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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0052381

Facility Name: Providence Palos Heights

Address: 13259 S. Central Avenue (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 01/01/17 to 12/31/17 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, 200 N. Martingale Road, Suite 900 Schaumburg, IL 60173
(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' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	12,044	7,495	27,992	47,531	8
9	SNF/PED					9
10	ICF	3,987	2,481		6,468	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,031	9,976	27,992	53,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.65%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 20,210

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	593,214	74,569		667,783		667,783		667,783			1
2	Food Purchase		436,941		436,941		436,941	(403)	436,538			2
3	Housekeeping	259,705	84,074		343,779		343,779		343,779			3
4	Laundry	94,036	46,034		140,070		140,070		140,070			4
5	Heat and Other Utilities			207,049	207,049		207,049	22,362	229,411			5
6	Maintenance	296,518		373,037	669,555		669,555	4,419	673,974			6
7	Other (specify):* See Supplemental											7
8	**TOTAL General Services**	1,243,473	641,618	580,086	2,465,177		2,465,177	26,378	2,491,555			8
	B. Health Care and Programs											
9	Medical Director			191,000	191,000		191,000		191,000			9
10	Nursing and Medical Records	5,785,640	667,076	277,912	6,730,628		6,730,628	(52)	6,730,576			10
10a	Therapy											10a
11	Activities	100,386	102,073	2,094	204,553		204,553		204,553			11
12	Social Services	197,477		1,540	199,017		199,017		199,017			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	6,083,503	769,149	472,546	7,325,198		7,325,198	(52)	7,325,146			16
	C. General Administration											
17	Administrative			2,222,947	2,222,947		2,222,947	(2,222,947)				17
18	Directors Fees											18
19	Professional Services			145,301	145,301		145,301	197,668	342,969			19
20	Dues, Fees, Subscriptions & Promotions			79,165	79,165		79,165	2,260	81,425			20
21	Clerical & General Office Expenses	479,201	9,100	1,300,935	1,789,236		1,789,236	79,149	1,868,385			21
22	Employee Benefits & Payroll Taxes			1,705,458	1,705,458		1,705,458		1,705,458			22
23	Inservice Training & Education			199	199		199		199			23
24	Travel and Seminar			22,133	22,133		22,133	57,318	79,451			24
25	Other Admin. Staff Transportation			2,004	2,004		2,004		2,004			25
26	Insurance-Prop.Liab.Malpractice			794,037	794,037		794,037	282,198	1,076,235			26
27	Other (specify):* See Supplemental							305,006	305,006			27
28	**TOTAL General Administration**	479,201	9,100	6,272,179	6,760,480		6,760,480	(1,299,348)	5,461,132			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,806,177	1,419,867	7,324,811	16,550,855		16,550,855	(1,273,022)	15,277,833			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
01/01/17 - 12/31/17

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				
Providence Life Services				-
Alloc. - Gen. Admin. Emp. Benefits			305,006	305,006
				-
				-
				-
				-
				-
Sub-Total	-	-	305,006	305,006

Facility Name & ID Number Providence Palos Heights #0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							463,385	463,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							207,378	207,378			32
33	Real Estate Taxes							14,077	14,077			33
34	Rent-Facility & Grounds			1,055,196	1,055,196		1,055,196	(1,055,196)				34
35	Rent-Equipment & Vehicles			20,821	20,821		20,821	52,789	73,610			35
36	Other (specify):* See Supplemental							33,610	33,610			36
37	TOTAL Ownership			1,076,017	1,076,017		1,076,017	(283,957)	792,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,105,378	2,578,965	3,684,343		3,684,343		3,684,343			39
40	Barber and Beauty Shops	2,580			2,580		2,580		2,580			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,920	310,920		310,920		310,920			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers	2,580	1,105,378	2,889,885	3,997,843		3,997,843		3,997,843			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,808,757	2,525,245	11,290,713	21,624,715		21,624,715	(1,556,979)	20,067,736			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
01/01/17 - 12/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
Providence Palos Heights, LLC				-
Mortgage Premium Insurance			33,610	33,610
				-
				-
				-
				-
				-
Sub-Total	-	-	33,610	33,610
Line 43 - Other Special Cost Centers				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(403)	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	(12,500)	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	(1,130,000)	21		24
25	Fund Raising, Advertising and Promotional	(20,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,503)	20		28
29	Other-Attach Schedule See Supplemental	(38,169)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,205,203)		$	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)	(351,776)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (351,776)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,556,979)		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

Providence Palos Heights

ID# 0052381

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Copy Income	$ (13,764)	21	1
2	Jury Duty Income	(52)	10	2
3	Other Income	(2,156)	21	3
4				4
5				5
6				6
7	Providence Palos Heights, LLC			7
8	Professional Fees	(8,250)	19	8
9	Amortization	(13,947)	31	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(38,169)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Providence Palos Heights **#** 0052381 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(403)	0	0	0	0	0	0	0	0	0	0	(403)	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	22,362	0	0	0	0	0	0	0	0	22,362	5
6	Maintenance	0	0	4,419	0	0	0	0	0	0	0	0	4,419	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(403)	0	26,781	0	0	0	0	0	0	0	0	26,378	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	(52)	0	0	0	0	0	0	0	0	0	0	(52)	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**	(52)	0	0	0	0	0	0	0	0	0	0	(52)	16
	C. General Administration													
17	Administrative	0	0	(2,222,947)	0	0	0	0	0	0	0	0	(2,222,947)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,250)	8,250	197,668	0	0	0	0	0	0	0	0	197,668	19
20	Fees, Subscriptions & Promotions	(24,131)	0	26,391	0	0	0	0	0	0	0	0	2,260	20
21	Clerical & General Office Expenses	(1,158,420)	0	1,237,569	0	0	0	0	0	0	0	0	79,149	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	57,318	0	0	0	0	0	0	0	0	57,318	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	266,003	16,195	0	0	0	0	0	0	0	0	282,198	26
27	Other (specify):*	0	0	305,006	0	0	0	0	0	0	0	0	305,006	27
28	**TOTAL General Administration**	(1,190,801)	274,253	(382,800)	0	0	0	0	0	0	0	0	(1,299,348)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,191,256)	274,253	(356,019)	0	0	0	0	0	0	0	0	(1,273,022)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Providence Palos Heights** **# 0052381** **Report Period Beginning:** **01/01/17** **Ending:** **12/31/17**

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	419,091	44,294	0	0	0	0	0	0	0	0	463,385	30
31	Amortization of Pre-Op. & Org.	(13,947)	13,947	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	191,362	16,016	0	0	0	0	0	0	0	0	207,378	32
33	Real Estate Taxes	0	0	14,077	0	0	0	0	0	0	0	0	14,077	33
34	Rent-Facility & Grounds	0	(1,055,196)	0	0	0	0	0	0	0	0	0	(1,055,196)	34
35	Rent-Equipment & Vehicles	0	0	52,789	0	0	0	0	0	0	0	0	52,789	35
36	Other (specify):*	0	33,610	0	0	0	0	0	0	0	0	0	33,610	36
37	**TOTAL Ownership**	(13,947)	(397,186)	127,176	0	0	0	0	0	0	0	0	(283,957)	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)**	(1,205,203)	(122,933)	(228,843)	0	0	0	0	0	0	0	0	(1,556,979)	45

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. [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)	
1	V	34	Rent	$ 1,055,196	Providence Palos Heights, LLC	100.00%	$	$ (1,055,196)	1
2	V	32	Interest	379	Providence Palos Heights, LLC	100.00%		(379)	2
3	V	19	Professional Fees		Providence Palos Heights, LLC	100.00%	8,250	8,250	3
4	V	21	Office		Providence Palos Heights, LLC	100.00%			4
5	V	26	Property Insurance		Providence Palos Heights, LLC	100.00%	266,003	266,003	5
6	V	30	Depreciation		Providence Palos Heights, LLC	100.00%	419,091	419,091	6
7	V	31	Amortization		Providence Palos Heights, LLC	100.00%	13,947	13,947	7
8	V	32	Interest		Providence Palos Heights, LLC	100.00%	191,741	191,741	8
9	V	33	Real Estate Taxes		Providence Palos Heights, LLC	100.00%			9
10	V	36	Mortgage Insurance Premiums		Providence Palos Heights, LLC	100.00%	33,610	33,610	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,055,575			$ 932,642	$ * (122,933)	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: 01/01/17 Ending: 12/31/17

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	Board of Directors / Governors							2
3								3
4								4
5	Justin Kats	N/A	Providence Healthcare & Rehabilitation	Palos Heights, IL	Village Woods	Crete, IL	Ast. & Ind. Living	5
6	Richard Van Hattem	N/A	Providence Healthcare & Rehabilitation	Downers Grove, IL	Saratoga Grove	Downers Grove, IL	Ast. & Ind. Living	6
7	Don Van Dyk	N/A	Providence Healthcare & Rehabilitation	Zeeland, MI	Royal Atrium Inn	Zeeland, MI	Ast. & Ind. Living	7
8	Robert Workman	N/A	Park Place Health & Wellness Center	Elmhurst, IL	Park Place	Elmhurst, IL	Ast. & Ind. Living	8
9	Lucette Bamford	N/A	Park Place of St. John	St. John, IN	Park Place St. John	St. John, IN	Ind. Living	9
10	Kevin Botma	N/A	Victorian Village Health & Wellness Ctr	Homer Glen, IL	Victorian Village	Home Glen, IL	Ast. & Ind. Living	10
11	Jean Cavanaugh	N/A	Plymouth Place	Lagrange Park, IL	Emerald Meadows	Grand Rapids, MI	Ast. Living	11
12	Dr. Al Diepstra	N/A			Thomas Park	Orland Park, IL	Ind. Living	12
13	Bastian Knoppers	N/A			Arbor Place	Lisle, IL	Ind. Living	13
14	Dave Larsen	N/A			Providence at Home	Tinley Park, IL	Home Health	14
15	Howard Rynberk, Jr.	N/A			Providence Hospice	Tinley Park, IL	Hospice	15
16	Gart Smit	N/A			Providence Mgmt.			16
17	Tim Smits	N/A			& Development Co	Tinley Park, IL	Mgmt. Company	17
18	Robert Van Staalduined	N/A			Providence Palos			18
19	Bill Zandstra	N/A			Heights, LLC	Tinley Park, IL	Bldg. Company	19
20	Tim Breems	N/A			Providence Downers			20
21	Norm Aardema	N/A			Grove, LLC	Tinley Park, IL	Bldg. Company	21
22	Janice DeBoer	N/A			Providence Zeeland	Tinley Park, IL	Bldg. Company	22
23	Don DeGraff	N/A			Providence of Grand			23
24	Arnold Koldenhoven	N/A			Rapids, LLC	Tinley Park, IL	Bldg. Company	24
25	Bruce Leep	N/A						25
26	Dick Molenhouse	N/A						26
27	Calvin Tameling	N/A						27
28	Roy Van Eck	N/A						28
29	Sam Van Til	N/A						29
30								30

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	02	Food	$	Providence Life Services	100.00%	$ 0	$	15
16	V	05	Utilities		Providence Life Services	100.00%	22,362	22,362	16
17	V	06	Maintenance		Providence Life Services	100.00%	4,419	4,419	17
18	V	17	Administration	2,222,947	Providence Life Services	100.00%	0	(2,222,947)	18
19	V	19	Professional Services		Providence Life Services	100.00%	197,668	197,668	19
20	V	20	Dues and Subscriptions		Providence Life Services	100.00%	26,391	26,391	20
21	V	21	Office and Clerical - Salary		Providence Life Services	100.00%	829,653	829,653	21
22	V	21	Office and Clerical - Other		Providence Life Services	100.00%	79,352	79,352	22
23	V	24	Travel and Seminar		Providence Life Services	100.00%	51,161	51,161	23
24	V	25	Other Admin. Staff Transp.		Providence Life Services	100.00%	0		24
25	V	26	Insurance		Providence Life Services	100.00%	16,038	16,038	25
26	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	203,082	203,082	26
27	V	30	Depreciation		Providence Life Services	100.00%	44,294	44,294	27
28	V	32	Interest		Providence Life Services	100.00%	16,016	16,016	28
29	V	33	Real Estate Taxes		Providence Life Services	100.00%	14,077	14,077	29
30	V	35	Rent - Equipment and Vehicles		Providence Life Services	100.00%	52,789	52,789	30
31	V								31
32	V	19	Professional Services		Providence Life Services	100.00%	0		32
33	V	21	Office and Clerical - Salary		Providence Life Services	100.00%	325,441	325,441	33
34	V	21	Office and Clerical		Providence Life Services	100.00%	3,123	3,123	34
35	V	24	Travel and Seminar		Providence Life Services	100.00%	6,157	6,157	35
36	V	26	Insurance		Providence Life Services	100.00%	157	157	36
37	V	27	Gen. Admin. - Emp. Ben.		Providence Life Services	100.00%	101,924	101,924	37
38	V								38
39	Total			$ 2,222,947			$ 1,994,104	$ * (228,843)	39

* 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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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 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	02	Food	Accumulated Cost	97,718,707	18	$	$	20,043,928	$	1
2	05	Utilities	Accumulated Cost	97,718,707	18	109,021	22,362	20,043,928	22,362	2
3	06	Maintenance	Accumulated Cost	97,718,707	18	21,544		20,043,928	4,419	3
4	17	Administration	Direct	1	1			1		4
5	19	Professional Services	Accumulated Cost	97,718,707	18	963,677		20,043,928	197,668	5
6	20	Dues and Subscriptions	Accumulated Cost	97,718,707	18	128,664		20,043,928	26,391	6
7	21	Office and Clerical - Salary	Accumulated Cost	97,718,707	18	4,044,652	4,044,652	20,043,928	829,653	7
8	21	Office and Clerical - Other	Accumulated Cost	97,718,707	18	386,858		20,043,928	79,352	8
9	24	Travel and Seminar	Accumulated Cost	97,718,707	18	249,422		20,043,928	51,161	9
10	25	Other Admin. Staff Transp.	Accumulated Cost	97,718,707	18			20,043,928		10
11	26	Insurance	Accumulated Cost	97,718,707	18	78,188		20,043,928	16,038	11
12	27	Gen. Admin. - Emp. Ben.	Accumulated Cost	97,718,707	18	990,072		20,043,928	203,082	12
13	30	Depreciation	Accumulated Cost	97,718,707	18	215,945		20,043,928	44,294	13
14	32	Interest	Accumulated Cost	97,718,707	18	78,081		20,043,928	16,016	14
15	33	Real Estate Taxes	Accumulated Cost	97,718,707	18	68,631		20,043,928	14,077	15
16	35	Rent - Equipment and Vehicles	Accumulated Cost	97,718,707	18	257,357		20,043,928	52,789	16
17										17
18	19	Professional Services	Direct	1	1			1		18
19	21	Office and Clerical - Salary	Direct	1	1	325,441	325,441	1	325,441	19
20	21	Office and Clerical	Direct	1	1	3,123		1	3,123	20
21	24	Travel and Seminar	Direct	1	1	6,157		1	6,157	21
22	26	Insurance	Direct	1	1	157		1	157	22
23	27	Gen. Admin. - Emp. Ben.	Direct	1	1	101,924		1	101,924	23
24										24
25	TOTALS					$ 8,028,914	$ 4,392,455		$ 1,994,104	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		08/15/13	$ 5,920,000	$ 5,249,019	09/01/38	3.600%	$ 191,741	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Alloc. - Providence Life Serv.		X								16,016	6
7												7
8												8
9	TOTAL Facility Related						$ 5,920,000	$ 5,249,019			$ 207,757	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income										(379)	13
14	TOTAL Non-Facility Related						$	$			$ (379)	14
15	TOTALS (line 9+line14)						$ 5,920,000	$ 5,249,019			$ 207,378	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 33,610 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.)

Facility Name & ID Number Providence Palos Heights # 0052381 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	$	14,077	2
3. Under or (over) accrual (line 2 minus line 1).	$	14,077	3
4. Real Estate Tax accrual used for 2017 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.	$	14,077	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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
Alloc. Providence Life Services = $14,077

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

2016 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.	Alloc. Providence Life Services	Home Office Allocation	$	$
4.		(See Supplemental Schedule)	$ 62,880.12	$ 14,077.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,880.12	$ 14,077.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

Providence Palos Heights
Medicaid Cost Report
01/01/17 - 12/31/17

Page 10 - Real Estate Supplemental Schedule

Parcel Number	Tax Year	Tax Paid	Amount
19 - 09 - 01 - 203 - 007 - 1001	2016	2017	16,986
19 - 09 - 01 - 203 - 007 - 1006	2016	2017	20,453
19 - 09 - 01 - 203 - 007 - 1007	2016	2017	25,441
Total			62,880

Facility Name	Alloc. Amount	Facility Units	Total Units	Alloc. Percentage	Allocated Amount
Providence Palos Hills	62,880	20,043,928	97,718,707	20.51%	12,898
Providence Downers Grove	62,880	13,855,781	97,718,707	14.18%	8,916
Other Non-Care Entities	62,880	63,818,998	97,718,707	65.31%	41,066
					-
Total					62,880

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

See Page 12A, Line 70 for total

**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: 01/01/17 Ending: 12/31/17

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	Various	2013	271,763						50
51	Millwork and Ceramic (Vinyl) Tile - Unit 1 Lobby	2014	13,964						51
52	Renovation Carryover - Floording - Unit 1	2014	3,127						52
53	B & C Paint, Wallpaper Removal, TV Wiring - Unit 2	2014	27,250						53
54	Lobby Carpeting, Painting and Wallpaper - Unit 1	2014	5,907						54
55	B & C Carpeting - Unit 2	2014	2,910						55
56	Practioner and DON Office - Carpeting	2014	3,742						56
57	IT Email Archiving	2014	5,817						57
58	Landscaping - Chapel Courtyard	2014	9,845						58
59	Egress System - IT Cabling and Wiring - Throughout Building	2014	30,219						59
60	Chiller - 15 Ton - Unit 1	2014	32,898						60
61	Furnace - Unit 2	2014	6,859						61
62	Icare Licensing	2014	10,199						62
63	Lobby - Millwork, Painting, Wallpaper, and Carpeting - Unit 1	2014	29,490						63
64	Bathrooms - Ceramic Tile, Plumbing, Painting, Electrical - Unit 1	2014	40,352						64
65	HVAC - New Fan Motor - Unit 2	2014	3,932						65
66	Blacktop and Paving - East Parking Lot	2014	90,000						66
67	Air Conditioning Units	2014	4,997						67
68	Disposal Replacement - Unit 1	2014	5,384						68
69	Doctor and DON Office - Paint and Carpet	2014	17,888						69
70	TOTAL (lines 4 thru 69)		$ 9,554,737	$		$	$	$	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: 01/01/17 Ending: 12/31/17

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		$ 9,554,737	$		$	$	$	1
2									2
3	Touchscreen Replacement	2014	25,000						3
4	Doors - Laundry and Activity Rooms	2014	3,125						4
5	Doors - Laundry and Activity Rooms	2014	4,220						5
6	HVAC Fan Coils	2014	23,212						6
7	Patching and Sealcoating - Front, Sout, and East Lots	2014	12,694						7
8	Door Handles and Handrails	2014	5,879						8
9	Entry Sliding Door - Unit 1	2015	2,998						9
10	Elevator Pit Springs - Unit 2	2015	10,008						10
11	Fan Coils - Unit 1 and 2	2015	3,520						11
12	Sprinkler Heads - IDPH Survey	2015	14,582						12
13	Asbestos Abatement	2015	17,800						13
14	Egress System	2015	45,890						14
15	Parkint Lot Repavement	2015	93,774						15
16	R&M - Parking Lot Striping	2015	5,755						16
17	R&M - Parking Lot Excavating with Trench and Stone	2015	6,250						17
18	R&M - Move Toilet off Dining Hall	2015	6,850						18
19	R&M - HVAC - Remove and Replace 7 Fan Coils - Unit 1&2	2015	13,762						19
20	R&M - Elevator Pit Pipe, Ladder, and Restrictors	2015	8,783						20
21	R&M - Roofing Repairs & Three Skylights Installed	2015	4,890						21
22	R&M - Boiler - Installed New Motor Coupling	2015	4,329						22
23	R&M - Piping Replacement - D Wing	2015	3,800						23
24	R&M - Boiler Water Line Insulation Install	2015	3,193						24
25	R&M - Hallway Key Switches	2015	2,698						25
26	R&M - Main Entry Door Control and Motor Gear Box	2015	2,607						26
27	Smoke Detectors and Installation - Wicker Room	2016	6,147						27
28	Emergency Distribution System - Power Separation	2016	89,061						28
29	Chiller - 90 Tons - Unit 2	2016	60,988						29
30	Railings - Entrance, D Exit, B Exit, and Laundry	2016	36,800						30
31	Wiring - Emergency Distribution System - Power Separation	2016	7,250						31
32	R&M - Door Closers & Locks - Pedestrian and Storate Rooms	2016	13,737						32
33	R&M - Chiller Repairs	2016	15,481						33
34	TOTAL (lines 1 thru 33)		$ 10,109,820	$		$	$	$	34

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: 01/01/17 Ending: 12/31/17

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		$ 10,109,820	$		$	$	$	1
2									2
3	R&M - Fire System Valve Replacement and Asphalt Repair	2016	8,503						3
4	R&M - Repair Broken 2" Galvanized Vent Line	2016	3,875						4
5	R&M - Elevator - Install Sold State Starter	2016	7,411						5
6	Flooring - Family Room	2017	24,156						6
7	Fan Coils and Exhaust Fans - Resident Rooms	2017	49,000						7
8	HVAC - Lower Level Conference Room	2017	8,344						8
9	Landscaping - Main Entrance and Sign Areas	2017	39,633						9
10	Nurses Station - Carpentry and Cabinets - Unit 1	2017	43,770						10
11	Brick Tuckpoint	2017	16,460						11
12	Furnaces - Main Lobby	2017	14,200						12
13	Wall Repair - Studs, Drywall, Paint - Lobby	2017	6,645						13
14	Exterior Fencing - Chapel	2017	12,470						14
15	Lobby Bathroom - Tile, Wall Repair, Wall Paper, and Paint	2017	14,908						15
16	Carpet - Social Services, Business Office, and Chapel	2017	28,694						16
17	Curtains - Resident Rooms	2017	10,366						17
18	Elevator - Valve Replacement	2017	19,930						18
19	Wallpaper, Paint, and Carpet - Resident Rooms	2017	55,170						19
20	Window Treatments - Resident Rooms	2017	10,679						20
21	Shower Room - Tile, Faucets, Paint - Unit 1	2017	22,500						21
22	Dining Room - Piping, Sprinkler System, Electrical, Drywall, and	2017	20,690						22
23	Ejector Pumps - Kitchen and Wash Room	2017	10,134						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation - Providence Palos Heights, LLC			419,091		419,091		13,450,987	31
32	Depreciation - Providence Life Services			44,294		44,294			32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,537,358	$ 463,385		$ 463,385	$	$ 13,450,987	34

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: 01/01/17 Ending: 12/31/17

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	$ 6,036,518	$	$	$		$	71
72	Current Year Purchases	436,542						72
73	Fully Depreciated Assets							73
74	See Supplemental							74
75	TOTALS	$ 6,473,060	$	$	$		$	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)	$ 17,040,418	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 463,385	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 463,385	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)	$ 13,450,987	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.

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] 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.				0			5
6								6
7	TOTAL				$ **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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

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

16. Rental Amount for movable equipment: $ 65,193 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' PREPARATION REPORT

Providence Palos Heights
Medicaid Cost Report
01/01/17 - 12/31/17

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
N/A		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Dietary Equipment	12,404	12,404
		-
Alloc. - Providence Life Services	52,789	52,789
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	65,193	65,193

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 991,347	$		$ 991,347	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			375,158			375,158	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			955,181			955,181	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				1,044,513		1,044,513	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					60,865		60,865	12
13	Other (specify): See Supplemental	39 - 03				257,279			257,279	13
14	TOTAL			$		$ 2,578,965	$ 1,105,378		$ 3,684,343	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		60,865		60,865
Radiology			98,856	98,856
Laboratory			99,926	99,926
Respiratory Therapy			58,497	58,497
				-
				-
				-
				-
				-
				-
				-
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				-
				-
Total	-	60,865	257,279	318,144

STATE OF ILLINOIS

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$ 48,821	1
2	Cash-Patient Deposits	18,044	18,044	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,477,048)	5,465,865	5,465,865	3
4	Supply Inventory (priced at Cost / FIFO)	4,332	4,332	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,924	6,924	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule		627,388	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,496,665	$ 6,171,374	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		10,116,614	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		6,565,563	16
17	Accumulated Depreciation (book methods)		(13,450,987)	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		182,931	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 3,444,121	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,496,665	$ 9,615,495	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,469,588	$ 1,469,588	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,044	18,044	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,527	91,527	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		21,379	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	8,472,308	10,304,137	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,051,467	$ 11,904,675	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,249,019	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)**	$	$ 5,249,019	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,051,467	$ 17,153,694	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,554,802)	$ (7,538,199)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,496,665	$ 9,615,495	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Providence Palos Heights
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Escrow - Insurance		117,814	117,814
Escrow - Replacement		200,647	200,647
Escrow - Mortgage Insurance		8,449	8,449
Escrow - Debt Service		199,828	199,828
A/R - Other		100,650	100,650
Sub-Total	-	627,388	627,388
Line 23 - Long Term Assets			
Financing Costs (Net of Amortization)		182,931	182,931
			-
			-
			-
			-
Sub-Total	-	182,931	182,931
Line 36 - Other Current Liability			
Due to Affiliated Organizations	8,472,308	1,656,901	10,129,209
Asbestos Retirement Obligation		174,928	174,928
			-
			-
			-
Sub-Total	8,472,308	1,831,829	10,304,137
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,020,432)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment - Post Cost Report Filing**	(126,474)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,146,906)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,407,896)	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)**	$ (1,407,896)	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)**	$ (4,554,802)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 20,127,815	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 20,127,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,458	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 70,458	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	1,230	13
14	Non-Patient Meals	403	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)**	$ 1,633	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	16,913	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,913	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,216,819	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,465,177	31
32	Health Care	7,325,198	32
33	General Administration	6,760,480	33
	B. Capital Expense		
34	Ownership	1,076,017	34
	C. Ancillary Expense		
35	Special Cost Centers	3,686,923	35
36	Provider Participation Fee	310,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,624,715	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,407,896)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,407,896)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,223,821	44
45	Private Pay - Net Inpatient Revenue	2,405,200	45
46	Medicare - Net Inpatient Revenue	11,666,298	46
47	Other-(specify) Insurance - Net Inpatient Revenue	2,832,496	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 20,127,815	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

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Description		Amount		Total
Copy Revenue		13,764		13,764
Jury Duty Revenue		52		52
Bad Debt Recovery		941		941
Other Revenue		2,156		2,156
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		16,913		16,913

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,934	2,021	$ 131,892	$ 65.26	1
2	Assistant Director of Nursing	5,215	5,985	226,760	37.89	2
3	Registered Nurses	70,165	72,752	2,642,319	36.32	3
4	Licensed Practical Nurses	11,916	12,940	416,905	32.22	4
5	CNAs & Orderlies	146,124	151,820	2,300,711	15.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,010	2,170	43,615	20.10	9
10	Activity Assistants	4,418	4,596	56,771	12.35	10
11	Social Service Workers	7,990	8,820	197,477	22.39	11
12	Dietician	2,915	3,032	89,606	29.55	12
13	Food Service Supervisor	2,028	2,116	54,679	25.84	13
14	Head Cook	3,986	4,302	72,669	16.89	14
15	Cook Helpers/Assistants	13,556	14,446	219,211	15.17	15
16	Dishwashers	13,133	13,672	157,049	11.49	16
17	Maintenance Workers	16,561	17,615	296,518	16.83	17
18	Housekeepers	17,352	18,992	259,705	13.67	18
19	Laundry	7,040	7,462	94,036	12.60	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,756	24,662	479,201	19.43	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	3,623	3,990	67,053	16.81	31
32	Other Health Care(specify)					32
33	Other(specify)	237	276	2,580	9.35	33
34	TOTAL (lines 1 - 33)	352,959	371,669	$ 7,808,757 *	$ 21.01	34

SEE ACCOUNTANTS' PREPARATION 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		119,000	09 - 03	36
37	Medical Records Consultant		1,264	10 - 03	37
38	Nurse Consultant		64,085	10 - 03	38
39	Pharmacist Consultant		19,140	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		1,540	12 - 03	45
46	Other(specify)				46
47	See Supplemental				47
48					48
49	TOTAL (lines 35 - 48)		$ 205,893		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 90,284	10 - 03	50
51	Licensed Practical Nurses		93,952	10 - 03	51
52	Certified Nurse Assistants/Aides		9,187	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 193,423		53

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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Beautician	40	237	276	2,580	9.35		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		237	276	2,580	9.35		
Contracted Services							
Total						-	-

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 2,222,947
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,222,947
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jackson Lewis, LLP	Legal	$ 7,992
Much Shelist	Legal	68,482
Gerado Dean	Legal	8,000
Stone, Pogrund & Korey	Legal	325
Plante & Moran, PLLC	Audit, Tax & Cost Reports	31,709
Paylocity	Data Processing / IT	12,348
Experian Health	Data Processing / IT	256
Allscripts	Data Processing / IT	1,254
Direct Supply	Data Processing / IT	1,050
Acutrans	Translating Service	4,550
Collaborative Healthcare	Emergency Services Cons.	7,250
Other	Other Professional Services	2,085
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 145,301

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 310,737
Unemployment Compensation Insurance	32,078
FICA Taxes	574,176
Employee Health Insurance	609,905
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Benefits	103,396
Other Employee Benefits	75,166
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,705,458

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	6,160
Health Care Worker Background Check	10,056
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Licenses	22,933
Accredidation	13,895
Advertising and Promotion	24,131
Alloc. - Providence Life Services	26,391
Less: Public Relations Expense	( )
Non-allowable advertising	(20,628)
Yellow page advertising	(3,503)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 81,425

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	22,133
Alloc. - Providence Life Services	57,318
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 79,451

* Attach copy of IMRF notifications

**See instructions.

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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Jackson Lewis LLP	Employee Related Matters	04/12/17	312		312
Jackson Lewis LLP	Employee Related Matters	07/13/17	7,372		7,372
Jackson Lewis LLP	Employee Related Matters	09/08/17	308		308
Much Shelist	General Counsel	02/01/17	1,705		1,705
Much Shelist	General Counsel	02/01/17	75		75
Much Shelist	General Counsel	03/01/17	15,450		15,450
Much Shelist	General Counsel	04/01/17	12,980		12,980
Much Shelist	General Counsel	05/01/17	21,519		21,519
Much Shelist	General Counsel	06/01/17	15,632		15,632
Much Shelist	General Counsel	07/01/17	434		434
Much Shelist	General Counsel	09/01/17	193		193
Much Shelist	General Counsel	09/01/17	495		495
Stone, Pogrund & Korey	General Counsel	12/31/17	325		325
Gerado Dean	Employee Related Matters	06/30/17	8,000		8,000
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
					-
Total			84,799	-	84,799

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Page 21 Supplemental Schedule - Seminar

Vendor	Session Title	Location	Attendee	Date	Amount	Non-Allowable	Allowable
Pritchett & Hull				01/11/17	155		155
Wound Care Education				02/24/17	2,997		2,997
Niu Outreach				03/24/17	3,839		3,839
Wound Care Education				03/24/17	60		60
Starbucks Store 02566				03/24/17	16		16
Wound Care Education				03/24/17	60		60
Illinois Council On Lo				04/24/17	270		270
Par-A-Dice Hotel				05/24/17	112		112
Par-A-Dice Hotel				05/24/17	112		112
Illinois Nursing Home				05/24/17	290		290
Leadingage Illinois				05/24/17	298		298
Leadingage Illinois				06/26/17	239		239
Leadingage Illinois				07/24/17	195		195
Best Western Hotels				07/24/17	81		81
Becky Dorner & Associa				07/24/17	35		35
Leadingage Illinois				07/24/17	390		390
Leadingage Illinois				07/24/17	478		478
Kelly Stewart				08/23/17	650		650
Illinois Council On Lo				08/24/17	700		700
Jimmy Johns # 646 - E				08/24/17	178		178
Leadingage Illinois				08/24/17	447		447
Myevent.Com Acmcwoundc				08/24/17	400		400
Illinois Council On Lo				08/24/17	450		450
Leadingage Illinois				09/25/17	149		149
Leadingage Illinois				09/25/17	298		298
Aanac				09/25/17	1,050		1,050
Aanac				09/25/17	1,050		1,050
Leadingage Illinois				09/25/17	447		447
Leadingage Illinois				09/25/17	298		298
Prairie State College				09/27/17	375		375
Recl Unv. Of Florida 9/1 Inv.				09/30/17	495		495
Jan Boger				10/16/17	100		100

Leadingage Illinois				10/24/17	199		199
Aanac				10/24/17	397		397
Leadingage Illinois				10/24/17	1,194		1,194
Alisha Thorton				10/30/17	198		198
Prairie State College				11/07/17	275		275
Prairie State College				11/07/17	375		375
Prairie State College				11/07/17	375		375
Prairie State College				11/07/17	375		375
Efoodcard.Com				12/01/17	8		8
Efoodcard.Com				12/01/17	8		8
Www.Eatrightin.Org				12/01/17	25		25
Leadingage Illinois				12/01/17	99		99
Hr Direct				12/06/17	441		441
Oakton Community Colle				12/26/17	459		459
Efoodcard.Com				12/26/17	8		8
Efoodcard.Com				12/26/17	8		8
Leadingage Illinois				12/26/17	298		298
Leadingage Illinois				12/26/17	678		678
Alloc. - Providence Life Services					57,318		57,318

Total					79,451	-	79,451

Facility Name & ID Number Providence Palos Heights # 0052381 Report Period Beginning: 01/01/17 Ending: 12/31/17

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**

(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. $ **139,419** 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. $ **310,920**
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' PREPARATION 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. $ **403**

(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 Final**

(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