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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051136

Facility Name: PALOS HILLS HEALTHCARE

Address: 10426 SOUTH ROBERTS (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: SANFORD BOKOR **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 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, 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: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed 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	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	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			6,758	6,758	8
9	SNF/PED					9
10	ICF	39,286	3,913	423	43,622	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,286	3,913	7,181	50,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.81%

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 6,758

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	351,202	29,622	13,885	394,709		394,709	3,581	398,290			1
2	Food Purchase		295,449		295,449		295,449		295,449			2
3	Housekeeping	295,180	44,656		339,836		339,836		339,836			3
4	Laundry	103,111	17,474	2,986	123,571		123,571		123,571			4
5	Heat and Other Utilities			125,116	125,116		125,116		125,116			5
6	Maintenance	103,963	49,973	15,762	169,698		169,698		169,698			6
7	Other (specify):*			25,181	25,181		25,181		25,181			7
8	**TOTAL General Services**	853,456	437,174	182,930	1,473,560		1,473,560	3,581	1,477,141			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,524,251	326,239	38,388	2,888,878		2,888,878	4,640	2,893,518			10
10a	Therapy	107,639		68,857	176,496		176,496		176,496			10a
11	Activities	117,847	4,949	1,830	124,626		124,626		124,626			11
12	Social Services	130,965	3,450	1,725	136,140		136,140		136,140			12
13	CNA Training											13
14	Program Transportation			804	804		804		804			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,880,702	334,638	135,604	3,350,944		3,350,944	4,640	3,355,584			16
	C. General Administration											
17	Administrative	95,565		647,241	742,806		742,806	(177,280)	565,526			17
18	Directors Fees											18
19	Professional Services			228,002	228,002		228,002	(98,217)	129,785			19
20	Dues, Fees, Subscriptions & Promotions			83,565	83,565		83,565	(17,334)	66,231			20
21	Clerical & General Office Expenses	277,412	26,141	58,549	362,102		362,102	13,737	375,839			21
22	Employee Benefits & Payroll Taxes			742,464	742,464		742,464		742,464			22
23	Inservice Training & Education			2,107	2,107		2,107	463	2,570			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,715	14,715		14,715	4,601	19,316			25
26	Insurance-Prop.Liab.Malpractice			165,306	165,306		165,306	723	166,029			26
27	Other (specify):*			612,344	612,344		612,344	(583,161)	29,183			27
28	**TOTAL General Administration**	372,977	26,141	2,554,293	2,953,411		2,953,411	(856,468)	2,096,943			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,107,135	797,953	2,872,827	7,777,915		7,777,915	(848,247)	6,929,668			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: 01/01/2012** **Ending: 12/31/2012**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	13,500	
	REPAIRS & MAINTENANCE		385	
			0	13,885
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,986	
			0	2,986
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,109	
	ELECTRICITY		42,015	
	WATER		42,435	
	CABLE TV - LOBBY		4,557	
			0	125,116
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,600	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		788	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		8,374	
			0	
			0	
			0	
			0	15,762
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		25,181	
	SECURITY SERVICE		0	
			0	
			0	25,181
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	24,000	24,000

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	1,140	
	PHARMACY CONSULTANT	XVIII B 39-2	7,248	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	30,000	
			0	
			0	38,388
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	14,888	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	13,468	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	35,992	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	4,509	
				68,857
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,830	
			0	1,830
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,725	
	SOCIAL WORKER	XVIII B 45-2	0	
				1,725
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PALOS HILLS HEALTHCARE **#0051136** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		804	804
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	647,241	647,241
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	28,013	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	39,284	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		160,705	228,002
20				
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	21,776	
	EMPLOYEE WANT ADS	XIX F	45,341	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	9,675	
	LICENSES & PERMITS	XIX F	2,972	
	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	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	291	
	PATIENT BACKGROUND CHECKS	XIX F	2,510	
				83,565
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,684	
	EQUIPMENT REPAIR & MAINTENANCE		18,627	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	767	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27,945	
	MESSENGER SERVICE		6,193	
	LEGAL SETTLEMENT		3,333	58,549

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	311,674	
	UNEMPLOYMENT COMPENSATION	XIX D	102,866	
	WORKERS COMPENSATION INSURANC	XIX D	174,344	
	HOSPITALIZATION INSURANCE	XIX D	144,720	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,860	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	742,464
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,107	
				2,107
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,715	
				14,715
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		165,306	
				165,306
27	**OTHER**			
	BAD DEBTS	VI 24	612,344	
				612,344

GRAND TOTAL COLUMN 3 OTHER **2,872,827**

PALOS HILLS HEALTHCARE
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	295,449
LESS SALES TAX	0
NET FOOD	295,449
TOTAL PATIENT CENSUS	50,380
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	151,140
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	151,140
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	151,140
NET FOOD	295,449
DIVIDE TOTAL MEALS/YEAR	151,140
COST PER MEAL	1.95
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number PALOS HILLS HEALTHCARE #0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			44,585	44,585		44,585	28,971	73,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,302	44,302		44,302	76,876	121,178			32
33	Real Estate Taxes			36,284	36,284		36,284	30,535	66,819			33
34	Rent-Facility & Grounds			717,660	717,660		717,660	(705,390)	12,270			34
35	Rent-Equipment & Vehicles			30,617	30,617		30,617	741	31,358			35
36	Other (specify):*											36
37	TOTAL Ownership			873,448	873,448		873,448	(568,267)	305,181			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,780	757,138	1,004,918		1,004,918		1,004,918			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			511,795	511,795		511,795		511,795			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		247,780	1,268,933	1,516,713		1,516,713		1,516,713			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,107,135	1,045,733	5,015,208	10,168,076		10,168,076	(1,416,514)	8,751,562			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: 01/01/2012 Ending: 12/31/2012

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	(12,662)	30		9
10	Interest and Other Investment Income	(99)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(767)	21		18
19	Entertainment		20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(3,736)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(612,344)	27		24
25	Fund Raising, Advertising and Promotional	(21,776)	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	(47,821)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (700,205)		$	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)	(716,309)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (716,309)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,416,514)		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: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (47,821)	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**	(47,821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	(973)	4,554	0	0	0	0	0	0	0	3,581	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	(973)	4,554	0	0	0	0	0	0	0	3,581	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(11,500)	16,140	0	0	0	0	0	0	0	4,640	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(11,500)	16,140	0	0	0	0	0	0	0	4,640	16
	C. General Administration													
17	Administrative	0	0	(102,309)	(74,971)	0	0	0	0	0	0	0	(177,280)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,736)	0	(29,141)	(65,340)	0	0	0	0	0	0	0	(98,217)	19
20	Fees, Subscriptions & Promotions	(22,776)	0	4,131	1,311	0	0	0	0	0	0	0	(17,334)	20
21	Clerical & General Office Expenses	(48,588)	0	57,037	5,288	0	0	0	0	0	0	0	13,737	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	213	250	0	0	0	0	0	0	0	463	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	3,412	1,189	0	0	0	0	0	0	0	4,601	25
26	Insurance-Prop.Liab.Malpractice	0	0	405	318	0	0	0	0	0	0	0	723	26
27	Other (specify):*	(612,344)	0	23,956	5,227	0	0	0	0	0	0	0	(583,161)	27
28	**TOTAL General Administration**	(687,444)	0	(42,296)	(126,728)	0	0	0	0	0	0	0	(856,468)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(687,444)	0	(54,769)	(106,034)	0	0	0	0	0	0	0	(848,247)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(12,662)	40,218	1,415	0	0	0	0	0	0	0	0	28,971	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(99)	76,975	0	0	0	0	0	0	0	0	0	76,876	32
33	Real Estate Taxes	0	30,535	0	0	0	0	0	0	0	0	0	30,535	33
34	Rent-Facility & Grounds	0	(717,660)	9,148	3,122	0	0	0	0	0	0	0	(705,390)	34
35	Rent-Equipment & Vehicles	0	0	429	312	0	0	0	0	0	0	0	741	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,761)	(569,932)	10,992	3,434	0	0	0	0	0	0	0	(568,267)	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)	(700,205)	(569,932)	(43,777)	(102,600)	0	0	0	0	0	0	0	(1,416,514)	45

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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	$ 717,660	PM NURSING & REHAB		$	$ (717,660)	1
2	V	30	DEPRECIATION				40,218	40,218	2
3	V	32	INTEREST EXPENSE				73,385	73,385	3
4	V	32	AMORT LOAN COST				3,590	3,590	4
5	V	33	REAL ESTATE TAXES				30,535	30,535	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			$ 717,660			$ 147,728	$ * (569,932)	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: 01/01/2012 Ending: 12/31/2012

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 CONSULTANT	$ 13,500	WEISS MANAGEMENT GROUP, INC.		$	$ (13,500)	15
16	V	10	NURSING CONSULTANT	30,000				(30,000)	16
17	V	17	MANAGEMENT FEES	464,396				(464,396)	17
18	V	19	ADMIN./BKKP. FEES	30,000				(30,000)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V	1	DIETARY SALARIES				12,527	12,527	24
25	V	10	NURSING SALARIES				18,500	18,500	25
26	V	17	ADMINISTRATIVE SALARIES				362,087	362,087	26
27	V	19	PROFESSIONAL FEES				859	859	27
28	V	20	EMPLOYEE WANT ADS				4,131	4,131	28
29	V	21	OFFICE EXPENSES				57,037	57,037	29
30	V	23	SEMINARS				213	213	30
31	V	25	TRANSPORTATION STAFF				3,412	3,412	31
32	V	26	INSURANCE				405	405	32
33	V	27	EMPLOYEE BENEFITS				23,956	23,956	33
34	V	30	DEPRECIATION (SL)				1,415	1,415	34
35	V	34	OFFICE RENT				9,148	9,148	35
36	V	35	AUTO LEASE				429	429	36
37	V								37
38	V								38
39	Total			$ 537,896			$ 494,119	$ * (43,777)	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: 01/01/2012 Ending: 12/31/2012

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	17	MANAGEMENT FEES	$ 74,971	BRIA HEALTH SERVICES, LLC		$	$ (74,971)	15
16	V	19	BKKPNG/ADMIN SERVICES	70,500				(70,500)	16
17	V								17
18	V								18
19	V								19
20	V	1	DIETARY SALARIES				4,554	4,554	20
21	V	10	NURSING SALARIES				16,140	16,140	21
22	V	19	PROFESSIONAL FEES				5,160	5,160	22
23	V	20	WANT ADS				1,311	1,311	23
24	V	21	TOTAL OFFICE				3,736	3,736	24
25	V	21	CLERICAL SALARIES				1,552	1,552	25
26	V	23	SEMINARS				250	250	26
27	V	25	TRANSPORTATIONAL STAFF				1,189	1,189	27
28	V	26	INSURANCE				318	318	28
29	V	27	EMPLOYEE BENEFITS				5,227	5,227	29
30	V	34	OFFICE RENT				3,122	3,122	30
31	V	35	AUTO LEASE				312	312	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 145,471			$ 42,871	$ * (102,600)	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: 01/01/2012 Ending: 12/31/2012

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	DANIEL WEISS	16.67	ATRIUM HEALTHCARE & REHABILITATION		WEISS MGMT		MANAGEMENT/	2
3	NATAN WEISS	16.67	CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	AVRUM WEINFELD	16.67						4
5	DEANNA KAPLAN	49.99	BELLEVILLE HEALTHCARE & REHAB		BRIA HEALTH		MANAGEMENT	5
6			CENTER	BELLEVILLE	SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7								7
8			GENEVA NURSING & REHAB CENTER	GENEVA	PM NURSING &		REAL ESTATE	8
9					REHAB	LINCOLNWOOD		9
10			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO				10
11				HEIGHTS				11
12								12
13			LAKE PARK CENTER	WAUKEGAN				13
14								14
15			WESTMONT NURSING & REHAB					15
16			CENTER, LLC	WESTMONT				16
17								17
18			FOREST EDGE HEALTHCARE REHAB					18
19			CENTER	CHICAGO				19
20								20
21			RIVER OAKS HEALTHCARE REHAB					21
22			CENTER	BURNHAM				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: 01/01/2012 Ending: 12/31/2012

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	ALLOCATIONS FROM WEI	PRESIDENT	ADMINISTRATOR						$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIC	16.67	SEE			SALARY	110,300	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	16.67	SCHEDULE	6	15.00	SALARY	133,015	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	16.67		9	22.50	SALARY	118,773	17.7	6
7											7
8	ALLOCATIONS FROM BRIA HEALTH SERVICES, LLC:										8
9	DOV SEGAL	PURCHASING	CONSULTING	0.00				SALARY	5,115	19-1	9
10		CONSULTANT									10
11											11
12											12
13								TOTAL	$ 367,203		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: 01/01/2012 Ending: 2/31/2012

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: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	193,748	4	$ 48,175	$ 48,175	50,380	$ 12,527	1
2	10	NURSING SALARIES	PATIENT CENSUS	287,415	6	105,543	105,543	50,380	18,500	2
3	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	176,223	4	1,266,537	1,266,537	50,380	362,087	3
4	19	PROFESSIONAL FEES	PATIENT CENSUS	176,223	4	3,003		50,380	859	4
5	20	EMPLOYEE WANT ADS	PATIENT CENSUS	176,223	4	14,450		50,380	4,131	5
6	21	OFFICE EXPENSES	PATIENT CENSUS	176,223	4	199,508	128,614	50,380	57,037	6
7	23	SEMINARS	PATIENT CENSUS	176,223	4	745		50,380	213	7
8	25	TRANSPORTATION STAFF	PATIENT CENSUS	176,223	4	11,934		50,380	3,412	8
9	26	INSURANCE	PATIENT CENSUS	176,223	4	1,416		50,380	405	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	176,223	4	83,794		50,380	23,956	10
11	30	DEPRECIATION (SL)	PATIENT CENSUS	176,223	4	4,949		50,380	1,415	11
12	34	OFFICE RENT	PATIENT CENSUS	176,223	4	32,000		50,380	9,148	12
13	35	AUTO LEASE	PATIENT CENSUS	176,223	4	1,500		50,380	429	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					$ 1,773,554	$ 1,548,869		$ 494,119	25

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: BRIA HEALTH SERVICES, LLC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	322,729	8	$ 29,170	$ 29,170	50,380	$ 4,554	1
2	10	NURSING SALARIES	PATIENT CENSUS	322,729	8	103,388	103,388	50,380	16,140	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	322,729	8	33,054	32,765	50,380	5,160	3
4	20	WANT ADS	PATIENT CENSUS	322,729	8	8,400		50,380	1,311	4
5	21	TOTAL OFFICE	PATIENT CENSUS	322,729	8	23,931		50,380	3,736	5
6	21	CLERICAL SALARIES	PATIENT CENSUS	322,729	8	9,940	9,940	50,380	1,552	6
7	23	SEMINARS	PATIENT CENSUS	322,729	8	1,599		50,380	250	7
8	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	322,729	8	7,616		50,380	1,189	8
9	26	INSURANCE	PATIENT CENSUS	322,729	8	2,036		50,380	318	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	322,729	8	33,481		50,380	5,227	10
11	34	OFFICE RENT	PATIENT CENSUS	322,729	8	20,000		50,380	3,122	11
12	35	AUTO LEASE	PATIENT CENSUS	322,729	8	2,000		50,380	312	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					$ 274,615	$ 175,263		$ 42,871	25

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	RELATED PARTY: PM NURSING & REHAB						$	$			$	1
2	BANK FINANCIAL	X		MORTGAGE	$10,333.54	01/18/01	1,800,000	1,764,706	01/18/15	4.7500	78,385	2
3	AMORT LOAN COST			AMORT OVER 5 YEARS		07/01/12	35,901	35,901			3,590	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	08/01/10	750,000	2,096,829		PRIME+	41,205	6
7		X		INSURANCE FINANCING							3,097	7
8												8
9	TOTAL Facility Related				$10,333.54		$ 2,585,901	$ 3,897,436			$ 126,277	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,585,901	$ 3,897,436			$ 126,277	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: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 30,535	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,535	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 36,284	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.		$ 66,819	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009	461,644	10
	2010	255,263	11
	2011	30,535	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-14-224-003-0000	NURSING HOME	$ 1,210.18	$ 1,210.18
2.	23-14-224-004-0000	NURSING HOME	$ 1,210.18	$ 1,210.18
3.	23-14-224-017-0000	NURSING HOME	$ 28,114.85	$ 28,114.85
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,535.21	$ 30,535.21

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 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	203		2012		$ 1,636,707	$ 40,218	39	$ 40,218	$	$ 40,218	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF TOP AIR CONDITION			2010	9,124	912	5	912		6,614	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		4,752	18
19	SOUTH HALL, NORTH/DINING, BEATY SHOP-PAINTING			2011	12,000	3,840	5	3,840		6,240	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	1,291	27.5	1,291		2,313	29
30	NORTH HALL, FRONT HALL-PAINTING			2011	13,350	4,272	5	4,272		6,942	30
31	INSTALL ANTI-FREEZE SYSTEM BELOW CANOPY			2011	5,135	187	27.5	187		366	31
32	INSTALL INTELLIGENT PHOTO DETECTOR			2011	7,998	291	27.5	291		570	32
33	LOBBY-INSTALL NEW CERAMIC TILE, MILLWORK, GROUT			2011	8,537	310	27.5	310		478	33
34	PARKING LOT-PAVED WITH 1.5" OF NEW ASPHALT			2011	29,850	1,990	15	1,990		2,819	34
35	INSTALL FIVE DELAYED EGRESS LOCKS-DOUBLE & SINGLE			2011	8,368	304	27.5	304		393	35
36	REPLACED 4 DEFECTIVE MOTORS ON EXHAUST FANS			2001	2,622	95	27.5	95		107	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REROOFED PROPERTY USING SINGLE PLY MODIFIED		$	$		$	$	$	37
38	BITUMEN; INSTALL 6 NEW RETRO FIT DRAINS	2011	35,700	1,298	27.5	1,298		1,352	38
39	INSTALLATION AND WIRING FOR WAP'S	2012	4,730	151	27.5	151		151	39
40	CORRIDOR-HANDRAILS, CORNER GUARDS	2012	5,225	150	27.5	150		150	40
41	REPLACEMENT OF A/C SOUTHEAST UNIT COMPRESSOR	2012	2,618	1,571	5	1,571		1,571	41
42	APPLIED A PATCH TO THE FIELD OR WALL FLASHINGS	2012	2,800	30	27.5	30		30	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
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)		$ 1,880,625	$ 59,104		$ 59,104	$	$ 75,066	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: 01/01/2012 Ending: 12/31/2012

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	$ 82,126	$ 2,750	$ 10,139	$ 7,389	3-10	$ 17,554	71
72	Current Year Purchases	38,247	22,949	2,898	(20,051)	5-10	2,898	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		1,415	1,415				74
75	TOTALS	$ 120,373	$ 27,114	$ 14,452	$ (12,662)		$ 20,452	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)	$ 2,000,998	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,218	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 73,556	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,662)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 95,518	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: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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.		$
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 25,390 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	$ 5,227	17
18					18
19					19
20					20
21	TOTAL		$ 580.81	$ 5,227	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: 01/01/2012 Ending: 12/31/2012

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.

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$		$ 293,770	$		$ 293,770	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			103,289			103,289	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			360,079			360,079	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				227,778		227,778	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39-2					8,296		8,296	12
13	MEDICAL SUPPLIES Other (specify): RADIOLOGY	39-2 39-2					10,318 1,388		10,318 1,388	13
14	TOTAL			$		$ 757,138	$ 247,780		$ 1,004,918	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: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 54,933	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,000)	4,991,733		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	171,452		6
7	Other Prepaid Expenses	79,205		7
8	Accounts Receivable (owners or related parties)	377,243		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,674,566	$	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	243,918		15
16	Equipment, at Historical Cost	120,373		16
17	Accumulated Depreciation (book methods)	(137,171)		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): CONSTRUCTION ESCROW	8,069		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 235,189	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,909,755	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,359,394	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,096,829		29
30	Accrued Salaries Payable	194,597		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,567		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)**	$ 3,676,387	$	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)**	$ 3,676,387	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,233,368	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,909,755	$	48

***(See instructions.)**

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,526,158	1	
2	Restatements (describe):		2	
3	REPLACEMENT TAX	(15,242)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,510,916	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	722,452	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)**	$ 722,452	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)**	$ 2,233,368	24	*

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,936,122	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,936,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,953,107	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,953,107	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***	99	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 99	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,890,528	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,473,560	31
32	Health Care	3,350,944	32
33	General Administration	2,953,411	33
	B. Capital Expense		
34	Ownership	873,448	34
	C. Ancillary Expense		
35	Special Cost Centers	1,004,918	35
36	Provider Participation Fee	511,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,168,076	40
41	**Income before Income Taxes (line 30 minus line 40)****	722,452	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 722,452	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,466,872	44
45	Private Pay - Net Inpatient Revenue	573,004	45
46	Medicare - Net Inpatient Revenue	1,762,200	46
47	Other-(specify) MANAGED CARE	134,046	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,936,122	49

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

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

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

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2,024	2,088	$ 91,088	$ 43.62	1
2	Assistant Director of Nursing	2,066	2,176	74,733	34.34	2
3	Registered Nurses	10,641	10,851	311,888	28.74	3
4	Licensed Practical Nurses	41,332	42,572	1,023,378	24.04	4
5	CNAs & Orderlies	78,533	80,729	800,566	9.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,410	7,873	107,639	13.67	8
9	Activity Director					9
10	Activity Assistants	9,796	10,165	117,847	11.59	10
11	Social Service Workers	10,084	10,243	130,965	12.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,914	33,102	351,202	10.61	15
16	Dishwashers					16
17	Maintenance Workers	7,904	8,046	103,963	12.92	17
18	Housekeepers	28,085	29,551	295,180	9.99	18
19	Laundry	9,443	9,990	103,111	10.32	19
20	Administrator	2,080	2,080	95,565	45.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,703	15,927	277,412	17.42	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	4,598	4,672	78,893	16.89	31
32	Other Health C: Care Plan Coord	4,434	4,684	143,705	30.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	266,047	274,749	$ 4,107,135 *	$ 14.95	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	$ 13,500	1-3	35
36	Medical Director	O	24,000	9-3	36
37	Medical Records Consultant	N	1,140	10-3	37
38	Nurse Consultant	T	30,000	10-3	38
39	Pharmacist Consultant	H	7,248	10-3	39
40	Physical Therapy Consultant	L	14,888	10a-3	40
41	Occupational Therapy Consultant	Y	13,468	10a-3	41
42	Respiratory Therapy Consultant		35,992	10a-3	42
43	Speech Therapy Consultant	F	4,509	10a-3	43
44	Activity Consultant	E	1,830	11-3	44
45	Social Service Consultant	E	1,725	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 148,300		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: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MATTHEW GIDNEY	ADMINISTRATOR	0	$ 95,565
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,565

B. Administrative - Other

Description		Amount
WEISS MANAGEMENT GROUP	MANAGEMENT FEES	$ 464,396
BRIA HEALTH SERVICES, LLC	MANAGEMENT FEES	74,971
MINSKY MANAGEMENT LLC	MANAGEMENT FEES	107,874
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 647,241

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		228,002
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 228,002

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,344
Unemployment Compensation Insurance	102,866
FICA Taxes	311,674
Employee Health Insurance	144,720
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,860
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 742,464

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	$ 1,990
Advertising: Employee Recruitment	45,341
Health Care Worker Background Check	291
(Indicate # of checks performed 14)	
Patient Background Checks 251	2,510
TRUST/FRANCHISE/CONTRIB/ETC	1,000
MARKETING/ADV/PROMO	21,776
LICENSES/DUES/SUBSCRIPTIONS	10,657
MGMT CO ALLOC	5,442
TRUST/FRANCHISE/CONTRIB/ETC	(1,000)
Less: Public Relations Expense	(0)
Non-allowable advertising	(21,776)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,231

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: 01/01/2012 Ending: 12/31/2012

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													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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?
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $ 9,480**

(3) Did the nursing home make political contributions or payments to a political 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. $ **31,892** 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 for 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 Department during this cost report period. $ **511,795**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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 for 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 other 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 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.