		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0051136

Facility Name: PALOS HILLS HEALTHCARE

Address: 10426 SOUTH ROBERTS ROAD (Number) PALOS HILLS (City) 60465 (Zip Code)

County: COOK

Telephone Number: (708) 598-3460 **Fax #** (708) 598-0520

HFS ID Number:

Date of Initial License for Current Owners: 07/01/10

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
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 01/01/2011 to 12/31/2011 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) NATAN WEISS
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 _____

	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	135	Skilled (SNF)	135	49,275	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	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			5,651	5,651	8
9	SNF/PED					9
10	ICF	39,488	4,255	173	43,916	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,488	4,255	5,824	49,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.90%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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 07/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 5,651

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	332,007	25,371	18,260	375,638		375,638	(7,477)	368,161			1
2	Food Purchase		296,692		296,692		296,692	(373)	296,319			2
3	Housekeeping	240,094	34,136		274,230		274,230		274,230			3
4	Laundry	99,322	13,275	2,694	115,291		115,291		115,291			4
5	Heat and Other Utilities			137,748	137,748		137,748		137,748			5
6	Maintenance	73,004	63,487	19,793	156,284		156,284		156,284			6
7	Other (specify):*			24,952	24,952		24,952		24,952			7
8	**TOTAL General Services**	744,427	432,961	203,447	1,380,835		1,380,835	(7,850)	1,372,985			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,438,199	326,924	82,768	2,847,891		2,847,891	(12,569)	2,835,322			10
10a	Therapy			5,424	5,424		5,424		5,424			10a
11	Activities	105,707	2,953	2,685	111,345		111,345		111,345			11
12	Social Services	98,550	70	2,080	100,700		100,700		100,700			12
13	CNA Training											13
14	Program Transportation			213	213		213		213			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,642,456	329,947	106,170	3,078,573		3,078,573	(12,569)	3,066,004			16
	C. General Administration											
17	Administrative	84,773		385,186	469,959		469,959	10,996	480,955			17
18	Directors Fees											18
19	Professional Services			169,646	169,646		169,646	(67,206)	102,440			19
20	Dues, Fees, Subscriptions & Promotions			86,083	86,083		86,083	(11,495)	74,588			20
21	Clerical & General Office Expenses	207,770	27,116	34,527	269,413		269,413	63,144	332,557			21
22	Employee Benefits & Payroll Taxes			732,133	732,133		732,133		732,133			22
23	Inservice Training & Education			500	500		500	567	1,067			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,908	2,908		2,908	4,784	7,692			25
26	Insurance-Prop.Liab.Malpractice			156,465	156,465		156,465	2,189	158,654			26
27	Other (specify):*			66,000	66,000		66,000	(42,614)	23,386			27
28	**TOTAL General Administration**	292,543	27,116	1,633,448	1,953,107		1,953,107	(39,635)	1,913,472			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,679,426	790,024	1,943,065	6,412,515		6,412,515	(60,054)	6,352,461			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PALOS HILLS HEALTHCARE #0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,500	
	REPAIRS & MAINTENANCE		3,760	
			0	18,260
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,694	
			0	2,694
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		49,619	
	ELECTRICITY		46,854	
	WATER		37,072	
	CABLE TV - LOBBY		4,203	
			0	137,748
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,021	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,442	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		6,330	
			0	
			0	
			0	
			0	19,793
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		24,952	
	SECURITY SERVICE		0	
			0	
			0	24,952
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	13,000	13,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,020	
	PHARMACY CONSULTANT	XVIII B 39-2	7,248	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	500	
	RN CONSULTANT	XVIII B 38-2	72,000	
			0	
			0	82,768
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,582	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,648	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,194	
				5,424
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,685	
			0	2,685
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,080	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,080
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PALOS HILLS HEALTHCARE **#0051136** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		213	213
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	385,186	385,186
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,933	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	70,713	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		74,000	169,646
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	10,481	
	EMPLOYEE WANT ADS	XIX F	51,905	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	13,610	
	LICENSES & PERMITS	XIX F	4,057	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,250	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,400	
	PATIENT BACKGROUND CHECKS	XIX F	2,380	
				86,083
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		85	
	EQUIPMENT REPAIR & MAINTENANCE		5,365	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		25,596	
	MESSENGER SERVICE		3,481	
			0	34,527

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	290,725	
	UNEMPLOYMENT COMPENSATION	XIX D	109,229	
	WORKERS COMPENSATION INSURANC	XIX D	147,721	
	HOSPITALIZATION INSURANCE	XIX D	140,424	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,950	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	41,084	
	CHICAGO HEAD TAX	XIX D	0	
			0	732,133
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		500	
				500
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,908	
				2,908
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		156,465	
				156,465
27	**OTHER**			
	BAD DEBTS	VI 24	66,000	
				66,000

GRAND TOTAL COLUMN 3 OTHER **1,943,065**

PALOS HILLS HEALTHCARE
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	296,692
LESS SALES TAX	(373)
NET FOOD	296,319
TOTAL PATIENT CENSUS	49,567
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	148,701
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	148,701
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	148,701
NET FOOD	296,319
DIVIDE TOTAL MEALS/YEAR	148,701
COST PER MEAL	1.99
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number PALOS HILLS HEALTHCARE #0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			77,767	77,767		77,767	(64,864)	12,903			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,093	29,093		29,093	(994)	28,099			32
33	Real Estate Taxes			163,674	163,674		163,674		163,674			33
34	Rent-Facility & Grounds			100,000	100,000		100,000	5,553	105,553			34
35	Rent-Equipment & Vehicles			31,086	31,086		31,086	12,363	43,449			35
36	Other (specify):*											36
37	**TOTAL Ownership**			401,620	401,620		401,620	(47,942)	353,678			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,282	579,597	767,879		767,879		767,879			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		188,282	690,740	879,022		879,022		879,022			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,679,426	978,306	3,035,425	7,693,157		7,693,157	(107,996)	7,585,161			45

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
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	(65,991)	30		9
10	Interest and Other Investment Income	(994)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,481)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(10,256)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (155,345)		$	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)	47,349		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 47,349		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,996)		37

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

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

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

PALOS HILLS HEALTHCARE

ID# 0051136

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ -10,256	21	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				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**	(10,256)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(14,500)	7,023	0	0	0	0	0	0	0	0	(7,477)	1
2	Food Purchase	(373)	0	0	0	0	0	0	0	0	0	0	(373)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(373)	(14,500)	7,023	0	0	0	0	0	0	0	0	(7,850)	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	(72,000)	59,431	0	0	0	0	0	0	0	0	(12,569)	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	(72,000)	59,431	0	0	0	0	0	0	0	0	(12,569)	16
	C. General Administration													
17	Administrative	0	(385,186)	396,182	0	0	0	0	0	0	0	0	10,996	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(74,000)	6,794	0	0	0	0	0	0	0	0	(67,206)	19
20	Fees, Subscriptions & Promotions	(11,731)	0	236	0	0	0	0	0	0	0	0	(11,495)	20
21	Clerical & General Office Expenses	(10,256)	0	73,400	0	0	0	0	0	0	0	0	63,144	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	567	0	0	0	0	0	0	0	0	567	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	4,784	0	0	0	0	0	0	0	0	4,784	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,189	0	0	0	0	0	0	0	0	2,189	26
27	Other (specify):*	(66,000)	0	23,386	0	0	0	0	0	0	0	0	(42,614)	27
28	**TOTAL General Administration**	(87,987)	(459,186)	507,538	0	0	0	0	0	0	0	0	(39,635)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,360)	(545,686)	573,992	0	0	0	0	0	0	0	0	(60,054)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PALOS HILLS HEALTHCARE **#** 0051136 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(65,991)	0	1,127	0	0	0	0	0	0	0	0	(64,864)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(994)	0	0	0	0	0	0	0	0	0	0	(994)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,553	0	0	0	0	0	0	0	0	5,553	34
35	Rent-Equipment & Vehicles	0	0	12,363	0	0	0	0	0	0	0	0	12,363	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(66,985)	0	19,043	0	0	0	0	0	0	0	0	(47,942)	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)**	(155,345)	(545,686)	593,035	0	0	0	0	0	0	0	0	(107,996)	45

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
		ATRIUM HEALTH CARE & REHABILITATION		WEISS MGMT.		
		CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC.	SKOKIE	MGMT/CLERICAL
SEE ATTACHED SCHEDULE		BELLEVILLE HEALTHCARE & REHAB CENTER	BELLEVILLE			
		GENEVA NURSING & REHAB CENTER	GENEVA			

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	10	NURSING CONSULTANT	$ 72,000	WEISS MANAGEMENT GROUP, INC.		$	$ (72,000)	1
2	V	17	MANAGEMENT FEES	385,186				(385,186)	2
3	V	19	ADMIN./BKKP. FEES	74,000				(74,000)	3
4	V	1	DIETARY CONSULTANT	14,500				(14,500)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 545,686			$	$ * (545,686)	14

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1	DIETARY SALARIES	$	WEISS MANAGEMENT GROUP, INC.		$ 7,023	$ 7,023	15
16	V	10	NURSING SALARIES				59,431	59,431	16
17	V	17	ADMINISTRATIVE SALARIES				396,182	396,182	17
18	V	19	PROFESSIONAL FEES				6,794	6,794	18
19	V	20	LICENSES & PERMITS				236	236	19
20	V	21	OFFICE EXPENSES				73,400	73,400	20
21	V	23	SEMINARS				567	567	21
22	V	25	TRANSPORTATION STAFF				4,784	4,784	22
23	V	26	INSURANCE				2,189	2,189	23
24	V	27	EMPLOYEE BENEFITS				23,386	23,386	24
25	V	30	DEPRECIATION (SL)				1,127	1,127	25
26	V	34	OFFICE RENT				5,553	5,553	26
27	V	35	AUTO LEASE				12,363	12,363	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 593,035	$ * 593,035	39

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	MARTIN WEISS	PRESIDENT	ADMINISTRATOR					SALARY	$ 118,034	17-7	1
2					SEE						2
3	DANIEL WEISS	MANAGER	MANAGEMENT	16.67	ATTACHED	8	20.00	SALARY	150,647	17-7	3
4					SCHEDULE						4
5	NATAN WEISS	CFO	FINANCE/MGMT	16.67		10	25.00	SALARY	127,502	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 396,183		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 PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: WEISS MANAGEMENT GROUP, INC
Street Address: 3856 OAKTON STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 933-9200
Fax Number: (847) 933-9765

	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	DIETARY SALARIES	PATIENT CENSUS	158,674	4	$ 22,482	$ 22,482	49,567	$ 7,023	1
2	10	NURSING SALARIES	PATIENT CENSUS	158,674	4	190,250	190,250	49,567	59,431	2
3	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	158,674	4	1,268,260	1,268,260	49,567	396,182	3
4	19	PROFESSIONAL FEES	PATIENT CENSUS	158,674	4	21,748		49,567	6,794	4
5	20	LICENSES & PERMITS	PATIENT CENSUS	158,674	4	757		49,567	236	5
6	21	OFFICE EXPENSES	PATIENT CENSUS	158,674	4	234,967	179,529	49,567	73,400	6
7	23	SEMINARS	PATIENT CENSUS	158,674	4	1,816		49,567	567	7
8	25	TRANSPORTATION STAFF	PATIENT CENSUS	158,674	4	15,315		49,567	4,784	8
9	26	INSURANCE	PATIENT CENSUS	158,674	4	7,007		49,567	2,189	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	158,674	4	74,863		49,567	23,386	10
11	30	DEPRECIATION (SL)	PATIENT CENSUS	158,674	4	3,607		49,567	1,127	11
12	34	OFFICE RENT	PATIENT CENSUS	158,674	4	17,775		49,567	5,553	12
13	35	AUTO LEASE	PATIENT CENSUS	158,674	4	39,578		49,567	12,363	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					$ 1,898,425	$ 1,660,521		$ 593,035	25

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL		08/01/10	750,000			PRIME+	25,834	6
7		X		INSURANCE FINANCING							3,259	7
8												8
9	TOTAL Facility Related						$ 750,000	$			$ 29,093	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 750,000	$			$ 29,093	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 231,000	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).		$ (231,000)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 363,000	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.)**		$ 31,674	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.		$ 163,674	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008		10
2009	461,644	11
2010	255,263	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PALOS HILLS HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051136

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-14-224-003-0000	NURSING HOME	$ 3,580.98	$ 3,580.98
2.	23-14-224-004-0000	NURSING HOME	$ 3,580.98	$ 3,580.98
3.	23-14-224-017-0000	NURSING HOME	$ 248,101.28	$ 248,101.32
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 255,263.24	$ 255,263.28

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF TOP AIR CONDITION			2010	9,124	912	5	912		5,702	9
10	LOBBY: MILLWORK,CROWN MOLDING,REPLACE OUTLETS,										10
11	WALLCOVERING										11
12	CORRIDOR #1:CEILING TILE,HANDRAILS,PAINTING WALLS,										12
13	MILLWORK										13
14	CORRIDOR #2:CEILING TILE,HANDRAILS,MILLWORK,LIGHT										14
15	FIXTURE										15
16	THERAPY AND RESIDENT ROOMS;CEILING TILE,WINDOW										16
17	TREATMENTS,FLOORING,WALLCOVERING, LIGHT FIXTURES,										17
18	INSTALL NEW VCT AND COVE BASE			2010	60,347	2,194	27.5	2,194		2,558	18
19	SOUTH HALL, NORTH/DINING, BEATY SHOP-PAINTING			2011	12,000	2,400	5	2,400		2,400	19
20	PHONE ROOM AREA-INSTALL NEW WIREGLASS WINDOW;										20
21	DINING ROOM-CEILING TILE,WALLCOVERING,CHAIR RAIL'										21
22	BUILD TWO NEW WALLS;										22
23	THERAPY ROOM-INSTALL NEW DOOR,PAINT WALLS;										23
24	RESIDENT BATHROOMS-PAINT,CEILINGS, COVE BASE;										24
25	RECETTION AREA-DEMOLISH TWO WALLS,INSTALL NEW										25
26	COUNTERTOP, PAINT;										26
27	ADMISSION OFFICE-BUID NEW WALL,WALLCOVERING ,PAINT										27
28	INSTALLATION OF WINDOW TREATMENTS,ROLLER SHADES,										28
29	CUBICLE CURTAINS			2011	35,514	1,022	27.5	1,022		1,022	29
30	NORTH HALL, FRONT HALL-PAINTING			2011	13,350	2,670	5	2,670		2,670	30
31	INSTALL ANTI-FREEZE SYSTEM BELOW CANOPY			2011	5,135	179	27.5	179		179	31
32	INSTALL INTELLIGENT PHOTO DETECTOR			2011	7,998	279	27.5	279		279	32
33	LOBBY-INSTALL NEW CERAMIC TILE, MILLWORK, GROUT			2011	8,537	168	27.5	168		168	33
34	PARKING LOT-PAVED WITH 1.5" OF NEW ASPHALT			2011	29,850	829	15	829		829	34
35	INSTALL FIVE DELAYED EGRESS LOCKS-DOUBLE & SINGLE			2011	8,368	89	27.5	89		89	35
36	REPLACED 4 DEFECTIVE MOTORS ON EXHAUST FANS			2001	2,622	12	27.5	12		12	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	REROOFED PROPERTY USING SINGLE PLY MODIFIED		$	$		$	$	$	37
38	BITUMEN; INSTALL 6 NEW RETRO FIT DRAINS	2011	35,700	54	27.5	54		54	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 228,545	$ 10,808		$ 10,808	$	$ 15,962	70

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 9,665	$	$ 968	$ 968	10 YRS	$ 1,452	71
72	Current Year Purchases	72,461	66,959		(66,959)			72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		1,127	1,127				74
75	TOTALS	$ 82,126	$ 68,086	$ 2,095	$ (65,991)		$ 1,452	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)	$ 310,671	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 78,894	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 12,903	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (65,991)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 17,414	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 PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: PINE MANOR TERRACE LLC

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:		203	07/01/10	$ 100,000			3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 100,000 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/10
Ending 12/31/30

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$ 564,974
13.	/2013	$ 583,498
14.	/2014	$

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: $ 24,050 Description: SEE SCHEDULE ATTACHED
(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	ADMINISTRATIVE	2007 HUMMER	$ 580.81	$ 7,036	17
18					18
19					19
20					20
21	TOTAL		$ 580.81	$ 7,036	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.

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	39-3	hrs	$		$ 222,073	$		$ 222,073	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			108,281			108,281	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			249,243			249,243	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				181,113		181,113	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39-2					1,358		1,358	12
13	Other (specify): RADIOLOGY	39-2					5,811		5,811	13
14	TOTAL			$		$ 579,597	$ 188,282		$ 767,879	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.

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ (247,425)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 166,000)	3,494,545		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	134,086		6
7	Other Prepaid Expenses	1,984		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,383,190	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	228,545		15
16	Equipment, at Historical Cost	82,126		16
17	Accumulated Depreciation (book methods)	(92,586)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 218,085	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,601,275	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 808,535	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,440		28
29	Short-Term Notes Payable	724,471		29
30	Accrued Salaries Payable	141,080		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,591		31
32	Accrued Real Estate Taxes(Sch.IX-B)	363,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,075,117	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,075,117	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,526,158	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,601,275	$	48

***(See instructions.)**

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 592,599	1	
2	Restatements (describe):		2	
3	**PRIOR YEAR ADJUSTMENTS**	(17,242)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 575,357	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	950,801	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)**	$ 950,801	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)**	$ 1,526,158	24	*

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,585,465	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,585,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,057,399	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,057,399	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	994	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 994	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	100	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 100	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,643,958	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,380,835	31
32	Health Care	3,078,573	32
33	General Administration	1,953,107	33
	B. Capital Expense		
34	Ownership	401,620	34
	C. Ancillary Expense		
35	Special Cost Centers	767,879	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,693,157	40
41	**Income before Income Taxes (line 30 minus line 40)****	950,801	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 950,801	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

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

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,312	1,328	$ 53,195	$ 40.06	1
2	Assistant Director of Nursing	2,576	2,720	79,451	29.21	2
3	Registered Nurses	13,731	14,256	454,369	31.87	3
4	Licensed Practical Nurses	36,804	37,942	815,982	21.51	4
5	CNAs & Orderlies	80,763	82,299	869,457	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,480	8,675		0.00	8
9	Activity Director					9
10	Activity Assistants	8,984	9,279	105,707	11.39	10
11	Social Service Workers	7,656	7,862	98,550	12.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,769	31,647	332,007	10.49	15
16	Dishwashers					16
17	Maintenance Workers	4,625	4,785	73,004	15.26	17
18	Housekeepers	22,707	23,313	240,094	10.30	18
19	Laundry	10,981	11,241	99,322	8.84	19
20	Administrator	2,104	2,296	84,773	36.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,321	12,719	207,770	16.34	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	2,516	2,676	41,127	15.37	31
32	Other Health Ca Care Plan Coord	4,048	4,224	124,618	29.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	250,377	257,262	$ 3,679,426 *	$ 14.30	34

* 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	M	$ 14,500	1-3	35
36	Medical Director	O	13,000	9-3	36
37	Medical Records Consultant	N	3,020	10-3	37
38	Nurse Consultant	T	72,000	10-3	38
39	Pharmacist Consultant	H	7,248	10-3	39
40	Physical Therapy Consultant	L	2,582	10a-3	40
41	Occupational Therapy Consultant	Y	1,648	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	1,194	10a-3	43
44	Activity Consultant	E	2,685	11-3	44
45	Social Service Consultant	E	2,080	12-3	45
46	Other(specify) PSYCHIATRIC	S	500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 120,457		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MATTHEW GIDNEY	ADMINISTRATOR	0	$ 67,513
LIZA ORZADA	ADMINISTRATOR	0	17,260
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,773

B. Administrative - Other

Description		Amount
WEISS MANAGEMENT GROUP	MANAGEMENT FEES	$ 385,186
TOTAL (agree to Schedule V, line 17, col. 3)		$ 385,186
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		169,646
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 169,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,721
Unemployment Compensation Insurance	109,229
FICA Taxes	290,725
Employee Health Insurance	140,424
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,950
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	41,084
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 732,133

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,437
Advertising: Employee Recruitment	51,905
Health Care Worker Background Check	2,400
(Indicate # of checks performed 240)	
Patient Background Checks 238	2,380
TRUST/FRANCHISE/CONTRIB/ETC	1,250
MARKETING/ADV/PROMO	10,481
LICENSES/DUES/SUBSCRIPTIONS	15,230
MGMT CO ALLOC	236
TRUST/FRANCHISE/CONTRIB/ETC	(1,250)
Less: Public Relations Expense	(0)
Non-allowable advertising	(10,481)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 74,588

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $13,440**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(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?

(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? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **32,430** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(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 fo
Schedule VII)? YES **X** NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
PALOS HILLS EXTENDED CARE LLC, IDPH #0046029 07/01/2010

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **111,143**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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? **N/A** Indicate the amount. $

(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 fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
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? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees