

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0052381</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Providence Palos Heights</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.	
Address: <u>13259 S Central Ave</u> <u>Palos Heights</u> <u>60463</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(708) 597 - 1000</u> Fax # <u>(708) 389 - 9990</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>02/10/60</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code <u>501(c)(3)</u> ☐ 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: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u>			
Email Address: _____			

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Providence Palos Heights

#

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	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	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	14,878	6,460	24,735	46,073	8
9	SNF/PED					9
10	ICF	4,925	2,139		7,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,803	8,599	24,735	53,137	14

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

75.22%

SEE ACCOUNTANTS' PREPARATION REPORT

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)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

X

NO

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

YES

NO

X

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

Date started

02/01/60

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

YES

Date

NO

X

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

YES

X

NO

If YES, enter number of beds certified

145

and days of care provided

20,358

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/16

Fiscal Year:

12/31/16

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	599,674	75,520		675,194		675,194		675,194			1
2	Food Purchase		472,350		472,350		472,350	12,575	484,925			2
3	Housekeeping	258,126	110,208		368,334		368,334		368,334			3
4	Laundry	86,132	64,620		150,752		150,752		150,752			4
5	Heat and Other Utilities			206,542	206,542		206,542	21,036	227,578			5
6	Maintenance	305,299		436,577	741,876		741,876	(58,489)	683,387			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	1,249,231	722,698	643,119	2,615,048		2,615,048	(24,878)	2,590,170			8
	B. Health Care and Programs											
9	Medical Director			167,500	167,500		167,500		167,500			9
10	Nursing and Medical Records	5,012,212	704,600	1,358,656	7,075,468		7,075,468	(75)	7,075,393			10
10a	Therapy											10a
11	Activities	92,488	81,666	1,384	175,538		175,538		175,538			11
12	Social Services	202,606		1,364	203,970		203,970		203,970			12
13	CNA Training											13
14	Program Transportation	13,329			13,329		13,329		13,329			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	5,320,635	786,266	1,528,904	7,635,805		7,635,805	(75)	7,635,730			16
	C. General Administration											
17	Administrative			2,129,974	2,129,974		2,129,974	(2,129,974)				17
18	Directors Fees											18
19	Professional Services			127,407	127,407		127,407	65,920	193,327			19
20	Dues, Fees, Subscriptions & Promotions			158,633	158,633		158,633	(5,689)	152,944			20
21	Clerical & General Office Expenses	457,896	13,940	420,286	892,122		892,122	1,125,125	2,017,247			21
22	Employee Benefits & Payroll Taxes			1,528,715	1,528,715		1,528,715		1,528,715			22
23	Inservice Training & Education			1,088	1,088		1,088		1,088			23
24	Travel and Seminar			7,772	7,772		7,772	21,262	29,034			24
25	Other Admin. Staff Transportation			4,997	4,997		4,997	12,536	17,533			25
26	Insurance-Prop.Liab.Malpractice			228,991	228,991		228,991	268,003	496,994			26
27	Other (specify):* See Supplemental							183,069	183,069			27
28	TOTAL General Administration	457,896	13,940	4,607,863	5,079,699		5,079,699	(459,748)	4,619,951			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,027,762	1,522,904	6,779,886	15,330,552		15,330,552	(484,701)	14,845,851			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Providence Palos Heights
 Medicaid Cost Report
 01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total								-
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total								-
Line 27 - Other General Administration								
Alloc. Providence Life Services								-
Gen. Admin. Employee Benefits						183,069		183,069
								-
								-
								-
								-
								-
Sub-Total						183,069		183,069

**Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16****Page 3 Supplemental Schedule - Other Staff Administration Travel Expense**

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Ann Sleboda	Business Matters	Various	Various	3,553	-	-	3,553
Diane Giglio	Business Matters	Various	Various	573	-	-	573
Joanne Steif-Nazimek	Business Matters	Various	Various	303	-	-	303
Joseph Nowak	Business Matters	Various	Various	100	-	-	100
Victor Ortuno	Business Matters	Various	Various	469	-	-	469
							-
							-
							-
							-
							-
Alloc. Providence Life Services	Business Matters	Various	Various	12,536	-	-	12,536
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				17,533	-	-	17,533

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							444,738	444,738			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			169	169		169	211,408	211,577			32
33	Real Estate Taxes							1,127	1,127			33
34	Rent-Facility & Grounds			906,537	906,537		906,537	(867,584)	38,953			34
35	Rent-Equipment & Vehicles			17,369	17,369		17,369		17,369			35
36	Other (specify):* See Supplemental							34,891	34,891			36
37	TOTAL Ownership			924,075	924,075		924,075	(175,420)	748,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,396,445	2,508,779	3,905,224		3,905,224		3,905,224			39
40	Barber and Beauty Shops	3,146			3,146		3,146		3,146			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,630	304,630		304,630		304,630			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers	3,146	1,396,445	2,813,409	4,213,000		4,213,000		4,213,000			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,030,908	2,919,349	10,517,370	20,467,627		20,467,627	(660,121)	19,807,506			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
Providence Palos Heights, LLC								-
Mortgage Insurance Premiums						34,891		34,891
								-
								-
								-
								-
Sub-Total		-		-		34,891		34,891
Line 43 - Other Special Cost Centers								
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,413)	02		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				8
9	Non-Straightline Depreciation				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	(25,000)	21		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	(235,480)	21		24
25	Fund Raising, Advertising and Promotional	(4,581)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,887)	20		28
29	Other-Attach Schedule Supplemental Schedule	(93,010)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (363,371)		\$	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)	(296,750)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (296,750)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (660,121)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Copy Income	\$ (4,712)	21	1
2	Jury Duty Income	(75)	10	2
3	Other Income	(1,695)	21	3
4	Capitalized R&M - LIMP - > \$2,500	(49,007)	06	4
5	Capitalized R&M - EQIP - > \$2,500	(15,272)	06	5
6				6
7				7
8	Providence Palos Heights, LLC			8
9	Professional Fees	(8,250)	19	9
10	Amortization	(13,999)	31	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	(93,010)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Providence Palos Heights# 0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,413)	0	13,988	0	0	0	0	0	0	0	0	12,575	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	21,036	0	0	0	0	0	0	0	0	21,036	5
6	Maintenance	(64,279)	0	5,790	0	0	0	0	0	0	0	0	(58,489)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(65,692)	0	40,814	0	0	0	0	0	0	0	0	(24,878)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(75)	0	0	0	0	0	0	0	0	0	0	(75)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(75)	0	0	0	0	0	0	0	0	0	0	(75)	16
	C. General Administration													
17	Administrative	0	0	(2,129,974)	0	0	0	0	0	0	0	0	(2,129,974)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,250)	8,250	65,920	0	0	0	0	0	0	0	0	65,920	19
20	Fees, Subscriptions & Promotions	(8,468)	0	2,779	0	0	0	0	0	0	0	0	(5,689)	20
21	Clerical & General Office Expenses	(266,887)	0	1,392,012	0	0	0	0	0	0	0	0	1,125,125	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	21,262	0	0	0	0	0	0	0	0	21,262	24
25	Other Admin. Staff Transportation	0	0	12,536	0	0	0	0	0	0	0	0	12,536	25
26	Insurance-Prop.Liab.Malpractice	0	264,060	3,943	0	0	0	0	0	0	0	0	268,003	26
27	Other (specify):*	0	0	183,069	0	0	0	0	0	0	0	0	183,069	27
28	TOTAL General Administration	(283,605)	272,310	(448,453)	0	0	0	0	0	0	0	0	(459,748)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(349,372)	272,310	(407,639)	0	0	0	0	0	0	0	0	(484,701)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	380,607	64,131	0	0	0	0	0	0	0	0	444,738	30
31	Amortization of Pre-Op. & Org.	(13,999)	13,999	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	197,308	14,100	0	0	0	0	0	0	0	0	211,408	32
33	Real Estate Taxes	0	0	1,127	0	0	0	0	0	0	0	0	1,127	33
34	Rent-Facility & Grounds	0	(906,537)	38,953	0	0	0	0	0	0	0	0	(867,584)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	34,891	0	0	0	0	0	0	0	0	0	34,891	36
37	TOTAL Ownership	(13,999)	(279,732)	118,311	0	0	0	0	0	0	0	0	(175,420)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(363,371)	(7,422)	(289,328)	0	0	0	0	0	0	0	0	(660,121)	45

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
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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	34	Rent	\$ 906,537	Providence Palos Heights, LLC	100.00%	\$	\$ (906,537)	1
2	V	32	Interest	356	Providence Palos Heights, LLC	100.00%		(356)	2
3	V	19	Professional Fees		Providence Palos Heights, LLC	100.00%	8,250	8,250	3
4	V	21	Office and Clerical		Providence Palos Heights, LLC	100.00%			4
5	V	26	Insurance		Providence Palos Heights, LLC	100.00%	264,060	264,060	5
6	V	30	Depreciation		Providence Palos Heights, LLC	100.00%	380,607	380,607	6
7	V	31	Amortization		Providence Palos Heights, LLC	100.00%	13,999	13,999	7
8	V	32	Interest		Providence Palos Heights, LLC	100.00%	197,664	197,664	8
9	V	36	Mortgage Insurance		Providence Palos Heights, LLC	100.00%	34,891	34,891	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 906,893			\$ 899,471	\$ * (7,422)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Providence Palos Heights

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Providence Life Services	100.00%						1
2								2
3	Board of Directors / Governors							3
4								4
5	Tim Breems	N/A	Providence Healthcare & Rehabilitation	Palos Heights, IL	Village Woods	Crete, IL	Ast. & Ind. Living	5
6	Calvin Tameling	N/A	Providence Healthcare & Rehabilitation	Downers Grove, IL	Saratoga Grove	Downers Grove, IL	Ast. & Ind. Living	6
7	Justin Kats	N/A	Providence Healthcare & Rehabilitation	Zeeland, MI	Royal Atrium Inn	Zeeland, MI	Ast. & Ind. Living	7
8	Sharon Clousing	N/A	Park Place Health & Wellness Center	Elmhurst, IL	Park Place	Elmhurst, IL	Ast. & Ind. Living	8
9	Richard Schutt	N/A	Park Place of St. John	St. John, IN	Park Place St. John	St. John, IN	Ind. Living	9
10	Lucette Bamford	N/A	Victorian Village Health & Wellness Ctr	Homer Glen, IL	Victorian Village	Home Glen, IL	Ast. & Ind. Living	10
11	Hal Brown	N/A	Plymouth Place	Lagrange Park, IL	Emerald Meadows	Grand Rapids, MI	Ast. Living	11
12	Jean Cavanaugh	N/A			Thomas Park	Orland Park, IL	Ind. Living	12
13	Dr. Al Diepstra	N/A			Arbor Place	Lisle, IL	Ind. Living	13
14	Gary Ellens	N/A			Providence at Home	Tinley Park, IL	Home Health	14
15	Howard Hoff	N/A			Providence Hospice	Tinley Park, IL	Hospice	15
16	Ken Schoon	N/A			Providence Mgmt.			16
17	Tim Smits	N/A			& Development Co	Tinley Park, IL	Mgmt. Company	17
18	Don Van Dyk	N/A			Providence Palos			18
19	Richard Van Hattem	N/A			Heights, LLC	Tinley Park, IL	Bldg. Company	19
20	Robert Van Staalduned	N/A			Providence Downers			20
21	Robert Workman	N/A			Grove, LLC	Tinley Park, IL	Bldg. Company	21
22	Norma Aardema	N/A			Providence Zeeland	Tinley Park, IL	Bldg. Company	22
23	Janice DeBoer	N/A			Providence of Grand			23
24	Don DeGraff	N/A			Rapids, LLC	Tinley Park, IL	Bldg. Company	24
25	Arnold Kolenhoven	N/A						25
26	Jim Lagestee	N/A						26
27	Bruce Leep	N/A						27
28	Dick Molenhouse	N/A						28
29	Roy Van Eck	N/A						29
30	Sam Van Til	N/A						30

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	02	Food	\$	Providence Life Services	100.00%	\$ 13,988	\$ 13,988	15
16	V	05	Utilities		Providence Life Services	100.00%	21,036	21,036	16
17	V	06	Maintenance		Providence Life Services	100.00%	5,790	5,790	17
18	V	17	Administration	2,129,974	Providence Life Services	100.00%	0	(2,129,974)	18
19	V	19	Professional Services		Providence Life Services	100.00%	65,553	65,553	19
20	V	20	Dues and Subscriptions		Providence Life Services	100.00%	2,678	2,678	20
21	V	21	Office and Clerical - Salary		Providence Life Services	100.00%	720,034	720,034	21
22	V	21	Office and Clerical - Other		Providence Life Services	100.00%	271,688	271,688	22
23	V	24	Travel and Seminar		Providence Life Services	100.00%	21,262	21,262	23
24	V	25	Other Admin. Staff Trans.		Providence Life Services	100.00%	12,483	12,483	24
25	V	26	Insurance		Providence Life Services	100.00%	3,943	3,943	25
26	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	96,478	96,478	26
27	V	30	Depreciation		Providence Life Services	100.00%	64,131	64,131	27
28	V	32	Interest		Providence Life Services	100.00%	14,100	14,100	28
29	V	33	Real Estate Taxes		Providence Life Services	100.00%	1,127	1,127	29
30	V	34	Rent - Facility and Grounds		Providence Life Services	100.00%	38,953	38,953	30
31	V								31
32	V	19	Professional Services		Providence Life Services	100.00%	367	367	32
33	V	20	Dues and Subscriptions		Providence Life Services	100.00%	101	101	33
34	V	21	Office and Clerical - Salary		Providence Life Services	100.00%	385,142	385,142	34
35	V	21	Office and Clerical		Providence Life Services	100.00%	15,148	15,148	35
36	V	25	Other Admin. Staff Trans.		Providence Life Services	100.00%	53	53	36
37	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	86,591	86,591	37
38	V								38
39	Total			\$ 2,129,974			\$ 1,840,646	\$ * (289,328)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Palos Heights, LLC
Street Address 18601 North Creek Drive, Suite A
City / State / Zip Code Tinley Park, Illinois 60477
Phone Number (708) 342 - 8100
Fax Number (708) 342 - 8006

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Life Services
Street Address 18601 North Creek Drive, Suite A
City / State / Zip Code Tinley Park, Illinois 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	02	Food	Accumulated Cost	97,942,435	22	\$ 83,136	\$	16,479,248	\$ 13,988	1
2	05	Utilities	Accumulated Cost	97,942,435	22	125,025		16,479,248	21,036	2
3	06	Maintenance	Accumulated Cost	97,942,435	22	34,413		16,479,248	5,790	3
4	17	Administration	Direct	1	1	2,195,852				4
5	19	Professional Services	Accumulated Cost	97,942,435	22	389,607		16,479,248	65,553	5
6	20	Dues and Subscriptions	Accumulated Cost	97,942,435	22	15,919		16,479,248	2,678	6
7	21	Office and Clerical - Salary	Accumulated Cost	97,942,435	22	4,279,434	4,279,434	16,479,248	720,034	7
8	21	Office and Clerical - Other	Accumulated Cost	97,942,435	22	1,614,746		16,479,248	271,688	8
9	24	Travel and Seminar	Accumulated Cost	97,942,435	22	126,368		16,479,248	21,262	9
10	25	Other Admin. Staff Transp.	Accumulated Cost	97,942,435	22	74,194		16,479,248	12,483	10
11	26	Insurance	Accumulated Cost	97,942,435	22	23,435		16,479,248	3,943	11
12	27	Gen. Admin. - Emp. Ben.	Accumulated Cost	97,942,435	22	573,406		16,479,248	96,478	12
13	30	Depreciation	Accumulated Cost	97,942,435	22	381,152		16,479,248	64,131	13
14	32	Interest	Accumulated Cost	97,942,435	22	83,801		16,479,248	14,100	14
15	33	Real Estate Taxes	Accumulated Cost	97,942,435	22	6,699		16,479,248	1,127	15
16	34	Rent - Facility and Grounds	Accumulated Cost	97,942,435	22	231,512		16,479,248	38,953	16
17										17
18	19	Professional Services	Direct	1	1	367		1	367	18
19	20	Dues and Subscriptions	Direct	1	1	101		1	101	19
20	21	Office and Clerical - Salary	Direct	1	1	385,142	385,142	1	385,142	20
21	21	Office and Clerical	Direct	1	1	15,148		1	15,148	21
22	25	Other Admin. Staff Transp.	Direct	1	1	53		1	53	22
23	27	Gen. Admin. - Emp. Ben.	Direct	1	1	86,591		1	86,591	23
24										24
25	TOTALS					\$ 10,726,101	\$ 4,664,576		\$ 1,840,646	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	FHA		X	Mortgage		08/15/13	\$ 5,920,000	\$ 5,416,240	09/01/38	3.600%	\$ 197,664	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Other										169	6	
7	Alloc. Providence Life Serv.										14,100	7	
8												8	
9	TOTAL Facility Related						\$ 5,920,000	\$ 5,416,240			\$ 211,933	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	Interest Income - Building										(356)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (356)	14	
15	TOTALS (line 9+line14)						\$ 5,920,000	\$ 5,416,240			\$ 211,577	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 34,891

Line # 36 - 03

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 2015 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.)				\$	1,1272
3. Under or (over) accrual (line 2 minus line 1).				\$	1,1273
4. Real Estate Tax accrual used for 2016 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.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	1,1277
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
Providence Palos Heights - Not Subject to Real Estate Taxes		13	FOR BHF USE ONLY		
Alloc. Providence Life Services = \$1,127		13	FROM R. E. TAX STATEMENT FOR 2015 \$		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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Providence Palos Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052381

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. N/A		\$	\$
2.		\$	\$
3. Alloc. Providence Life Services	Home Office Allocation	\$ 62,325.84	\$ 1,127.14
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 62,325.84	\$ 1,127.14

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? YES X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16

Page 10 - Real Estate Supplemental Schedule

Parcel Number	Tax Year	Tax Paid						Amount
19 - 09 - 01 - 203 - 007 - 1001	2015	2016						16,837
19 - 09 - 01 - 203 - 007 - 1006	2015	2016						20,273
19 - 09 - 01 - 203 - 007 - 1006	2015	2016						25,217
Total								62,326

Facility Name	Alloc. Amount	Facility Units	Total Units	Alloc. Percentage				Allocated Amount
Providence Palos Hills	6,699	16,479,248	97,942,435	16.83%				1,127
Providence Downers Grove	6,699	12,063,733	97,942,435	12.32%				825
Other Nursing Home Entities	6,699	69,399,454	97,942,435	70.86%				4,747
Other Non-Care Entities	55,627							55,627
Total								62,326

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).

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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50		1960	1960	\$ 341,041	\$		\$	\$	\$	4
5	50		1962	1962	122,119						5
6			1963	1963	86,546						6
7	93		1967	1967	585,862						7
8			1975	1975	147,301						8
	Improvement Type**										
9	Various			1967	312,475						9
10	Various			1970	74,824						10
11	Various			1971	10,740						11
12	Various			1972	3,992						12
13	Various			1973	2,002						13
14	Various			1974	1,001						14
15	Various			1976	8,418						15
16	Various			1977	1,073						16
17	Various			1979	450						17
18	Various			1980	629						18
19	Various			1982	3,077						19
20	Various			1983	4,063						20
21	Various			1984	11,366						21
22	Various			1985	5,552						22
23	Various			1986	308,545						23
24	Various			1987	242,285						24
25	Various			1988	144,720						25
26	Various			1989	75,090						26
27	Various			1990	258,016						27
28	Various			1991	88,476						28
29	Various			1992	51,572						29
30	Various			1993	283,946						30
31	Various			1994	396,618						31
32	Various			1995	221,026						32
33	Various			1996	688,195						33
34	Various			1997	629,702						34
35	Various			1998	297,552						35
36	Various			1999	289,532						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
37	Various	2000	\$ 271,326	\$		\$	\$	\$	37
38	Various	2001	140,957						38
39	Various	2002	245,058						39
40	Various	2003	221,647						40
41	Various	2004	87,909						41
42	Various	2005	215,550						42
43	Various	2006	423,397						43
44	Various	2007	395,211						44
45	Various	2008	187,517						45
46	Various	2009	217,504						46
47	Various	2010	362,679						47
48	Various	2011	256,876						48
49	Various	2012	214,757						49
50	Boiler	2013	5,291						50
51	HVAC - Chapel Rooftop	2013	15,000						51
52	Concerte Pad and Sidewalk	2013	7,895						52
53	Elevator Repairs	2013	9,967						53
54	Outpatient Ramp Awning	2013	9,850						54
55	Oven Pad Removal	2013	2,601						55
56	Pave Chapel and Dock Lot	2013	27,555						56
57	Roof Duct Insulation	2013	18,986						57
58	Water Heaters - Unit 2	2013	18,342						58
59	Whirlpool Renovations - Unit 2	2013	21,940						59
60	Building Renovations - Cabling, Carpeting, Etc. - Unit 2	2013	98,430						60
61	Pave Chapel and Dock Lot	2013	2,500						61
62	HVAC - Chapel Rooftop	2013	33,406						62
63	Millwork and Ceramic (Vinyl) Tile - Unit 1 Lobby	2014	13,964						63
64	Renovation Carryover - Floording - Unit 1	2014	3,127						64
65	B & C Paint, Wallpaper Removal, TV Wiring - Unit 2	2014	27,250						65
66	Lobby Carpeting, Painting and Wallpaper - Unit 1	2014	5,907						66
67	B & C Carpeting - Unit 2	2014	2,910						67
68	Practioner and DON Office - Carpeting	2014	3,742						68
69	IT Email Archiving	2014	5,817						69
70	TOTAL (lines 4 thru 69)		\$ 9,272,674	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Providence Palos Heights

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
1	Totals from Page 12A, Carried Forward		\$ 9,272,674	\$		\$	\$	\$	1
2									2
3	Landscaping - Chapel Courtyard	2014	9,845						3
4	Egress System - IT Cabling and Wiring - Throughout Building	2014	30,219						4
5	Chiller - 15 Ton - Unit 1	2014	32,898						5
6	Furnace - Unit 2	2014	6,859						6
7	Icare Licensing	2014	10,199						7
8	Lobby - Millwork, Painting, Wallpaper, and Carpeting - Unit 1	2014	29,490						8
9	Bathrooms - Ceramic Tile, Plumbing, Painting, Electrical - Unit 1	2014	40,352						9
10	HVAC - New Fan Motor - Unit 2	2014	3,932						10
11	Blacktop and Paving - East Parking Lot	2014	90,000						11
12	Air Conditioning Units	2014	4,997						12
13	Disposal Replacement - Unit 1	2014	5,384						13
14	Doctor and DON Office - Paint and Carpet	2014	17,888						14
15	Touchscreen Replacement	2014	25,000						15
16	Doors - Laundry and Activity Rooms	2014	3,125						16
17	Doors - Laundry and Activity Rooms	2014	4,220						17
18	HVAC Fan Coils	2014	23,212						18
19	Patching and Sealcoating - Front, Sout, and East Lots	2014	12,694						19
20	Door Handles and Handrails	2014	5,879						20
21	Entry Sliding Door - Unit 1	2015	2,998						21
22	Elevator Pit Springs - Unit 2	2015	10,008						22
23	Fan Coils - Unit 1 and 2	2015	3,520						23
24	Sprinkler Heads - IDPH Survey	2015	14,582						24
25	Asbestos Abatement	2015	17,800						25
26	Egress System	2015	45,890						26
27	Parkint Lot Repavement	2015	93,774						27
28	R&M - Parking Lot Striping	2015	5,755						28
29	R&M - Parking Lot Excavating with Trench and Stone	2015	6,250						29
30	R&M - Move Toilet off Dining Hall	2015	6,850						30
31	R&M - HVAC - Remove and Replace 7 Fan Coils - Unit 1&2	2015	13,762						31
32	R&M - Elevator Pit Pipe, Ladder, and Restrictors	2015	8,783						32
33	R&M - Roofing Repairs & Three Skylights Installed	2015	4,890						33
34	TOTAL (lines 1 thru 33)		\$ 9,863,729	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 9,863,729	\$		\$	\$	\$	1
2								2
3 R&M - Boiler - Installed New Motor Coupling	2015	4,329						3
4 R&M - Piping Replacement - D Wing	2015	3,800						4
5 R&M - Boiler Water Line Insulation Install	2015	3,193						5
6 R&M - Hallway Key Switches	2015	2,698						6
7 R&M - Main Entry Door Control and Motor Gear Box	2015	2,607						7
8 Smoke Detectors and Installation - Wicker Room	2016	6,147						8
9 Emergency Distribution System - Power Separation	2016	89,061						9
10 Chiller - 90 Tons - Unit 2	2016	60,988						10
11 Railings - Entrance, D Exit, B Exit, and Laundry	2016	36,800						11
12 Wiring - Emergency Distribution System - Power Separation	2016	7,250						12
13 R&M - Door Closers & Locks - Pedestrian and Storate Rooms	2016	13,737						13
14 R&M - Chiller Repairs	2016	15,481						14
15 R&M - Fire System Valve Replacement and Asphalt Repair	2016	8,503						15
16 R&M - Repair Broken 2" Galvanized Vent Line	2016	3,875						16
17 R&M - Elevator - Install Sold State Starter	2016	7,411						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 Depreciation - Providence Palos Heights, LLC			206,382		206,382		7,791,083	31
32 Depreciation - Providence Life Services			64,131		64,131			32
33								33
34 TOTAL (lines 1 thru 33)		\$ 10,129,609	\$ 270,513		\$ 270,513	\$	\$ 7,791,083	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 5,822,633	\$ 146,999	\$ 146,999	\$	3 - 10	\$ 5,213,587	71
72	Current Year Purchases	198,613	27,226	27,226		3 - 10	27,226	72
73	Fully Depreciated Assets							73
74	Capitalized R&M	15,272						74
75	TOTALS	\$ 6,036,518	\$ 174,225	\$ 174,225	\$		\$ 5,240,813	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 16,196,127	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 444,738	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 444,738	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,031,896	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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? ☐ YES ☐ NO
- If NO, see instructions.

		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	See Suppl				38,953			5
6								6
7	TOTAL				\$ 38,953			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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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 .
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: \$ 8,987 Description: See Supplemental Schedule
- (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	Facility Maintenance	GMC Truck	\$ 698.47	\$ 8,382	17
18					18
19					19
20					20
21	TOTAL		\$ 698.47	\$ 8,382	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Description		Amount	Total
Building Rental			
Alloc. Providence Life Services		38,953	38,953
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
Total		38,953	38,953
Equipment Rental			
Dietary Equipment		8,987	8,987
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
Total		8,987	8,987

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

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)

		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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

IL478-2471

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 - 03	hrs	\$		\$ 952,660	\$		\$ 952,660	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			406,512			406,512	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			897,887			897,887	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				1,279,872		1,279,872	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					116,573		116,573	12
13	Other (specify): See Supplemental	39 - 03				251,720			251,720	13
14	TOTAL			\$		\$ 2,508,779	\$ 1,396,445		\$ 3,905,224	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Providence Palos Heights
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Salaries		Supplies		Other		Total
Medical Supplies				116,573			116,573
Radiology						140,955	140,955
Laboratory						110,765	110,765
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
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							-
							-
							-
							-
Total		-		116,573		251,720	368,293

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	\$ 1,500	\$ 200,189	1
2	Cash-Patient Deposits	14,140	14,140	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 676,994)	4,701,563	4,701,563	3
4	Supply Inventory (priced at Cost - FIFO)	4,031	4,031	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,134	20,134	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule		483,702	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,741,368	\$ 5,423,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost		9,718,999	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		6,118,925	16
17	Accumulated Depreciation (book methods)		(13,031,896)	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): See Supplemental Schedule		191,783	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 3,027,811	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,741,368	\$ 8,451,570	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,603,727	\$ 2,603,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,140	14,140	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,715	75,715	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		22,064	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	5,068,218	6,196,450	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,761,800	\$ 8,912,096	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,416,240	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,416,240	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,761,800	\$ 14,328,336	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,020,432)	\$ (5,876,766)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,741,368	\$ 8,451,570	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Escrow - Insurance				129,342		129,342
Escrow - Replacement				146,009		146,009
Escrow - Mortgage Insurance				8,723		8,723
Escrow - Debt Service				199,628		199,628
						-
Sub-Total		-		483,702		483,702
Line 23 - Long Term Assets						
Financing Costs (Net of Amortization)				191,783		191,783
						-
						-
						-
						-
Sub-Total		-		191,783		191,783
Line 36 - Other Current Liability						
Due to Affiliated Organizations		5,068,218		958,399		6,026,617
Asbestos Retirement Obligation				169,833		169,833
						-
						-
						-
Sub-Total		5,068,218		1,128,232		6,196,450
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (962,240)	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Post Cost Report Filing	104,385	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (857,855)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,162,577)	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)	\$ (2,162,577)	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)	\$ (3,020,432)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights

0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,189,329	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,189,329	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,353	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 106,353	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	1,473	13
14	Non-Patient Meals	1,413	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,886	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	6,482	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,482	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,305,050	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,615,048	31
32	Health Care	7,635,805	32
33	General Administration	5,079,699	33
	B. Capital Expense		
34	Ownership	924,075	34
	C. Ancillary Expense		
35	Special Cost Centers	3,908,370	35
36	Provider Participation Fee	304,630	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,467,627	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,162,577)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,162,577)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,437,642	44
45	Private Pay - Net Inpatient Revenue	2,110,274	45
46	Medicare - Net Inpatient Revenue	10,528,259	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	2,113,154	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,189,329	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

**Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16**

Page 19 Supplemental Schedule

[illegible]

Facility Name & ID Number Providence Palos Heights# 0052381

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,968	2,080	\$ 107,366	\$ 51.62	1
2	Assistant Director of Nursing	2,280	2,439	89,127	36.54	2
3	Registered Nurses	62,718	64,462	2,305,432	35.76	3
4	Licensed Practical Nurses	15,801	17,316	532,693	30.76	4
5	CNAs & Orderlies	125,706	131,994	1,904,682	14.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,160	41,211	19.08	9
10	Activity Assistants	4,427	4,557	51,277	11.25	10
11	Social Service Workers	8,458	8,962	202,606	22.61	11
12	Dietician	2,024	2,097	59,927	28.58	12
13	Food Service Supervisor	1,981	2,079	60,074	28.90	13
14	Head Cook	3,878	4,091	67,180	16.42	14
15	Cook Helpers/Assistants	13,744	14,679	210,627	14.35	15
16	Dishwashers	18,282	19,188	201,866	10.52	16
17	Maintenance Workers	19,817	21,259	305,299	14.36	17
18	Housekeepers	18,863	20,388	258,126	12.66	18
19	Laundry	6,498	6,917	86,132	12.45	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,601	20,246	457,896	22.62	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	3,049	3,697	72,912	19.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	990	1,134	16,475	14.53	33
34	TOTAL (lines 1 - 33)	332,077	349,745	\$ 7,030,908 *	\$ 20.10	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		167,500	09 - 03	36
37	Medical Records Consultant		1,148	10 - 03	37
38	Nurse Consultant		86,241	10 - 03	38
39	Pharmacist Consultant		19,695	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		19,270	10 - 03	42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,384	11 - 03	44
45	Social Service Consultant		1,364	12 - 03	45
46	Other(specify)				46
47	<u>See Supplemental Schedule</u>				47
48					48
49	TOTAL (lines 35 - 48)		\$ 296,602		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 112,539	10 - 03	50
51	Licensed Practical Nurses		272,323	10 - 03	51
52	Certified Nurse Assistants/Aides		847,440	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 1,232,302		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Providence Palos Heights
Medicaid Cost Report
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Concierge	14	648	770	13,329	17.31		
Beautician	40	342	364	3,146	8.64		
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Total		990	1,134	16,475	14.53		

Contracted Services							
Total						-	-

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
			\$	Workers' Compensation Insurance	\$	374,576	IDPH License Fee	\$ 1,990
				Unemployment Compensation Insurance		87,644	Advertising: Employee Recruitment	91,449
				FICA Taxes		520,039	Health Care Worker Background Check	
				Employee Health Insurance		410,652	(Indicate # of checks performed)	24,317
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues - Leading Age	17,486
				Employee Retirement Benefits		78,000	Dues and Licenses	3,505
				Employee Benefits - Other		57,804	Accreditation	11,419
TOTAL (agree to Schedule V, line 17, col. 1)							Advertising and Marketing	8,467
(List each licensed administrator separately.)							Alloc. Providence Life Services	2,779
							Less: Public Relations Expense	(4,581)
B. Administrative - Other							Non-allowable advertising (	
Description			Amount				Yellow page advertising	(3,887)
Providence Life Services - Management Fees			\$ 2,129,974					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	1,528,715	TOTAL (agree to Sch. V,	\$ 152,944
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Jackson Lewis	Legal		\$ 8,508				Out-of-State Travel	\$
Much Shelist	Legal		98,904					
Plante & Moran, PLLC	Audit / Cost Reports		18,554					
Direct Supply, Inc.	Data Processing		1,050				In-State Travel	
Other			390					
							Seminar Expense	7,772
							Alloc. Providence Life Services	21,262
							Entertainment Expense (	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)					\$		line 24, col. 8)	\$ 29,034
			\$ 127,407					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

**Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16****Page 21 Supplemental Schedule - Legal Invoice Detail**

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Jackson Lewis LLP	General Corporate	02/29/16		2,923		2,923
Jackson Lewis LLP	General Corporate	03/31/16		2,136		2,136
Jackson Lewis LLP	General Corporate	05/26/16		2,845		2,845
Jackson Lewis LLP	General Corporate	08/01/16		604		604
Much Shelist	IDPH Survey	03/01/16		749		749
Much Shelist	IDPH Survey	04/01/16		15,013		15,013
Much Shelist	IDPH Survey	05/01/16		11,256		11,256
Much Shelist	IDPH Survey	06/01/16		3,791		3,791
Much Shelist	IDPH Survey	08/01/16		2,851		2,851
Much Shelist	IDPH Survey	08/17/16		8,365		8,365
Much Shelist	IDPH Survey	10/12/16		658		658
Much Shelist	IDPH Survey	12/01/16		12,757		12,757
Much Shelist	IDPH Survey	12/01/16		34,216		34,216
Much Shelist	IDPH Survey	12/01/16		9,251		9,251
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**Providence Palos Heights
Medicaid Cost Report
01/01/16 - 12/31/16**

Page 21 Supplemental Schedule - Seminar

[illegible]

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.

Leading Age - \$17,486

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 - 10 Yrs

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

137,306

 Line

10 - 02

(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. \$

304,630

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?

Yes

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. \$

1,413

(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?

Ln 14

d. Have vehicle usage logs been maintained?

Yes

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:

Plante & Moran, PLLC - Not Finished

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees
- SEE ACCOUNTANTS' PREPARATION REPORT
- HFS 3745 (N-4-99)
- IL478-2471