - Replace Flooring and Tile	2009	53,790		40	1,345	1,345	4,707	4
5									5
6									6
7	Pipe Replacement	2010	7,000		10	700	700	1,750	7
8	Wandergaurd System	2010	189,317		10	18,932	18,932	47,330	8
9	Freight Elevator	2010	62,430		20	3,122	3,122	7,804	9
10	Ejector Pump in Basement	2010	10,950		20	548	548	1,369	10
11	Repair and Paint Basement Floor	2010	2,875		20	144	144	360	11
12	P3 Pump & Exhaust Fan Replacement	2010	5,630		20	282	282	704	12
13	Sewer Pipe Replacement	2010	3,250		20	163	163	407	13
14	South hall-Wireless installation	2011	70,020		10	7,002	7,002	10,503	14
15	Installed hot Water system	2011	61,950		15	4,130	4,130	6,195	15
16	Purchased Boiler	2011	52,140		15	3,476	3,476	5,214	16
17	Puchased Ceiling Pipe	2011	10,230		20	512	512	768	17
18	Installed power pack and replaced doors holders	2011	3,550		20	178	178	267	18
19	Replaced Coil in walk in collar	2011	2,780		20	139	139	209	19
20	Added new conductor in A&B Elevator	2011	3,157		20	158	158	237	20
21									21
22	South Hall carpet replacement	2012	34,538		7	2,467	2,467	2,467	22
23	South Hall handrails	2012	24,850		20	621	621	621	23
24	Fire Alarm	2012	4,293		10	215	215	215	24
25	Ice Maker	2012	3,456		5	346	346	346	25
26									26
27									27
28									28
29									29
30	Current Book Depreciation for Building & Improvements	2012		388,504			(388,504)		30
31	Allocated from Home Office 2012	2012	599,797			26,788	26,788	160,345	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,633,321	\$ 388,504		\$ 373,700	\$ (14,804)	\$ 5,151,974	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	\$ 2,556,295	\$ 106,987	\$ 244,890	\$ 137,903	3-10	\$ 2,712,819	71
72	Current Year Purchases	11,871		560	560	3-10	560	72
73	Fully Depreciated Assets	1,508,733				3-15	1,508,733	73
74	Allocation from Home Office	632,918		16,910	16,910	3-15	596,063	74
75	TOTALS	\$ 4,709,817	\$ 106,987	\$ 262,360	\$ 155,373		\$ 4,818,175	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			\$ 8,129	\$	\$ 513	\$ 513		\$ 7,725	76
77										77
78										78
79										79
80	TOTALS			\$ 8,129	\$	\$ 513	\$ 513		\$ 7,725	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,382,572	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 495,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 636,573	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 141,082	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,977,875	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:				\$			3
4	Additions							4
5								5
6		Allocation from Home Office			10,369			6
7	TOTAL				\$ 10,369			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: N/A *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 2,269
- Description: Dietary Equipment - \$2,269

(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.)

		1	2	3	4	5	6	7	8	
	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	\$	12,305	\$ 885,976	\$	12,305	\$ 885,976	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,571	257,141		3,571	257,141	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		13,504	972,309	30,019	13,504	1,002,328	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				1,272,902		1,272,902	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			\$	29,380	\$ 2,115,426	\$ 1,302,921	29,380	\$ 3,418,347	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 850	\$ 850	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,000)	3,453,278	3,453,278	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,345	9,345	7
8	Accounts Receivable (owners or related parties)	35,037	35,037	8
9	Other(specify): BC/BS Excess	41,228	41,228	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,539,738	\$ 3,539,738	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,305	31,305	13
14	Buildings, at Historical Cost	9,076,281	9,633,321	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,853,595	4,717,946	16
17	Accumulated Depreciation (book methods)	(9,856,425)	(9,977,875)	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)	\$ 3,104,756	\$ 4,404,697	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,644,494	\$ 7,944,435	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,164	1,164	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,251	57,251	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	344	344	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	TDA Match-South	408,698	408,698	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 467,457	\$ 467,457	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	23,500	23,500	39
40	Mortgage Payable			40
41	Bonds Payable		2,155,582	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Long-Term Liabilities	229,383	229,383	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 252,883	\$ 2,408,465	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 720,340	\$ 2,875,922	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,924,154	\$ 5,068,513	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,644,494	\$ 7,944,435	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,574,971	1
2	Restatements (describe):		2
3	Prior period adjustment	56,814	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,631,785	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(707,631)	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)	\$ (707,631)	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)	\$ 5,924,154	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Providence South Holland**# **0023242**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	\$ 16,778,930	1
2	Discounts and Allowances for all Levels	(4,574,308)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,204,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	428,603	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 428,603	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	1,054	14
15	Telephone, Television and Radio	15,050	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,276,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	141,543	19
20	Radiology and X-Ray	69,319	20
21	Other Medical Services	442,291	21
22	Laundry	650	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,945,934	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	Other Income	5,075	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,075	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,584,234	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,049,293	31
32	Health Care	4,204,837	32
33	General Administration	3,720,572	33
	B. Capital Expense		
34	Ownership	652,466	34
	C. Ancillary Expense		
35	Special Cost Centers	4,416,300	35
36	Provider Participation Fee	248,397	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,291,865	40
41	Income before Income Taxes (line 30 minus line 40)**	(707,631)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (707,631)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,117,147	44
45	Private Pay - Net Inpatient Revenue	1,727,802	45
46	Medicare - Net Inpatient Revenue	9,359,673	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,204,622	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.

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	888	960	\$ 43,920	\$ 45.75	1
2	Assistant Director of Nursing	1,540	1,674	58,076	34.69	2
3	Registered Nurses	30,471	32,116	1,001,591	31.19	3
4	Licensed Practical Nurses	28,699	30,179	751,615	24.91	4
5	CNAs & Orderlies	94,539	99,257	1,296,204	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,847	16,122	243,183	15.08	10
11	Social Service Workers	7,140	7,940	164,210	20.68	11
12	Dietician	96	135	2,957	21.90	12
13	Food Service Supervisor					13
14	Head Cook	9,854	10,614	124,738	11.75	14
15	Cook Helpers/Assistants	24,341	25,491	279,131	10.95	15
16	Dishwashers					16
17	Maintenance Workers	15,893	16,789	225,652	13.44	17
18	Housekeepers	16,701	18,271	226,888	12.42	18
19	Laundry	12,746	13,365	165,148	12.36	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	34,664	37,368	721,142	19.30	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,419	310,281	\$ 5,304,455 *	\$ 17.10	34

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	18,988	9(3)	36
37	Medical Records Consultant	Monthly	1,748	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	10(3)	39
40	Physical Therapy Consultant	Monthly	14,429	39(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	520	11(3)	44
45	Social Service Consultant	Monthly	2,992	12(3)	45
46	Other(specify)				46
47	Chaplin	Monthly	2,535	12(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 43,012		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	18	\$ 1,121	10(3)	50
51	Licensed Practical Nurses	28	1,106	10(3)	51
52	Certified Nurse Assistants/Aides	169	5,208	10(3)	52
53	TOTAL (lines 50 - 52)	215	\$ 7,435		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Providence South Holland

0023242

Report Period Beginning:

01/01/2012

Page 21

Ending:

12/31/2012

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	
David Tiemersma	Administrator	0	\$ 118,436	Workers' Compensation Insurance	\$ 314,698	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	66,466	Advertising: Employee Recruitment	1,194	
Amount paid out of Home Office in column 7				FICA Taxes	376,293	Health Care Worker Background Check		
				Employee Health Insurance	384,905	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	491 5,896	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of Illinois	11,465	
				Uniforms	3,278	Miscellaneous Subscriptions	5,000	
				TDA Expense	58,141	Miscellaneous Lisc & Fees	3,464	
				Drug Testing	16,880			
				Employee Welfare	44,244	Allocated from Home Office	2,961	
				Employee Education	159	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 118,436					
(List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,265,064	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 31,970	
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 Fee (Eliminated in Col 7)			\$ 1,291,008	N/A			Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,291,008					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
Myers Carden & Sax	Legal		111					
Laner Muchin Dombrow Becker	Legal		2,048					
Much Shelist	Legal		17,399					
John Russell	Legal		9,158					
McGladrey LLP	Accounting		10,000					
KPMG, LLP	Accounting		5,544					
Achieve Accreditation	Survey		11,520					
Metro Infectious Disease	Consulting		26,249					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	4,704
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 82,029				Allocated from Home Office	10,120
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 14,824

* Attach copy of IMRF notifications

**See instructions.

Providence Life Service - South Holland
Provider #: 0023242
01/01/12 to 12/31/12

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	82,029
Allocated from Home Office : Other Professional Fees	10,488
Disallowed out of period legal	(2,754)
Total (agree to Schedule V, line 19, column 8)	<u><u>89,763</u></u>

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. LSN \$11,465

(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 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 108,210 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.

\$ 248,397

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. \$ 1,054

(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?

Yes

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 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.