FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 (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
  - ☐ Charitable Corp.
  - ☐ Trust
- ☐ PROPRIETARY
  - ☐ Individual
  - ☐ Partnership
  - ☐ Corporation
  - ☐ "Sub-S" Corp.
  - ☐ Limited Liability Co.
  - ☐ Trust
  - ☐ Other
- ☐ GOVERNMENTAL
  - ☐ State
  - ☐ County
  - ☐ Other

IRS Exemption Code

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 01/01/2013 to 12/31/2013 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) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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: 01/01/2013 Ending: 12/31/2013

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			6,936	6,936	8
9	SNF/PED					9
10	ICF	38,378	3,860	437	42,675	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,378	3,860	7,373	49,611	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.96%

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 6,936

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	366,643	35,949	856	403,448		403,448	8,098	411,546			1
2	Food Purchase		284,105		284,105		284,105		284,105			2
3	Housekeeping	311,183	43,997		355,180		355,180		355,180			3
4	Laundry	86,271	19,424	4,471	110,166		110,166		110,166			4
5	Heat and Other Utilities			131,400	131,400		131,400	84	131,484			5
6	Maintenance	123,899	97,634	36,138	257,671		257,671	180	257,851			6
7	Other (specify):*			25,524	25,524		25,524		25,524			7
8	**TOTAL General Services**	887,996	481,109	198,389	1,567,494		1,567,494	8,362	1,575,856			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,673,175	264,883	7,060	2,945,118		2,945,118	30,108	2,975,226			10
10a	Therapy	125,424		37,010	162,434		162,434		162,434			10a
11	Activities	122,867	2,706	3,218	128,791		128,791		128,791			11
12	Social Services	172,671	4,977	2,603	180,251		180,251		180,251			12
13	CNA Training											13
14	Program Transportation			1,188	1,188		1,188		1,188			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,094,137	272,566	75,079	3,441,782		3,441,782	30,108	3,471,890			16
	C. General Administration											
17	Administrative	101,181		620,307	721,488		721,488	(516,924)	204,564			17
18	Directors Fees											18
19	Professional Services			390,213	390,213		390,213	(138,921)	251,292			19
20	Dues, Fees, Subscriptions & Promotions			63,562	63,562		63,562	(19,540)	44,022			20
21	Clerical & General Office Expenses	274,958	34,125	77,372	386,455		386,455	(46,569)	339,886			21
22	Employee Benefits & Payroll Taxes			795,901	795,901		795,901		795,901			22
23	Inservice Training & Education			2,742	2,742		2,742	533	3,275			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			32,092	32,092		32,092	3,844	35,936			25
26	Insurance-Prop.Liab.Malpractice			195,626	195,626		195,626	4,555	200,181			26
27	Other (specify):*			479,593	479,593		479,593	(469,810)	9,783			27
28	**TOTAL General Administration**	376,139	34,125	2,657,408	3,067,672		3,067,672	(1,182,832)	1,884,840			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,358,272	787,800	2,930,876	8,076,948		8,076,948	(1,144,362)	6,932,586			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: 01/01/2013** **Ending: 12/31/2013**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		856	
			0	856
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,471	
			0	4,471
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,041	
	ELECTRICITY		54,629	
	WATER		40,121	
	CABLE TV - LOBBY		4,609	
			0	131,400
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		19,376	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		722	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		16,040	
			0	
			0	
			0	
			0	36,138
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		25,524	
	SECURITY SERVICE		0	
			0	
			0	25,524
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	1,020	
	PHARMACY CONSULTANT	XVIII B 39-2	6,040	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	7,060
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	11,770	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,939	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	15,314	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,987	
				37,010
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,218	
			0	3,218
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,603	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,603
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PALOS HILLS HEALTHCARE **#0051136** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,188	1,188
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	620,307	620,307
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	30,602	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	68,973	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		290,638	390,213
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24,092	
	EMPLOYEE WANT ADS	XIX F	17,482	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	15,495	
	LICENSES & PERMITS	XIX F	3,683	
	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	250	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	2,560	
				63,562
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		600	
	EQUIPMENT REPAIR & MAINTENANCE		32,428	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	320	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		34,443	
	MESSENGER SERVICE		9,581	
			0	77,372

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	329,297	
	UNEMPLOYMENT COMPENSATION	XIX D	121,231	
	WORKERS COMPENSATION INSURANC	XIX D	170,677	
	HOSPITALIZATION INSURANCE	XIX D	162,824	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,872	
	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	795,901
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,742	
				2,742
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		32,092	
				32,092
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		195,626	
				195,626
27	**OTHER**			
	BAD DEBTS	VI 24	479,593	
				479,593

GRAND TOTAL COLUMN 3 OTHER **2,930,876**

PALOS HILLS HEALTHCARE
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	284,105
LESS SALES TAX	0
NET FOOD	284,105
TOTAL PATIENT CENSUS	49,611
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	148,833
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	148,833
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	148,833
NET FOOD	284,105
DIVIDE TOTAL MEALS/YEAR	148,833
COST PER MEAL	1.91
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: 01/01/2013 Ending: 12/31/2013

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			61,262	61,262		61,262	20,072	81,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,396	61,396		61,396	77,038	138,434			32
33	Real Estate Taxes			34,677	34,677		34,677	352,817	387,494			33
34	Rent-Facility & Grounds			693,298	693,298		693,298	(687,038)	6,260			34
35	Rent-Equipment & Vehicles			19,996	19,996		19,996	1,908	21,904			35
36	Other (specify):*											36
37	**TOTAL Ownership**			870,629	870,629		870,629	(235,203)	635,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		259,365	894,524	1,153,889		1,153,889		1,153,889			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			371,818	371,818		371,818		371,818			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		259,365	1,266,342	1,525,707		1,525,707		1,525,707			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,358,272	1,047,165	5,067,847	10,473,284		10,473,284	(1,379,565)	9,093,719			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: 01/01/2013 Ending: 12/31/2013

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	(22,501)	30		9
10	Interest and Other Investment Income	(52,829)	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	(320)	21		18
19	Entertainment		20		19
20	Contributions	(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	(479,593)	27		24
25	Fund Raising, Advertising and Promotional	(24,092)	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	(57,909)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (637,494)		$	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)	(742,071)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (742,071)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,379,565)		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (57,909)	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**	(57,909)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	8,098	0	0	0	0	0	0	0	0	8,098	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	84	0	0	0	0	0	0	0	0	84	5
6	Maintenance	0	0	180	0	0	0	0	0	0	0	0	180	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	8,362	0	0	0	0	0	0	0	0	8,362	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	30,108	0	0	0	0	0	0	0	0	30,108	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	30,108	0	0	0	0	0	0	0	0	30,108	16
	C. General Administration													
17	Administrative	0	0	(516,924)	0	0	0	0	0	0	0	0	(516,924)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,698	(154,619)	0	0	0	0	0	0	0	0	(138,921)	19
20	Fees, Subscriptions & Promotions	(24,342)	0	4,802	0	0	0	0	0	0	0	0	(19,540)	20
21	Clerical & General Office Expenses	(58,229)	0	11,660	0	0	0	0	0	0	0	0	(46,569)	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	533	0	0	0	0	0	0	0	0	533	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	3,844	0	0	0	0	0	0	0	0	3,844	25
26	Insurance-Prop.Liab.Malpractice	0	3,539	1,016	0	0	0	0	0	0	0	0	4,555	26
27	Other (specify):*	(479,593)	0	9,783	0	0	0	0	0	0	0	0	(469,810)	27
28	**TOTAL General Administration**	(562,164)	19,237	(639,905)	0	0	0	0	0	0	0	0	(1,182,832)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(562,164)	19,237	(601,435)	0	0	0	0	0	0	0	0	(1,144,362)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	(22,501)	41,967	606	0	0	0	0	0	0	0	0	20,072	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(52,829)	129,719	148	0	0	0	0	0	0	0	0	77,038	32
33	Real Estate Taxes	0	352,284	533	0	0	0	0	0	0	0	0	352,817	33
34	Rent-Facility & Grounds	0	(693,298)	6,260	0	0	0	0	0	0	0	0	(687,038)	34
35	Rent-Equipment & Vehicles	0	0	1,908	0	0	0	0	0	0	0	0	1,908	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(75,330)	(169,328)	9,455	0	0	0	0	0	0	0	0	(235,203)	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)	(637,494)	(150,091)	(591,980)	0	0	0	0	0	0	0	0	(1,379,565)	45

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 693,298	PM NURSING & REHAB		$	$ (693,298)	1
2	V		30	DEPRECIATION				41,967	41,967	2
3	V		32	INTEREST EXPENSE				126,219	126,219	3
4	V		32	AMORT LOAN COST				3,500	3,500	4
5	V		33	REAL ESTATE TAXES				352,284	352,284	5
6	V		19	PROFESSIONAL FEES				15,698	15,698	6
7	V		26	INSURANCE				3,539	3,539	7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 693,298			$ 543,207	$ * (150,091)	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: 01/01/2013 Ending: 12/31/2013

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	$ 516,924	BRIA HEALTH SERVICES, LLC		$	$ (516,924)	15
16	V	19	BKKPNG/ADMIN SERVICES	195,450				(195,450)	16
17	V								17
18	V								18
19	V								19
20	V	1	DIETARY SALARIES				8,098	8,098	20
21	V	5	UTILITIES				84	84	21
22	V	6	REPAIR/MAINT				180	180	22
23	V	10	NURSING SALARIES				30,108	30,108	23
24	V	19	PROFESSIONAL FEES				40,831	40,831	24
25	V	20	WANT ADS, LICENSES				4,802	4,802	25
26	V	21	TOTAL OFFICE				11,660	11,660	26
27	V	23	SEMINARS				533	533	27
28	V	25	TRANSPORTATIONAL STAFF				3,844	3,844	28
29	V	26	INSURANCE				1,016	1,016	29
30	V	27	EMPLOYEE BENEFITS				9,783	9,783	30
31	V	30	DEPRECIATION (SL)				606	606	31
32	V	32	INTEREST				148	148	32
33	V	33	RE TAX				533	533	33
34	V	34	OFFICE RENT				6,260	6,260	34
35	V	35	EQUIPMENT RENTAL				1,908	1,908	35
36	V								36
37	V								37
38	V								38
39	Total			$ 712,374			$ 120,394	$ * (591,980)	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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2					SEE						2
3					ATTACHED						3
4					SCHEDULE						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	475,523	8	$ 77,622	$ 77,622	49,611	$ 8,098	1
2	5	UTILITIES	PATIENT CENSUS	475,523	8	806		49,611	84	2
3	6	REPAIR/MAINT	PATIENT CENSUS	475,523	8	1,722		49,611	180	3
4	10	NURSING SALARIES	PATIENT CENSUS	475,523	8	288,582	288,582	49,611	30,108	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	475,523	8	391,370	100,000	49,611	40,831	5
6	20	WANT ADS, LICENSES	PATIENT CENSUS	475,523	8	46,030		49,611	4,802	6
7	21	TOTAL OFFICE	PATIENT CENSUS	475,523	8	111,765	36,036	49,611	11,660	7
8	23	SEMINARS	PATIENT CENSUS	475,523	8	5,110		49,611	533	8
9	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	475,523	8	36,847		49,611	3,844	9
10	26	INSURANCE	PATIENT CENSUS	475,523	8	9,739		49,611	1,016	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	475,523	8	93,769		49,611	9,783	11
12	30	DEPRECIATION (SL)	PATIENT CENSUS	475,523	8	5,805		49,611	606	12
13	32	INTEREST	PATIENT CENSUS	475,523	8	1,420		49,611	148	13
14	33	RE TAX	PATIENT CENSUS	475,523	8	5,109		49,611	533	14
15	34	OFFICE RENT	PATIENT CENSUS	475,523	8	60,000		49,611	6,260	15
16	35	EQUIPMENT RENTAL	PATIENT CENSUS	475,523	8	18,286		49,611	1,908	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,153,982	$ 502,240		$ 120,394	25

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	01/18/12	1,764,706	1,724,816	01/18/15	4.7500	126,219	2
3	AMORT LOAN COST			AMORT OVER 5 YEARS		07/01/12	17,500	10,410			3,500	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	08/01/10	750,000	2,082,312		PRIME+	58,061	6
7		X		INSURANCE FINANCING							3,335	7
8	RELATED PARTY ALLOCATION										148	8
9	TOTAL Facility Related				$10,333.54		$ 2,532,206	$ 3,817,538			$ 191,263	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,532,206	$ 3,817,538			$ 191,263	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: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$ 352,284	2
3. Under or (over) accrual (line 2 minus line 1).		$ 352,284	3
4. Real Estate Tax accrual used for 2013 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.)**		$ 34,677	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.		$ 386,961	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009	461,644	9
2010	255,263	10
2011	30,535	11
2012	352,284	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PALOS HILLS HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051136

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-14-224-003-0000	NURSING HOME	$ 6,662.83	$ 6,662.83
2.	23-14-224-004-0000	NURSING HOME	$ 6,662.83	$ 6,662.83
3.	23-14-224-011-0000	NURSING HOME	$ 6,785.83	$ 6,785.83
4.	23-14-224-012-0000	NURSING HOME	$ 23,107.55	$ 23,107.55
5.	23-14-224-017-0000	NURSING HOME	$ 309,064.74	$ 309,064.74
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 352,283.78	$ 352,283.78

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/2013 Ending: 12/31/2013

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

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

D. Does the Operating Entity? [ ] (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			2012	$ 812,700	1
2					2
3	TOTALS			$ 812,700	3

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 41,967	39	$ 41,967	$	$ 82,185	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION					441		441			8
	Improvement Type**										
9	ROOF TOP AIR CONDITION			2010	9,124	912	5	912		7,526	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		6,946	18
19	SOUTH HALL, NORTH/DINING, BEATY SHOP-PAINTING			2011	12,000	2,304	5	2,304		8,544	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		3,604	29
30	NORTH HALL, FRONT HALL-PAINTING			2011	13,350	2,563	5	2,563		9,505	30
31	INSTALL ANTI-FREEZE SYSTEM BELOW CANOPY			2011	5,135	187	27.5	187		553	31
32	INSTALL INTELLIGENT PHOTO DETECTOR			2011	7,998	291	27.5	291		861	32
33	LOBBY-INSTALL NEW CERAMIC TILE, MILLWORK, GROUT			2011	8,537	310	27.5	310		788	33
34	PARKING LOT-PAVED WITH 1.5" OF NEW ASPHALT			2011	29,850	1,990	15	1,990		4,809	34
35	INSTALL FIVE DELAYED EGRESS LOCKS-DOUBLE & SINGLE			2011	8,368	304	27.5	304		697	35
36	REPLACED 4 DEFECTIVE MOTORS ON EXHAUST FANS			2001	2,622	95	27.5	95		202	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: 01/01/2013 Ending: 12/31/2013

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		2,650	38
39	INSTALLATION AND WIRING FOR WAP'S	2012	4,730	172	27.5	172		323	39
40	CORRIDOR-HANDRAILS, CORNER GUARDS	2012	5,225	190	27.5	190		340	40
41	REPLACEMENT OF A/C SOUTHEAST UNIT COMPRESSOR	2012	2,618	419	5	419		1,990	41
42	APPLIED A PATCH TO THE FIELD OR WALL FLASHINGS	2012	2,800	102	27.5	102		132	42
43	NURSES STATION; 2 BATHROOMS; NOTRH, WEST, SOUTH								43
44	CORRIDORS; CAFETERIA-INSTALL NEW CERAMIC TILE,								44
45	VCT AND MILLWORK	2013	36,893	1,286	27.5	1,286		1,286	45
46	APPLIED A PATCH TO THE FIELD USING SPMB OR WALL								46
47	FLASHING-EAST, SOUTH WING	2013	3,650	61	27.5	61		61	47
48	TUB ROOM; TRAINING TOILET; 2 SMALL SHOWER ROOMS								48
49	INSTALLATION OF CERAMIC FLOOR TILE	2013	18,583	197	27.5	197		197	49
50	FIRE SPRINKLER SYSTEM REPAIR-LABOT AND MATERIAL								50
51	TO COMPLETE WORK	2013	10,120	107	27.5	107		107	51
52	ALZHEIMERS DINING ROOM; SOUTH CORRIDOR; NORTH								52
53	SHOWER ROOM-INSTALL NEW VCT & MILLWORK	2013	26,867	204	27.5	204		204	53
54	REROOFED PROPERTY USING SINGLE PLY MODIFIED								54
55	BITUMEN ON FRONT PORTION OF THE CENTER AND								55
56	SOUTH WING	2013	79,040	599	27.5	599		599	56
57	REPLACEMENT OF A/C UNIT IN NORTH DIALYSIS ROOM	2013	8,602	65	27.5	65		65	57
58	INSTALL NEW FIRE ALARM SYSTEM; SMOKE DETECTOR								58
59	BASE	2013	24,108	183	27.5	183		183	59
60	REPLACE WITH NEW PIPE AND FITTINGS OF THE SEWER								60
61	LINE' TWO SEPARATE TRENCH EXCAVATIONS	2013	8,425	38	27.5	38		38	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,096,913	$ 59,770		$ 59,770	$	$ 134,395	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: 01/01/2013 Ending: 12/31/2013

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	$ 120,373	$ 8,871	$ 15,934	$ 7,063	3-10	$ 36,386	71
72	Current Year Purchases	64,300	35,029	5,465	(29,564)	3-10	5,465	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		165	165				74
75	TOTALS	$ 184,673	$ 44,065	$ 21,564	$ (22,501)		$ 41,851	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)	$ 3,094,286	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,835	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 81,334	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,501)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 176,246	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: 01/01/2013 Ending: 12/31/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 19,996 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			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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	$		$ 360,611	$		$ 360,611	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			94,209			94,209	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			439,704			439,704	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				201,672		201,672	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39-2					12,988		12,988	12
13	MEDICAL SUPPLY; I.V. THERAPT Other (specify): RADIOLOGY	39-2 39-2					40,305 4,400		40,305 4,400	13
14	TOTAL			$		$ 894,524	$ 259,365		$ 1,153,889	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: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ (58,051)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 240,000)	5,777,780		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	200,498		6
7	Other Prepaid Expenses	67,882		7
8	Accounts Receivable (owners or related parties)	6,185		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,994,294	$	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	460,206		15
16	Equipment, at Historical Cost	184,673		16
17	Accumulated Depreciation (book methods)	(198,433)		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	235,004		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 681,450	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,675,744	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,861,738	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,082,312		29
30	Accrued Salaries Payable	213,480		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,830		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	DUE TO PM NURSING & REHAB	391,757		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,580,117	$	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)**	$ 4,580,117	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,095,627	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,675,744	$	48

***(See instructions.)**

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,233,368	1	
2	Restatements (describe):		2	
3	REPLACEMENT TAX	(12,190)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,221,178	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(125,551)	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)**	$ (125,551)	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)**	$ 2,095,627	24	*

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

Facility Name & ID Number PALOS HILLS HEALTHCARE # 0051136 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 10,279,954	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,279,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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***	52,829	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,829	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	700	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 700	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,333,483	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,567,494	31
32	Health Care	3,441,782	32
33	General Administration	3,067,672	33
	B. Capital Expense		
34	Ownership	870,629	34
	C. Ancillary Expense		
35	Special Cost Centers	1,153,889	35
36	Provider Participation Fee	371,818	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES-INSURANCE	(14,250)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,459,034	40
41	**Income before Income Taxes (line 30 minus line 40)****	(125,551)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (125,551)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,566,872	44
45	Private Pay - Net Inpatient Revenue	599,635	45
46	Medicare - Net Inpatient Revenue	3,578,693	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	188,713	47
48	Other-(specify) MANAGED CARE	346,041	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,279,954	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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: 01/01/2013 Ending: 12/31/2013

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	2,069	2,165	$ 97,042	$ 44.82	1
2	Assistant Director of Nursing	1,344	1,400	54,505	38.93	2
3	Registered Nurses	10,381	10,615	319,793	30.13	3
4	Licensed Practical Nurses	43,041	44,732	1,092,875	24.43	4
5	CNAs & Orderlies	82,013	84,836	878,400	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,941	9,397	125,424	13.35	8
9	Activity Director					9
10	Activity Assistants	10,778	11,140	122,867	11.03	10
11	Social Service Workers	10,174	10,569	172,671	16.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,328	34,782	366,643	10.54	15
16	Dishwashers					16
17	Maintenance Workers	9,941	10,321	123,899	12.00	17
18	Housekeepers	29,009	30,479	311,183	10.21	18
19	Laundry	8,328	8,987	86,271	9.60	19
20	Administrator	2,064	2,080	101,181	48.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,747	15,112	274,958	18.19	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	6,040	6,240	99,706	15.98	31
32	Other Health C: Care Plan Coord	4,321	4,362	130,854	30.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	276,519	287,217	$ 4,358,272 *	$ 15.17	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	$ 0	1-3	35
36	Medical Director	O	24,000	9-3	36
37	Medical Records Consultant	N	1,020	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,040	10-3	39
40	Physical Therapy Consultant	L	11,770	10a-3	40
41	Occupational Therapy Consultant	Y	7,939	10a-3	41
42	Respiratory Therapy Consultant		15,314	10a-3	42
43	Speech Therapy Consultant	F	1,987	10a-3	43
44	Activity Consultant	E	3,218	11-3	44
45	Social Service Consultant	E	2,603	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 73,891		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: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MATTHEW GIDNEY	ADMINISTRATOR	0	$ 101,181
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,181

B. Administrative - Other

Description		Amount
BRIA HEALTH SERVICES, LLC	MANAGEMENT FEES	516,924
MINSKY MANAGEMENT LLC	MANAGEMENT FEES	103,383
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 620,307

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		390,213
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 390,213

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 170,677
Unemployment Compensation Insurance	121,231
FICA Taxes	329,297
Employee Health Insurance	162,824
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,872
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)	$ 795,901

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	17,482
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 256	2,560
TRUST/FRANCHISE/CONTRIB/ETC	250
MARKETING/ADV/PROMO	24,092
LICENSES/DUES/SUBSCRIPTIONS	17,188
MGMT CO ALLOC	4,802
TRUST/FRANCHISE/CONTRIB/ETC	(250)
Less: Public Relations Expense	(0)
Non-allowable advertising	(24,092)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,022

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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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 $15,300**

(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. $ **34,017** 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. $ **371,818**
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 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.