

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0046029</u></p> <p>Facility Name: <u>PALOS HILLS EXTENDED CARE</u></p> <p>Address: <u>10426 SOUTH ROBERTS</u> <u>PALOS HILLS</u> <u>60465</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 598-3460</u> Fax # <u>(708) 598-0520</u></p> <p>HFS ID Number: <u>81-0556995</u></p> <p>Date of Initial License for Current Owners: <u>06/01/02</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: <u>kvanstockum@kbkbcpa.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT KAPLAN</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MANAGER</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ROBERT KAPLAN</u> (Date) _____		(Title) <u>MANAGER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number PALOS HILLS EXTENDED CARE

0046029 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	24,486	982	6,242	31,710	8
9	SNF/PED					9
10	ICF	9,376	4,199		13,575	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,862	5,181	6,242	45,285	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.12%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 6/ 1 /2002

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 62 and days of care provided 5,448

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	318,989	1,373	10,586	330,948		330,948	330,948		1	
2	Food Purchase		327,690		327,690	(35,314)	292,376	292,376		2	
3	Housekeeping	343,409	26,065		369,474		369,474	369,474		3	
4	Laundry	84,581	19,344	10,086	114,011		114,011	114,011		4	
5	Heat and Other Utilities			121,850	121,850		121,850	121,850		5	
6	Maintenance	84,044	17,271	41,580	142,895		142,895	142,895		6	
7	Other (specify):*			30,786	30,786		30,786	30,786		7	
8	TOTAL General Services	831,023	391,743	214,888	1,437,654	(35,314)	1,402,340	1,402,340		8	
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000		9	
10	Nursing and Medical Records	2,812,881	336,730	14,639	3,164,250	11,500	3,175,750	3,175,750		10	
10a	Therapy	167,002			167,002		167,002	167,002		10a	
11	Activities	144,931	2,137		147,068		147,068	147,068		11	
12	Social Services	69,615		2,599	72,214		72,214	72,214		12	
13	CNA Training									13	
14	Program Transportation			954	954		954	954		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	3,194,429	338,867	30,192	3,563,488	11,500	3,574,988	3,574,988		16	
	C. General Administration										
17	Administrative	90,699			90,699		90,699	90,699		17	
18	Directors Fees									18	
19	Professional Services			139,677	139,677	(11,500)	128,177	83,798		19	
20	Dues, Fees, Subscriptions & Promotions			29,315	29,315		29,315	(11,857)	17,458	20	
21	Clerical & General Office Expenses	182,553	39,664	63,671	285,888		285,888	(16,396)	269,492	21	
22	Employee Benefits & Payroll Taxes			824,883	824,883	35,314	860,197	860,197		22	
23	Inservice Training & Education			190	190		190	190		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			318	318		318	318		25	
26	Insurance-Prop.Liab.Malpractice			244,796	244,796		244,796	244,796		26	
27	Other (specify):*			103,875	103,875		103,875	(103,875)		27	
28	TOTAL General Administration	273,252	39,664	1,406,725	1,719,641	23,814	1,743,455	(176,507)	1,566,948	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,298,704	770,274	1,651,805	6,720,783		6,720,783	(176,507)	6,544,276	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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,586
	REPAIRS & MAINTENANCE	0
		0
		10,586
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	10,086
		0
		10,086
5	HEAT & OTHER UTILITIES	
	GAS HEAT	37,166
	ELECTRICITY	48,643
	WATER	35,129
	CABLE TV - LOBBY	912
		0
		121,850
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,650
	PAINTING & DECORATING	0
	BUILDING REPAIRS	11,869
	MAINTENANCE TRAVEL	20,341
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,010
	FIRE SERVICE	645
	PAINTING & DECORATING	1,065
		0
		0
		0
		41,580
7	OTHER	
	SCAVENGER	30,211
	SECURITY SERVICE	575
		0
		0
		30,786
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	11,843
	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	360
	PHARMACY CONSULTANT XVIII B 39-2	2,436
	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
		14,639
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,599
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,599
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		954
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	0
18	DIRECTORS FEES		
	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	29,373
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	110,304
			0
			139,677
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,357
	EMPLOYEE WANT ADS	XIX F	3,539
	CONTRIBUTIONS	VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS	XIX F	10,838
	LICENSES & PERMITS	XIX F	880
	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	2,500
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,980
	PATIENT BACKGROUND CHECKS	XIX F	221
			29,315
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0
	EQUIPMENT REPAIR & MAINTENANCE		5,361
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	16,396
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		41,914
	MESSENGER SERVICE		0
			0
			63,671

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	328,403
	UNEMPLOYMENT COMPENSATION	XIX D	88,463
	WORKERS COMPENSATION INSURANC	XIX D	102,831
	HOSPITALIZATION INSURANCE	XIX D	304,995
	EMPLOYEE BENEFITS - OTHER	XIX D	191
	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
			824,883
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		190
			190
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		318
			318
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		244,796
			244,796
27	OTHER		
	BAD DEBTS	VI 24	103,875
			103,875

GRAND TOTAL COLUMN 3 OTHER

1,651,805

**PALOS HILLS EXTENDED CARE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	327,690
LESS SALES TAX	<u>0</u>
NET FOOD	327,690

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

TOTAL PATIENT CENSUS	45,285
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	135,855

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	16,425

PATIENT MEALS	135,855
ADD EMPLOYEE MEALS	<u>16,425</u>
TOTAL MEALS/YEAR	152,280

NET FOOD	327,690
DIVIDE TOTAL MEALS/YEAR	<u>152,280</u>

COST PER MEAL	2.15
TIME EMPLOYEE MEALS	<u>16,425</u>
EMPLOYEE MEAL RECLASSIFICATION	35,314

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Facility Name & ID Number PALOS HILLS EXTENDED CARE

#0046029

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,378	35,378	35,378	77,853	113,231				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,032	12,032	12,032	38,614	50,646				32
33	Real Estate Taxes			437,850	437,850	437,850		437,850				33
34	Rent-Facility & Grounds			120,000	120,000	120,000	(120,000)					34
35	Rent-Equipment & Vehicles			65,950	65,950	65,950		65,950				35
36	Other (specify):* Software amort			12,020	12,020	12,020		12,020				36
37	TOTAL Ownership			683,230	683,230	683,230	(3,533)	679,697				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		269,537	631,193	900,730	900,730		900,730				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143	111,143		111,143				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		269,537	742,336	1,011,873	1,011,873		1,011,873				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,298,704	1,039,811	3,077,371	8,415,886	8,415,886	(180,040)	8,235,846				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 EXTENDED CARE**

0046029

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	9,201	30		9
10	Interest and Other Investment Income		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	(8,376)	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	(16,396)	21		18
19	Entertainment		20		19
20	Contributions	(3,500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(44,379)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,875)	27		24
25	Fund Raising, Advertising and Promotional	(8,357)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (175,682)		\$	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	2	
		Amount	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)	(4,358)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,358)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (180,040)		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	2	3	4	
		Yes	No	Amount	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 EXTENDED CARE

ID# 0046029

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES

Amount

1	DEFERRED MAINTENANCE	\$	6	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		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PALOS HILLS EXTENDED CARE# 0046029

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(44,379)	0	0	0	0	0	0	0	0	0	0	(44,379)	19
20	Fees, Subscriptions & Promotions	(11,857)	0	0	0	0	0	0	0	0	0	0	(11,857)	20
21	Clerical & General Office Expenses	(16,396)	0	0	0	0	0	0	0	0	0	0	(16,396)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(103,875)	0	0	0	0	0	0	0	0	0	0	(103,875)	27
28	TOTAL General Administration	(176,507)	0	(176,507)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(176,507)	0	(176,507)	29									

STATE OF ILLINOIS

Facility Name & ID Number PALOS HILLS EXTENDED CARE# 0046029

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,201	68,652	0	0	0	0	0	0	0	0	0	77,853	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,376)	46,990	0	0	0	0	0	0	0	0	0	38,614	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	825	(4,358)	0	(3,533)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(175,682)	(4,358)	0	0	0	0	0	0	0	0	0	(180,040)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT KAPLAN	45			Pine Manor		
MICHAEL KAPLAN	45			Terrace LLC	PALOS HILLS	REAL ESTATE
ELISE KAPLAN	10					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 120,000	PINE MANOR TERRACE LLC			\$ (120,000)	1
2	V	30 DEPRCIATION				68,652	68,652	2
3	V	32 INTEREST				46,990	46,990	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 120,000			\$ 115,642	\$ * (4,358)	14

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

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

0046029

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization PINE MANOR TERRACE LLC
 Street Address 10426 S. ROBERTS ROAD
 City / State / Zip Code PALOS HILLS
 Phone Number (708)598 - 3460
 Fax Number (708)598-0520

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	30	DEPRECIATION	DIRECT	1	1	\$ 68,652	\$ 0	1	\$ 68,652	1
2	32	INTEREST	DIRECT	1	1	46,990	0	1	46,990	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 115,642	\$		\$ 115,642	25

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	MB FINANCIAL		X	MORTGAGE	\$23,261.00	10/01/02	\$ 2,500,000	\$	10/01/09		\$ 46,990	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6	INSURANCE			INSUR. POLICY FINANCE							3,656	6				
7												7				
8												8				
9	TOTAL Facility Related				\$23,261.00		\$ 2,500,000	\$			\$ 50,646	9				
B. Non-Facility Related*																
10	IRS, IDR, ETC		X	LATE FEES							8,376	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 8,376	14				
15	TOTALS (line 9+line14)						\$ 2,500,000	\$			\$ 59,022	15				

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

* 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	326,045	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$	(326,045)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	763,895	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	437,850	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	373,281	8
	2005	310,176	9
	2006	318,967	10
	2007	326,045	11
	2008	437,850	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PALOS HILLS EXTENDED CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0046029

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 2008 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 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>23-14-224-003-0000</u>	<u>NURSING HOME</u>	\$ <u>5,064.65</u>	\$ <u>5,064.65</u>
2.	<u>23-14-224-004-0000</u>	<u>NURSING HOME</u>	\$ <u>5,064.65</u>	\$ <u>5,064.65</u>
3.	<u>23-14-224-011-0000</u>	<u></u>	\$ <u>4,112.06</u>	\$ <u>4,112.06</u>

Facility Name & ID Number PALOS HILLS EXTENDED CARE

0046029

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	203	2002		\$ 1,887,931	\$ 68,652	27.5	\$ 68,652	\$	\$ 492,006	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	ELECTRICAL - FIRE ALARM WIRING	2002		4,046	147	27.5	147		1,029	9
10	DOOR	2002		1,928	70	27.5	70		490	10
11	DRYWALL / SHEET ROCK	2002		12,574	457	27.5	457		3,199	11
12	PATIO	2002		2,900	106	27.5	106		742	12
13	CARPET	2003		12,995		7	1,859	1,859	12,995	13
14	8 STATION DIALYSIS ROOM	2003		55,923	2,034	27.5	2,034		13,303	14
15	FLOORS	2003		12,958	471	27.5	471		3,081	15
16	FIRE ALARM	2003		15,915	579	27.5	579		3,788	16
17	EMERGENCY GENERATOR	2003		44,700	1,625	27.5	1,625		10,630	17
18	DOORS	2003		3,575	130	27.5	130		850	18
19	DRYWALL / SHEETROCK	2003		9,883	359	27.5	359		2,349	19
20	ROOF REPAIR & FLOORING	2003		5,500	200	27.5	200		1,308	20
21	OUTDOOR SIGN	2003		2,231	81	27.5	81		530	21
22	DRYWALL	2003		12,120	441	27.5	441		2,885	22
23	STORAGE ROOM	2003		6,800	247	27.5	247		1,617	23
24	ROOF REPAIR & FLOORING	2004		1,550	56	27.5	56		308	24
25	DOORS	2004		2,377	86	27.5	86		473	25
26	EMERGENCY GENERATOR	2004		18,522	674	27.5	674		3,773	26
27	REMODELING	2004		6,000	219	27.5	219		1,096	27
28	ROOF REPAIR	2005		4,590	167	27.5	167		758	28
29	ROOF TOP UNIT	2005		22,577	821	27.5	821		3,729	29
30	CHILLER UNIT	2005		14,188	516	27.5	516		2,343	30
31	ELECTRICAL DOOR / ALARM	2005		11,360	413	27.5	413		1,876	31
32	PARKING LOT	2005		8,200	547	15	547		2,462	32
33	HOT WATER HEATER	2006		10,098	367	27.5	367		1,330	33
34	FIRE SPRINKLERS	2006		5,075	185	27.5	185		655	34
35	HOT WATER HEATER	2006		7,500	273	27.5	273		921	35
36										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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ROOF	2006	\$ 59,825	\$ 2,175	27.5	\$ 2,175		\$ 6,797	37
38	NINE 4' ROOF HEADS & 4' PVC SEWER	2006	16,000	582	27.5	582		1,819	38
39	FLOORING	2006	3,500	403	5	700	297	2,800	39
40	ROOF REPAIR	2007	5,100	185	27.5	185		463	40
41	ROOF REPAIR	2007	5,800	211	27.5	211		527	41
42	ROOF REPAIR	2007	9,400	342	27.5	342		855	42
43	ROOF REPAIR	2007	16,500	600	27.5	600		1,500	43
44	ROOF EXHAUST FAN REPLACEMENT	2007	3,000	109	27.5	109		273	44
45	ROOF REPAIR	2008	25,099	913	27.5	913		1,179	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)		\$ 2,348,240	\$ 85,443		\$ 87,599	\$ 2,156	\$ 586,739	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 144,759	\$ 7,639	\$ 14,476	\$ 6,837	10 YR	\$ 82,645	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 144,759	\$ 7,639	\$ 14,476	\$ 6,837		\$ 82,645	75

D. Vehicle Depreciation (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	FACILTY USE	VAN	2004	\$ 45,383	\$ 4,348	\$ 4,540	\$ 192	5	\$ 45,383	76
77	FACILTY USE	24 pass Goshen bus - 2000	2007	17,720	4,040	3,544	(496)	5	8,860	77
78				8,000	1,824	1,600	(224)	5	4,000	78
79	MAITENANCE	2001 FORD F250 4X4	2009	14,722	736	1,472	736	5	1,472	79
80	TOTALS			\$ 85,825	\$ 10,948	\$ 11,156	\$ 208		\$ 59,715	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)	\$ 2,878,824	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 104,030	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,231	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,201	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 729,099	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:		203	6/01/02	\$ 120,000			3
4	Additions							4
5								5
6								6
7	TOTAL		203		\$ 120,000			7

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: _____ *

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: \$ 59,445 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	ADMINISTRATOR	2007 GMAC HUMMER	\$ _____	\$ 6,505	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 6,505	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39-3	hrs			555,801		555,801		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 prescripts				269,537	269,537		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):					75,392		75,392		12	
13	Other (specify):									13	
14	TOTAL			\$		\$ 631,193	\$ 269,537	\$ 900,730		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 EXTENDED CARE**

0046029

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(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	\$ 97,049	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,687,180		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	251,385		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,398		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,038,012	\$	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	460,309		15
16	Equipment, at Historical Cost	230,584		16
17	Accumulated Depreciation (book methods)	(316,356)		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 (spec <u>Comp Software</u>)	36,060		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 410,597	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,448,609	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 740,549	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,558		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,159,554		31
32	Accrued Real Estate Taxes(Sch.IX-B)	763,895		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,808,556	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,808,556	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 640,053	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,448,609	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 283,630	1
2	Restatements (describe):		2
3			3
4	Member loan restated as contributed capital	790,959	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,074,589	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(653,362)	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) CONTRIBUTED CAPITAL	218,826	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (434,536)	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)	\$ 640,053	24 *

* This must agree with page 17, line 47.

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,814,549	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,814,549	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***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE ADJ	(52,025)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (52,025)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,762,524	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,437,654	31
32	Health Care	3,563,488	32
33	General Administration	1,719,641	33
B. Capital Expense			
34	Ownership	683,230	34
C. Ancillary Expense			
35	Special Cost Centers	900,730	35
36	Provider Participation Fee	111,143	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,415,886	40
41	Income before Income Taxes (line 30 minus line 40)**	(653,362)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (653,362)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 EXTENDED CARE**

0046029

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,080	\$ 85,299	\$ 41.01	1
2	Assistant Director of Nursing	1,960	2,080	94,000	45.19	2
3	Registered Nurses	24,922	25,402	778,570	30.65	3
4	Licensed Practical Nurses	24,886	27,392	681,294	24.87	4
5	CNAs & Orderlies	94,236	97,996	1,057,261	10.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,866	15,429	167,002	10.82	8
9	Activity Director	19,960	2,080	42,823	20.59	9
10	Activity Assistants	10,842	11,096	102,108	9.20	10
11	Social Service Workers	3,551	3,726	69,615	18.68	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	42,195	20.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,559	27,818	276,794	9.95	15
16	Dishwashers					16
17	Maintenance Workers	4,003	4,221	84,044	19.91	17
18	Housekeepers	33,887	35,893	343,409	9.57	18
19	Laundry	9,296	10,023	84,581	8.44	19
20	Administrator	1,960	2,080	90,699	43.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,163	9,461	182,553	19.30	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					31
32	Other Health Care(specify)					32
33	Other(specify)	5,862	5,963	116,457	19.53	33
34	TOTAL (lines 1 - 33)	288,873	284,820	\$ 4,298,704 *	\$ 15.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 10,586	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	360	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,436	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,599	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,981		49

C. CONTRACT NURSES

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

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. ICLTC \$9947
- (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. \$ _____ 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 _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 111,143
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed 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. \$ 35,314 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.