FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0052381

Facility Name: Providence Palos Heights

Address: 13259 S Central Ave (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
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 01/01/15 to 12/31/15 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) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	193	TOTALS	193	70,445	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,009	4,528	25,883	34,420	8
9	SNF/PED					9
10	ICF	8,108	6,071		14,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,117	10,599	25,883	48,599	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.99%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 20,543

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: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	646,515	65,447		711,962		711,962		711,962			1
2	Food Purchase		444,813		444,813		444,813	(1,456)	443,357			2
3	Housekeeping	252,271	115,555		367,826		367,826		367,826			3
4	Laundry	88,455	53,056		141,511		141,511	(73)	141,438			4
5	Heat and Other Utilities			215,610	215,610		215,610	21,806	237,416			5
6	Maintenance	336,874		501,534	838,408		838,408	(71,490)	766,918			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	1,324,115	678,871	717,144	2,720,130		2,720,130	(51,213)	2,668,917			8
	B. Health Care and Programs											
9	Medical Director			165,000	165,000		165,000		165,000			9
10	Nursing and Medical Records	3,890,147	322,582	461,497	4,674,226		4,674,226		4,674,226			10
10a	Therapy	111,627	110,709	864	223,200		223,200		223,200			10a
11	Activities	175,799		3,000	178,799		178,799		178,799			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	4,177,573	433,291	630,361	5,241,225		5,241,225		5,241,225			16
	C. General Administration											
17	Administrative			1,894,821	1,894,821		1,894,821	(1,664,215)	230,606			17
18	Directors Fees											18
19	Professional Services			72,035	72,035		72,035	40,037	112,072			19
20	Dues, Fees, Subscriptions & Promotions			91,725	91,725		91,725	(9,013)	82,712			20
21	Clerical & General Office Expenses	522,721	9,025	346,700	878,446		878,446	556,769	1,435,215			21
22	Employee Benefits & Payroll Taxes			1,341,037	1,341,037		1,341,037		1,341,037			22
23	Inservice Training & Education			1,345	1,345		1,345		1,345			23
24	Travel and Seminar			7,468	7,468		7,468	27,035	34,503			24
25	Other Admin. Staff Transportation			10,950	10,950		10,950	5,432	16,382			25
26	Insurance-Prop.Liab.Malpractice			51,139	51,139		51,139	271,356	322,495			26
27	Other (specify):* See Supplemental							190,431	190,431			27
28	TOTAL General Administration	522,721	9,025	3,817,220	4,348,966		4,348,966	(582,168)	3,766,798			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,024,409	1,121,187	5,164,725	12,310,321		12,310,321	(633,381)	11,676,940			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Providence Palos Heights
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Total	-	-	-
Line 15 Detailed			
Total	-	-	-
Line 27 Detailed			
Providence Life Services			
Gen. Admin. - Employee Benefits			190,431
Total	-	-	190,431

Providence Palos Heights
Medicaid Cost Report
01/01/15 - 12/31/15

Page 3 Line 25 Other Admin Staff Transportation Expense

Payee	Amount	Allowable
Ann Sleboda	5,015	5,015
Laketa Jackson	516	516
UFW	626	626
Providence Life Services	2,536	2,536
Speedway Super America	1,505	1,505
Victor Ortuno	430	430
Osco Incorporates	323	323
Alloc. - Providence Life Services	5,432	5,432
Total	16,382	16,382

Facility Name & ID Number Providence Palos Heights #0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							369,510	369,510			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							207,617	207,617			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,003,051	1,003,051		1,003,051	(958,618)	44,433			34
35	Rent-Equipment & Vehicles			20,417	20,417		20,417		20,417			35
36	Other (specify):* See Supplemental							35,927	35,927			36
37	**TOTAL Ownership**			1,023,468	1,023,468		1,023,468	(345,564)	677,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,845,321	2,116,133	3,961,454		3,961,454		3,961,454			39
40	Barber and Beauty Shops	2,960			2,960		2,960		2,960			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,913	275,913		275,913		275,913			42
43	Other (specify):* See Supplemental											43
44	**TOTAL Special Cost Centers**	2,960	1,845,321	2,392,046	4,240,327		4,240,327		4,240,327			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,027,369	2,966,508	8,580,239	17,574,116		17,574,116	(978,945)	16,595,171			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Providence Palos Heights
Medicaid Cost Report
01/01/15 - 12/31/15

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Providence Palos Heights, LLC			
Mortgage Insurance Premium			35,927
Total	-	-	35,927
Line 43 Detailed			
Total	-	-	-

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(4,126)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,391)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(2,471)	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	(162,000)	21		24
25	Fund Raising, Advertising and Promotional	(8,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,008)	20		28
29	Other-Attach Schedule See Supplemental	(109,555)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (297,085)		$	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)	(681,860)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (681,860)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (978,945)		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' COMPILATION REPORT

Providence Palos Heights

ID# 0052381

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Laundry Income	$ (73)	04	1
2	Miscellaneous Income	(9,978)	21	2
3	R & M Capitalized > $2,500 Threshold	(74,281)	06	3
4				4
5				5
6				6
7				7
8	Providence Palos Heights, LLC			8
9	Professional Fees	(11,445)	19	9
10	Office and Clerical	(129)	21	10
11	Amortization	(13,649)	31	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**	(109,555)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Providence Palos Heights # 0052381 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,126)	0	2,670	0	0	0	0	0	0	0	0	(1,456)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(73)	0	0	0	0	0	0	0	0	0	0	(73)	4
5	Heat and Other Utilities	0	0	21,806	0	0	0	0	0	0	0	0	21,806	5
6	Maintenance	(74,281)	0	2,791	0	0	0	0	0	0	0	0	(71,490)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(78,480)	0	27,267	0	0	0	0	0	0	0	0	(51,213)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(1,664,215)	0	0	0	0	0	0	0	0	(1,664,215)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,445)	11,445	40,037	0	0	0	0	0	0	0	0	40,037	19
20	Fees, Subscriptions & Promotions	(12,542)	0	3,529	0	0	0	0	0	0	0	0	(9,013)	20
21	Clerical & General Office Expenses	(180,969)	129	737,609	0	0	0	0	0	0	0	0	556,769	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	27,035	0	0	0	0	0	0	0	0	27,035	24
25	Other Admin. Staff Transportation	0	0	5,432	0	0	0	0	0	0	0	0	5,432	25
26	Insurance-Prop.Liab.Malpractice	0	264,060	7,296	0	0	0	0	0	0	0	0	271,356	26
27	Other (specify):*	0	0	190,431	0	0	0	0	0	0	0	0	190,431	27
28	**TOTAL General Administration**	(204,956)	275,634	(652,846)	0	0	0	0	0	0	0	0	(582,168)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(283,436)	275,634	(625,579)	0	0	0	0	0	0	0	0	(633,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Providence Palos Heights # 0052381 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	353,575	15,935	0	0	0	0	0	0	0	0	369,510	30
31	Amortization of Pre-Op. & Org.	(13,649)	13,649	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	203,331	4,286	0	0	0	0	0	0	0	0	207,617	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,003,051)	44,433	0	0	0	0	0	0	0	0	(958,618)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	35,927	0	0	0	0	0	0	0	0	0	35,927	36
37	**TOTAL Ownership**	(13,649)	(396,569)	64,654	0	0	0	0	0	0	0	0	(345,564)	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)**	(297,085)	(120,935)	(560,925)	0	0	0	0	0	0	0	0	(978,945)	45

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X] 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 - Facility and Grounds	$ 1,003,051	Providence Palos Heights, LLC	100.00%	$	$ (1,003,051)	1
2	V	32	Interest	645	Providence Palos Heights, LLC	100.00%		(645)	2
3	V	19	Professional Fees		Providence Palos Heights, LLC	100.00%	11,445	11,445	3
4	V	21	Office and Clerical		Providence Palos Heights, LLC	100.00%	129	129	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%	353,575	353,575	6
7	V	31	Amortization		Providence Palos Heights, LLC	100.00%	13,649	13,649	7
8	V	32	Interest		Providence Palos Heights, LLC	100.00%	203,976	203,976	8
9	V	36	Mortgage Insurance		Providence Palos Heights, LLC	100.00%	35,927	35,927	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,003,696			$ 882,761	$ * (120,935)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%						1
2								2
3	Board of Directors / Governors		Providence Healthcare & Rehabilitation	Palos Heights, IL	Village Woods	Crete, IL	Ast. & Ind. Living	3
4			Providence Healthcare & Rehabilitation	Downers Grove, IL	Saratoga Grove	Downers Grove, IL	Ast. & Ind. Living	4
5	Tim Breems	N/A	Providence Healthcare & Rehabilitation	Zeeland, MI	Royal Atrium Inn	Zeeland, MI	Ast. & Ind. Living	5
6	Calvin Tameling	N/A	Park Place Health & Wellness Center	Elmhurst, IL	Park Place	Elmhurst, IL	Ast. & Ind. Living	6
7	Justin Kats	N/A	Park Place of St. John	St. John, IN	Park Place St. John	St. John, IN	Ind. Living	7
8	Sharon Clousing	N/A	Victorian Village Health & Wellness Ctr	Homer Glen, IL	Victorian Village	Home Glen, IL	Ast. & Ind. Living	8
9	Richard Schutt	N/A	Plymouth Place	Lagrange Park, IL	Emerald Meadows	Grand Rapids, MI	Ast. Living	9
10	Lucette Bamford	N/A			Thomas Park	Orland Park, IL	Ind. Living	10
11	Hal Brown	N/A			Arbor Place	Lisle, IL	Ind. Living	11
12	Jean Cavanaugh	N/A			Providence at Home	Tinley Park, IL	Home Health	12
13	Dr. Al Diepstra	N/A			Providence Hospice	Tinley Park, IL	Hospice	13
14	Gary Ellens	N/A			Providence Mgmt.			14
15	Howard Hoff	N/A			& Development Co	Tinley Park, IL	Mgmt. Company	15
16	Ken Schoon	N/A			Providence Palos			16
17	Tim Smits	N/A			Heights, LLC	Tinley Park, IL	Bldg. Company	17
18	Don Van Dyk	N/A			Providence Downers			18
19	Richard Van Hattem	N/A			Grove, LLC	Tinley Park, IL	Bldg. Company	19
20	Robert Van Staalduined	N/A			Providence Zeeland	Tinley Park, IL	Bldg. Company	20
21	Robert Workman	N/A			Providence of Grand	Tinley Park, IL	Bldg. Company	21
22	Norma Aardema	N/A			Rapids, LLC			22
23	Janice DeBoer	N/A						23
24	Don DeGraff	N/A						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' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	2	Food	$	Providence Life Services	100.00%	$ 2,670	$ 2,670	15
16	V	5	Utilities		Providence Life Services	100.00%	21,806	21,806	16
17	V	6	Maintenance		Providence Life Services	100.00%	2,791	2,791	17
18	V	17	Administrative	1,894,821	Providence Life Services	100.00%		(1,894,821)	18
19	V	19	Professional Services		Providence Life Services	100.00%	40,037	40,037	19
20	V	20	Dues, Fees & Subscriptions		Providence Life Services	100.00%	3,255	3,255	20
21	V	21	Office and Clerical - Salary		Providence Life Services	100.00%	586,236	586,236	21
22	V	21	Office and Clerical - Other		Providence Life Services	100.00%	150,626	150,626	22
23	V	24	Travel and Seminar		Providence Life Services	100.00%	22,844	22,844	23
24	V	25	Other Admin. Staff Transpor.		Providence Life Services	100.00%	5,432	5,432	24
25	V	26	Insurance		Providence Life Services	100.00%	7,296	7,296	25
26	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	145,681	145,681	26
27	V	30	Depreciation		Providence Life Services	100.00%	15,935	15,935	27
28	V	32	Interest		Providence Life Services	100.00%	4,286	4,286	28
29	V	33	Real Estate Taxes		Providence Life Services	100.00%			29
30	V	34	Rent - Facility and Grounds		Providence Life Services	100.00%	44,433	44,433	30
31	V								31
32	V	17	Administrative - Salary		Providence Life Services	100.00%	230,606	230,606	32
33	V	19	Professional Services		Providence Life Services	100.00%			33
34	V	20	Dues, Fees & Subscriptions		Providence Life Services	100.00%	274	274	34
35	V	21	Office and Clerical		Providence Life Services	100.00%	747	747	35
36	V	24	Travel and Seminar		Providence Life Services	100.00%	4,191	4,191	36
37	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	44,750	44,750	37
38	V								38
39	Total			$ 1,894,821			$ 1,333,896	$ * (560,925)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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									$		1
2	N/A										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' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated Cost	97,942,435	22	$ 16,799	$	15,566,778	$ 2,670	1
2	5	Utilities	Accumulated Cost	97,942,435	22	137,185		15,566,778	21,806	2
3	6	Maintenance	Accumulated Cost	97,942,435	22	17,556		15,566,778	2,791	3
4	17	Administrative	Direct			1,480,283				4
5	19	Professional Services	Accumulated Cost	97,942,435	22	251,886		15,566,778	40,037	5
6	20	Dues, Fees & Subscriptions	Accumulated Cost	97,942,435	22	20,478		15,566,778	3,255	6
7	21	Office and Clerical - Salary	Accumulated Cost	97,942,435	22	3,688,178	3,688,178	15,566,778	586,236	7
8	21	Office and Clerical - Other	Accumulated Cost	97,942,435	22	947,629		15,566,778	150,626	8
9	24	Travel and Seminar	Accumulated Cost	97,942,435	22	143,718		15,566,778	22,844	9
10	25	Other Admin. Staff Transpor.	Accumulated Cost	97,942,435	22	34,174		15,566,778	5,432	10
11	26	Insurance	Accumulated Cost	97,942,435	22	45,900		15,566,778	7,296	11
12	27	Gen. Admin. - Emp. Ben.	Accumulated Cost	97,942,435	22	916,519		15,566,778	145,681	12
13	30	Depreciation	Accumulated Cost	97,942,435	22	100,250		15,566,778	15,935	13
14	32	Interest	Accumulated Cost	97,942,435	22	26,965		15,566,778	4,286	14
15	33	Real Estate Taxes	Accumulated Cost	97,942,435	22			15,566,778		15
16	34	Rent - Facility and Grounds	Accumulated Cost	97,942,435	22	279,540		15,566,778	44,433	16
17										17
18	17	Administrative	Direct	230,606	1	230,606		230,606	230,606	18
19	19	Professional Services	Direct		1			1		19
20	20	Dues, Fees & Subscriptions	Direct	274	1	274		274	274	20
21	21	Office and Clerical - Salary	Direct	747	1	747		747	747	21
22	24	Travel and Seminar	Direct	4,191	1	4,191		4,191	4,191	22
23	27	Gen. Admin. - Emp. Ben.	Direct	44,750	1	44,750		44,750	44,750	23
24										24
25	TOTALS					$ 8,387,628	$ 3,688,178		$ 1,333,896	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	FHA		X	Mortgage	Varies	08/15/13	$ 5,920,000	$ 5,577,557	09/01/38	3.60 %	$ 203,976	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alloc. - Providence											6
7	Life Services		X								4,286	7
8												8
9	TOTAL Facility Related						$ 5,920,000	$ 5,577,557			$ 208,262	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income - Bldg. Part.										(645)	13
14	TOTAL Non-Facility Related						$	$			$ (645)	14
15	TOTALS (line 9+line14)						$ 5,920,000	$ 5,577,557			$ 207,617	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 35,927 Line # 36 - 07

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights # 0052381 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2015 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.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Providence Palos Heights - Not Subject to Real Estate Taxes

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' COMPILATION REPORT

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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? [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).

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: 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:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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									49
50	Flooring and Tile Work - Lobby and Dining Area	2012	21,812						50
51	Drywall and Ceiling - 2 Common Units	2012	144,203						51
52	Automatic Front Door	2012	2,730						52
53	Duct Work and Circulating Pump	2012	3,397						53
54	PVC Piping and Sewer Drain - Basement Hallways	2012	3,753						54
55	Paving - Remove and Install Concrete Pad, Wire Mesh, and Asphalt	2012	4,675						55
56	Stainless Steel Fire Door - Kitchen	2012	4,840						56
57	Thermostat and Guards - Chapel, Wicker Hallway, Garden Hally, Res Rc	2012	5,057						57
58	Spindles and Fabrication - NE Stairwell and Laundry Area	2012	6,155						58
59	Smoke Detectors	2012	7,332						59
60	HVAC	2012	10,803						60
61									61
62	Boiler - Business Office	2013	5,291						62
63	HVAC - Chapel Rooftop	2013	15,000						63
64	Concrete Pad and Sidewalk	2013	7,895						64
65	Elevator Repairs	2013	9,967						65
66	Outpatient Ramp Awning	2013	9,850						66
67	Oven Pad Removal	2013	2,601						67
68	Pave Chapel and Dock Lof	2013	27,555						68
69	Roof Duct Insulation	2013	18,986						69
70	TOTAL (lines 4 thru 69)		$ 9,035,339	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 9,035,339	$		$	$	$	1
2									2
3	Water Heaters - Unit 2	2013	18,342						3
4	Whirlpool Renovations - Unit 2	2013	21,940						4
5	Building Renovations - Cabling, Carpeting, Etc. - Unit 2	2013	98,430						5
6	Pave Chapel and Dock Lot	2013	2,500						6
7	HVAC - Chapel Rooftop	2013	33,406						7
8									8
9	Millwork and Ceramic (Vinyl) Tile - Unit 1 Lobby	2014	13,964						9
10	Renovation Carryover - Floording - Unit 1	2014	3,127						10
11	B & C Paint, Wallpaper Removal, TV Wiring - Unit 2	2014	27,250						11
12	Lobby Carpeting, Painting and Wallpaper - Unit 1	2014	5,907						12
13	B & C Carpeting - Unit 2	2014	2,910						13
14	Practioner and DON Office - Carpeting	2014	3,742						14
15	IT Email Archiving	2014	5,817						15
16	Landscaping - Chapel Courtyard	2014	9,845						16
17	Egress System - IT Cabling and Wiring - Throughout Building	2014	30,219						17
18	Chiller - 15 Ton - Unit 1	2014	32,898						18
19	Furnace - Unit 2	2014	6,859						19
20	Icare Licensing	2014	10,199						20
21	Lobby - Millwork, Painting, Wallpaper, and Carpeting - Unit 1	2014	29,490						21
22	Bathrooms - Ceramic Tile, Plumbing, Painting, Electrical - Unit 1	2014	40,352						22
23	HVAC - New Fan Motor - Unit 2	2014	3,932						23
24	Blacktop and Paving - East Parking Lot	2014	90,000						24
25	Air Conditioning Units	2014	4,997						25
26	Disposal Replacement - Unit 1	2014	5,384						26
27	Doctor and DON Office - Paint and Carpet	2014	17,888						27
28	Touchscreen Replacement	2014	25,000						28
29	Doors - Laundry and Activity Rooms	2014	3,125						29
30	Doors - Laundry and Activity Rooms	2014	4,220						30
31	HVAC Fan Coils	2014	23,212						31
32	Patching and Sealcoating - Front, Sout, and East Lots	2014	12,694						32
33	Door Handles and Handrails	2014	5,879						33
34	TOTAL (lines 1 thru 33)		$ 9,628,867	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 9,628,867	$		$	$	$	1
2									2
3	Entry Sliding Door - Unit 1	2015	2,998						3
4	Elevator Pit Springs - Unit 2	2015	10,008						4
5	Fan Coils - Unit 1 and 2	2015	3,520						5
6	Sprinkler Heads - IDPH Survey	2015	14,582						6
7	Asbestos Abatement	2015	17,800						7
8	Egress System	2015	45,890						8
9	Parkint Lot Repavement	2015	93,774						9
10									10
11	R&M Capitalized - Parking Lot Striping	2015	5,755						11
12	R&M Capitalized - Parking Lot Excavating with Trench and Stone	2015	6,250						12
13	R&M Capitalized - Move Toilet off Dining Hall	2015	6,850						13
14	R&M Capitalized - HVAC - Remove and Replace 7 Fan Coils - Unit 1&2	2015	13,762						14
15	R&M Capitalized - Elevator Pit Pipe, Ladder, and Restrictors	2015	8,783						15
16	R&M Capitalized - Roofing Repairs & Three Skylights Installed	2015	4,890						16
17	R&M Capitalized - Boiler - Installed New Motor Coupling	2015	4,329						17
18	R&M Capitalized - Piping Replacement - D Wing	2015	3,800						18
19	R&M Capitalized - Boiler Water Line Insulation Install	2015	3,193						19
20	R&M Capitalized - Hallway Key Switches	2015	2,698						20
21	R&M Capitalized - Main Entry Door Control and Motor Gear Box	2015	2,607						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Depreciation - Alloc. - Providence Palos Heights, LLC			210,148		210,148		7,584,701	30
31	Depreciation - Alloc. - Providence Life Services			15,935		15,935			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,880,356	$ 226,083		$ 226,083	$	$ 7,584,701	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 5,420,561	$ 104,356	$ 104,356	$		$ 5,027,516	71
72	Current Year Purchases	402,072	39,071	39,071			39,071	72
73	Fully Depreciated Assets							73
74	R.P. Allocations							74
75	TOTALS	$ 5,822,633	$ 143,427	$ 143,427	$		$ 5,066,587	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)	$ 15,732,989	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 369,510	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 369,510	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)	$ 12,651,288	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

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. [X] 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	See Suppl.				44,433			5
6								6
7	TOTAL				$ 44,433 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,000 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	$ 8,417	17
18					18
19					19
20					20
21	TOTAL		$ 698.47	$ 8,417	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' COMPILATION REPORT

Providence Palos Heights
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Alloc. - Providence Life Services	44,433
Total	44,433

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Amount
Dietary Equipment	12,000
Total	12,000

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	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 - 03	hrs	$		$ 837,273	$		$ 837,273	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			293,539			293,539	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			739,225			739,225	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				1,433,003		1,433,003	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					412,318		412,318	12
13	Other (specify): See Supplemental	39 - 03				246,096			246,096	13
14	TOTAL			$		$ 2,116,133	$ 1,845,321		$ 3,961,454	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Providence Palos Heights
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Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	412,318	
Laboratory		134,302
Radiology		111,794
Total	412,318	246,096

STATE OF ILLINOIS

Facility Name & ID Number Providence Palos Heights **#** 0052381 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$ 742,620	1
2	Cash-Patient Deposits	14,706	14,706	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,164)	3,110,854	3,110,854	3
4	Supply Inventory (priced at Cost - FIFO)	14,858	14,858	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,204	16,204	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule		623,093	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,158,122	$ 4,522,335	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		1,282,869	14
15	Leasehold Improvements, at Historical Cost		8,244,358	15
16	Equipment, at Historical Cost		5,913,063	16
17	Accumulated Depreciation (book methods)		(12,651,288)	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		291,496	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 3,110,498	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,158,122	$ 7,632,833	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,040,897	$ 2,205,583	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,706	14,706	28
29	Short-Term Notes Payable		161,317	29
30	Accrued Salaries Payable	73,763	73,763	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		22,548	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,990,996	3,454,935	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,120,362	$ 5,932,852	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)**	$ 4,120,362	$ 11,349,092	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (962,240)	$ (3,716,259)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,158,122	$ 7,632,833	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Providence Palos Heights
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Accounts Receivable Other		99,450
Escrow Account Reserves		523,643
Total	-	623,093
Line 23 - Other Long Term Assets		
Construction in Progress		90,861
Financing Costs (Net of Amortization)		200,635
Total	-	291,496
Line 36 - Other Current Liabilities		
Due to Affiliated Entities	1,990,996	3,454,935
Total	1,990,996	3,454,935
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,006,020)	1
2	Restatements (describe):		2
3	**PP Adjustment - Post Cost Report Adjustments**	2,665,198	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (340,822)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(621,418)	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)**	$ (621,418)	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)**	$ (962,240)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,854,456	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,854,456	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,677	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 74,677	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	2,997	13
14	Non-Patient Meals	4,126	14
15	Telephone, Television and Radio	6,391	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	73	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,587	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	See Supplemental Schedule	9,978	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,978	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,952,698	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,720,130	31
32	Health Care	5,241,225	32
33	General Administration	4,348,966	33
	B. Capital Expense		
34	Ownership	1,023,468	34
	C. Ancillary Expense		
35	Special Cost Centers	3,964,414	35
36	Provider Participation Fee	275,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,574,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	(621,418)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (621,418)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,474,771	44
45	Private Pay - Net Inpatient Revenue	1,930,532	45
46	Medicare - Net Inpatient Revenue	10,073,291	46
47	Other-(specify) Insurance - Net Inpatient Revenue	2,375,862	47
48	Other-(specify) Veterans and Hospice - Net Inpatient Revenue		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,854,456	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' COMPILATION REPORT

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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Miscellaneous Income	9,978	9,978
Total	9,978	9,978

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,160	$ 103,754	$ 48.03	1
2	Assistant Director of Nursing	4,169	4,465	130,930	29.32	2
3	Registered Nurses	52,763	55,647	1,821,999	32.74	3
4	Licensed Practical Nurses	14,771	16,076	447,660	27.85	4
5	CNAs & Orderlies	93,162	98,205	1,326,944	13.51	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	5,663	6,024	70,416	11.69	10
11	Social Service Workers	7,309	7,953	175,799	22.10	11
12	Dietician	1,935	2,049	57,251	27.94	12
13	Food Service Supervisor	1,921	2,108	65,641	31.14	13
14	Head Cook	3,960	4,445	75,691	17.03	14
15	Cook Helpers/Assistants	36,214	38,543	447,932	11.62	15
16	Dishwashers					16
17	Maintenance Workers	22,098	23,949	336,874	14.07	17
18	Housekeepers	19,238	20,630	252,271	12.23	18
19	Laundry	6,344	7,039	88,455	12.57	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,381	31,871	522,721	16.40	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	3,682	4,092	58,860	14.38	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	336	348	2,960	8.51	33
34	TOTAL (lines 1 - 33)	307,866	327,764	$ 6,027,369 *	$ 18.39	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		165,000	09 - 03	36
37	Medical Records Consultant		983	10 - 03	37
38	Nurse Consultant		54,436	10 - 03	38
39	Pharmacist Consultant		21,860	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		864	11 - 03	44
45	Social Service Consultant		3,000	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 246,143		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 135,760	10 - 03	50
51	Licensed Practical Nurses		161,458	10 - 03	51
52	Certified Nurse Assistants/Aides		87,000	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 384,218		53

Providence Palos Heights
Medicaid Cost Report
01/01/15 - 12/31/15

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Beautician (Line 40)	336	348	2,960
Total	336	348	2,960

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Providence Life Services - Management Fees	$ 1,894,821
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,894,821
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Much Shelist	Legal	$ 8,634
Smith, Hemmesch, Burke & K	Legal	8,460
Ditchey Geiger, LLC	Legal	876
Plante & Moran, PLLC	Audit, Tax & Cost Reports	20,004
Polaris Group	Consulting	32,804
Other	Other	1,258
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 72,035

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 381,132
Unemployment Compensation Insurance	29,169
FICA Taxes	451,078
Employee Health Insurance	345,853
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Benefits	79,069
Employee Benefits - Other	54,736
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,341,037

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	14,083
Health Care Worker Background Check	13,933
(Indicate # of checks performed)	
Patient Background Checks	
Accredidation - JCAHO	10,516
Licenses and Dues	38,661
Advertising and Promotion	12,542
Alloc. - Providence Life Services	3,529
Less: Public Relations Expense	(8,534)
Non-allowable advertising	( )
Yellow page advertising	(4,008)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,712

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,468
Alloc. - Providence Life Services	27,035
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,503

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Allowable Amount
Much Shelist	02/01/15	IDPH Survey	885	885
Much Shelist	04/01/15	IDPH Survey	7,645	7,645
Much Shelist	07/01/15	IDPH Survey	104	104
Smith, Hemmesch, Burke & Kaczynski	07/01/15	Property Exemption Revocation	4,110	4,110
Ditchey Geiger, LLC	09/01/15	Works Comp Insurance Claim	876	876
Smith, Hemmesch, Burke & Kaczynski	11/30/15	Property Exemption Revocation	4,350	4,350
Sub-Total			17,969	17,969

Page 21 Supplemental Schedule - Seminar Schedule

Payee	Amount	Amount Allowable
Pritchett & Huff	175	175
Providence Management & Development Company, Inc.	297	297
Providence Management & Development Company, Inc.	3,099	3,099
APIC Chicago	220	220
Providence Life Services	199	199
Providence Life Services	199	199
Trainint Concepts, Inc.	84	84
Providence Life Services	99	99
APIC Chicago	10	10
Elizabeth Hauser	75	75
Social Work Consultation Group, Inc.	518	518
Pritchett & Huff	140	140
Nadia Ghouleh	2,000	2,000
Providence Life Services	30	30
Healthcare Information Network	179	179
Valerie Bartel	145	145
Alloc. - Providence Life Services	27,035	27,035
Total	34,503	34,503

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 - $14,681**

(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. $ **105,671** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **275,913**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **4,126**

(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? **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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees