

ORIGINAL

11-104

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT- May 2010 Edition

ORIGINAL SIGNATURES

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED

This Section must be completed for all projects.

NOV 21 2011

Facility/Project Identification

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility Name: McAllister Nursing & Rehab		
Street Address: 18300 South LaVergne Avenue		
City and Zip Code: Tinley Park 60477		
County: Cook	Health Service Area: VII	Health Planning Area: 7-E

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: McAllister Property, LLC	
Address: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477	
Name of Registered Agent: Joel Atkin	
Name of Chief Executive Officer: Donna Atkin	
CEO Address:	
Telephone Number:	

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership	
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental	
<input checked="" type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Charles H. Foley, MHSA
Title: Health Care Consultant
Company Name: Charles H. Foley & Associates, Inc.
Address: 1638 South MacArthur Boulevard, Springfield, Illinois 62704
Telephone Number: (217) 544-1551
E-mail Address: foley.associates@sbcglobal.net
Fax Number: (217) 544-3615

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: John P Kniery
Title: Health Care Consultant
Company Name: Charles H. Foley & Associates, Inc.
Address: 1638 South MacArthur Boulevard
Telephone Number: (217) 544-1551
E-mail Address: jkniery@foleyandassociates.com
Fax Number: (217) 544-3615

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: McAllister Nursing & Rehab		
Street Address: 18300 South LaVergne Avenue		
City and Zip Code: Tinley Park 60477		
County: Cook	Health Service Area: VII	Health Planning Area: 7-E

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: McAllister Nursing & Rehab, LLC		
Address: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477		
Name of Registered Agent: Joel Atkin		
Name of Chief Executive Officer: Donna Atkin		
CEO Address:		
Telephone Number:		

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership	
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental	
<input checked="" type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship	<input type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Charles H. Foley, MHSA
Title: Health Care Consultant
Company Name: Charles H. Foley & Associates, Inc.
Address: 1638 South MacArthur Boulevard, Springfield, Illinois 62704
Telephone Number: (217) 544-1551
E-mail Address: foley.associates@sbcglobal.net
Fax Number: (217) 544-3615

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Elisha Atkin
Title: Facility Administrator
Company Name: McAllister Nursing & Rehab
Address: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477
Telephone Number: (708) 798-2272
E-mail Address: kishmere1@aol.com
Fax Number: (708) 798-2298

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name: Elisha Atkin
Title: Facility Administrator
Company Name: McAllister Nursing & Rehab
Address: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477
Telephone Number: (708) 798-2272
E-mail Address: kishmere1@aol.com
Fax Number: (708) 798-2298

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: McAllister Nursing & Rehab Properties, LLC
Address of Site Owner: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477
Street Address or Legal Description of Site: 18300 South LaVergne Avenue
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: McAllister Nursing & Rehab, LLC
Address: 18300 South LaVergne Avenue, Tinley Park, Illinois 60477
<input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> For-profit Corporation <input type="checkbox"/> Governmental <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
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Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. This map must be in a readable format. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT 5 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

<p>Part 1110 Classification:</p>	<p>Part 1120 Applicability or Classification: [Check one only.]</p>
<p><input checked="" type="checkbox"/> Substantive</p>	<p><input type="checkbox"/> Part 1120 Not Applicable</p>
<p><input type="checkbox"/> Non-substantive</p>	<p><input type="checkbox"/> Category A Project</p>
	<p><input checked="" type="checkbox"/> Category B Project</p>
	<p><input type="checkbox"/> DHS or DVA Project</p>

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The Applicant, McAllister Property, LLC and McAllister Nursing & Rehab, LLC currently own and operate McAllister Nursing & Rehab, a 111 bed general long-term nursing care facility located at 18300 South LaVergne Avenue, Tinley Park, Illinois. The Applicant proposes to construct a total replacement facility on the same site with a total of 200 nursing care beds for a net increase of 89 beds. The proposed four-story structure with a basement will have a total of 102,937 gross square feet and a total cost of \$24,910,942 to include demolition costs. This project will also include a home dialysis unit.

The facility located at 18300 South LaVergne Avenue in Tinley Park, Illinois is situated on approximately five acres. This project will result in a new physical layout and orientation of the campus. Since the project is in excess of the allowed threshold of \$8.8 million, this project is considered as "Substantive".

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$24,072	\$14,428	\$38,500
Site Survey and Soil Investigation	\$8,253	\$4,947	\$13,200
Site Preparation	\$103,164	\$61,836	\$165,000
Off Site Work	\$21,883	\$13,117	\$35,000
New Construction Contracts	\$13,047,645	\$7,820,681	\$20,868,326
Modernization Contracts	0	0	0
Contingencies	\$652,382,645	\$391,034	\$1,043,416
Architectural/Engineering Fees	\$434,540	\$260,460	\$695,000
Consulting and Other Fees	\$130,674	\$78,326	\$209,000
Movable or Other Equipment (not in construction contracts)	\$682,133	\$408,867	\$1,091,000
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	\$440,854	\$264,208	\$705,000
Fair Market Value of Leased Space or Equipment	0	0	0
Other Costs To Be Capitalized	\$29,699	17,801	\$47,500
Acquisition of Building or Other Property (excluding land)	0	0	
TOTAL USES OF FUNDS	\$15,575,238	\$9,335,705	\$24,910,942
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			\$2,610,942
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			\$22,300,000
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS			\$24,910,942
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Purchase Price:	\$ <u>320,000</u>	
Fair Market Value:	\$ _____	
The project involves the establishment of a new facility or a new category of service		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.		
Estimated start-up costs and operating deficit cost is \$ <u>100,000</u>		

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input checked="" type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>February 28, 2014</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals

Are the following submittals up to date as applicable:
<input type="checkbox"/> Cancer Registry
<input type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area DGSF or the building/area BGSF and cost. The type of gross square footage either DGSF or BGSF must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Department/Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Nursing	\$10,484,488	15,500	43,324	43,324	0	0	
Living/Dining/Activity	\$2,575,625	6,200	10,643	10,643	0	0	
Kitchen/Food Service	\$611,781	1,900	2,528	2,528	0	0	
P.T./O.T.	\$1,255,021	800	5,186	5,186	0	0	
Laundry	\$217,560	0	899	899	0	0	
Janitor Closets	\$41,382	100	171	171	0	0	
Clean/Soiled Utility	\$301,292	1,000	1,245	1,245	0	0	
Beauty/Barber	\$88,089	400	364	364	0	0	
Total Clinical	\$15,575,238	25,900	64,360	64,360	0	0	
NON-REVIEWABLE							
Office/Administration	\$776,584	2,500	3,209	3,209	0	0	
Employee Lounge	\$121,001	200	500	500	0	0	
Locker/Training	\$162,867	200	673	673	0	0	
Mechanical/Electrical	\$173,515	1,000	717	717	0	0	
Lobby	\$772,617	1,600	2,986	2,986	0	0	
Storage/Maintenance	\$362,035	500	1,496	1,496	0	0	
Corridor/Public							
Toilets	\$4,696,141	6,700	19,612	19,612	0	0	
Stair/Elevators	\$766,178	400	3,166	3,166	0	0	
Total Non-clinical	\$7,830,938	13,100	32,359	32,359	0	0	
Basement	\$1,504,767	8,800	6,218	6,218	0	0	
TOTAL	\$24,910,943	47,800	102,937	102,937	0	0	

APPEND DOCUMENTATION AS ATTACHMENT 9 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service. Any bed capacity discrepancy from the Inventory will result in the application being deemed **Incomplete**.

FACILITY NAME: McAllister Nursing & Rehab		CITY: Tinley Park			
REPORTING PERIOD DATES: From: August, 2009 to: July 2011					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care	111	179	35,546	+89	200
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	111	179	35,546	+89	200

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of McAllister Nursing & Rehab, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Donna Atkin
SIGNATURE
DONNA ATKIN
PRINTED NAME
MKTNG / MANAGEMENT
PRINTED TITLE

Jay Oblinsky
SIGNATURE
JAY OBLINSKY
PRINTED NAME
FINANCIAL OFFICER
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of JUNE, 2011

Notarization:
Subscribed and sworn to before me
this 7th day of JUNE, 2011

Stan Postupaka
Signature of Notary OFFICIAL SEAL
Seal STAN POSTUPAKA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/30/13

Stan Postupaka
Signature of Notary OFFICIAL SEAL
Seal STAN POSTUPAKA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/30/13

*Insert EXACT legal name of the applicant

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- o in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of McAllister Nursing & Rehab Properties, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Donna Atkin
 SIGNATURE
DONNA ATKIN
 PRINTED NAME
OWNER
 PRINTED TITLE

[Signature]
 SIGNATURE
JOEL ATKIN
 PRINTED NAME
OWNER
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 7th day of JUNE 2011

Notarization:
Subscribed and sworn to before me
this 7th day of JUNE 2011

Stan Postupaka
 Signature of Notary
 Seal
 OFFICIAL SEAL
 STAN POSTUPAKA
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:06/30/13
 *Insert EXACT legal name of the applicant

Stan Postupaka
 Signature of Notary
 Seal
 OFFICIAL SEAL
 STAN POSTUPAKA
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:06/30/13

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.



SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. This must be a narrative.
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;
 - c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/ SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Nursing	BGSF: 102,937 or 514BGSF/bed	BGSF/Bed: 435-713 or up to 142,600 BGSF	39,663	YES

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. A narrative of the rationale that supports the projections must be provided.

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
CY2014	Nursing	58,916	81%	90%	No
CY2015	Nursing	65,700	90%	90%	Yes

UNFINISHED OR SHELL SPACE: NOT GERMANE

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data are available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

ASSURANCES: NOT GERMANE

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

I. Criterion 1110.1730 - General Long Term Care

1. Applicants proposing to establish, expand and/or modernize General Long Term Care must submit the following information:

Indicate bed capacity changes by Service:
action(s):

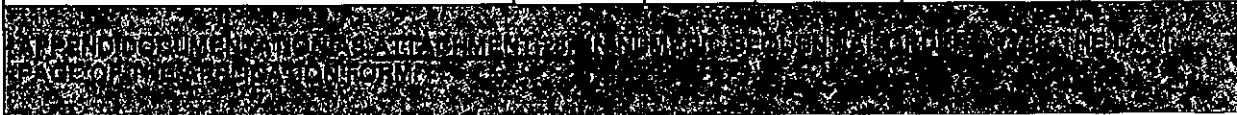
Indicate # of beds changed by

Category of Service	# Existing Beds	# Proposed Beds
<input checked="" type="checkbox"/> General Long Term Care	111	200

2. READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X				
1110.1730(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X			
1110.1730(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X				
1110.1730(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X			
1110.1730(b)(5) - Planning Area Need - Service Accessibility	X				
1110.1730(c)(1) - Description of Continuum of Care				X	
1110.1730(c)(2) - Components				X	
1110.1730(c)(3) - Documentation				X	
1110.1730(d)(1) - Description of Defined Population to be Served					X
1110.1730(d)(2) - Documentation of Need					X
1110.1730(d)(3) - Documentation Related to Cited Problems			X		
1110.1730(e)(1) - Unnecessary Duplication of Services	X				
1110.1730(e)(2) - Maldistribution	X				
1110.1730(e)(3) - Impact of Project on Other Area Providers	X				
1110.1730(f)(1) - Deteriorated Facilities			X		
1110.1730(f)(2) & (3) - Documentation			X		

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize	Continuum of Care- Establish or Expand	Defined Population Establish or Expand
1110.1730(f)(4) - Utilization			X		
1110.1730(g) - Staffing Availability	X	X		X	X
1110.1730(h) - Facility Size	X	X	X	X	X
1110.1730(i) - Community Related Functions	X		X	X	X
1110.1730(j) - Zoning	X		X	X	X
1110.1730(k) - Assurances	X	X	X	X	X



The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: Indicate the dollar amount to be provided from the following sources:

\$2,610,942	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
\$22,300,000	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage; such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
\$24,910,942	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

IX. 1120.130 - Financial Viability – McAllister Nursing & Rehab Properties, LLC

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
	2008	2009	2010	2015
Enter Historical and/or Projected Years				
Current Ratio	1.05	2.21	3.15	0.60
Net Margin Percentage	-77.77%	-78.87%	1.67%	-22.13%
Percent Debt to Total Capitalization	104%	97%	97%	98%
Projected Debt Service Coverage	0.97	1.63	2.50	1.01
Days Cash on Hand	1,817	1,873	2,290	37
Cushion Ratio	4.97	6.13	7.51	0.11

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERIC ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

IX. 1120.130 - Financial Viability - McAllister Nursing & Rehab, LLC

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
	2008	2009	2010	2015
Enter Historical and/or Projected Years:				
Current Ratio	.93	.93	1.02	3.14
Net Margin Percentage	2.07%	3.07%	7.03%	10.05%
Percent Debt to Total Capitalization	0.00%	0.00%	9.97%	0.00%
Projected Debt Service Coverage	5.4	1.7	6.0	12.3
Days Cash on Hand	2.7	4.0	1.6	146.0
Cushion Ratio	1.0	N/A	0.3	38.2

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERIC ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability - Combined Entities

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
	2008	2009	2010	2015
Enter Historical and/or Projected Years				
Current Ratio	0.98	1.21	1.51	2.80
Net Margin Percentage	-1.98%	-2.48%	7.16%	6.05%
Percent Debt to Total Capitalization	102%	95%	88%	84%
Projected Debt Service Coverage	1.5	1.6	3.5	1.8
Days Cash on Hand	97	98	102	156
Cushion Ratio	4.5	3.6	5.4	2.5

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Nursing	202.73		102,937				20,868,326		20,868,326
Contingency	10.14		102,937				1,043,416		1,043,416
TOTALS	212.87		102,937				21,911,742		21,911,742

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 43 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

XII. Charity Care Information

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3980/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 44 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant/Coapplicant Identification including Certificate of Good Standing	26-28
2	Site Ownership	29
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	30
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	31-35
5	Flood Plain Requirements	36-38
6	Historic Preservation Act Requirements	39-40
7	Project and Sources of Funds Itemization	41-48
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	
11	Background of the Applicant	49-53
12	Purpose of the Project	54-146
13	Alternatives to the Project	147-229
14	Size of the Project	230-232
15	Project Service Utilization	233-235
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	General Long Term Care	236-267
29	Specialized Long Term Care	
30	Selected Organ Transplantation	
31	Kidney Transplantation	
32	Subacute Care Hospital Model	
33	Post Surgical Recovery Care Center	
34	Children's Community-Based Health Care Center	
35	Community-Based Residential Rehabilitation Center	
36	Long Term Acute Care Hospital	
37	Clinical Service Areas Other than Categories of Service	
38	Freestanding Emergency Center Medical Services	
	Financial and Economic Feasibility:	
39	Availability of Funds	268-309
40	Financial Waiver	
41	Financial Viability	310-350
42	Economic Feasibility	351-355
43	Safety Net Impact Statement	
44	Charity Care Information	

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Applicant/Co-Applicant Identification

The Applicant for McAllister Nursing and Rehabilitation located in Tinley Park, Planning Area 7-E, Illinois is McAllister Property, LLC (ownership entity) and McAllister Nursing and Rehab, LLC (operator/licensee). A certificate of Good Standing for each limited liability corporation is appended as ATTACHMENT-1A.

ATTACHMENT-1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

MCALLISTER NURSING & REHAB, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 18, 2007, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1132400554

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 20TH day of NOVEMBER A.D. 2011

Jesse White

SECRETARY OF STATE

ATTACHMENT-1A



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

MCALLISTER PROPERTY, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON SEPTEMBER 18, 2007, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 1132400556

Authenticate at: <http://www.cyberdriveillinois.com>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 20TH day of NOVEMBER A.D. 2011

Jesse White

SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(Continued ii)

Site Ownership

The owner of the building and site is McAllister Property, LLC. The Certificate of Good Standing for this entity is appended as **ATTACHMENT-1A**.

ATTACHMENT-2

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(Continued iii)

Operating Identity/Licensee

The operating entity/Licensee to McAllister Nursing and Rehabilitation is McAllister Nursing & Rehab, LLC. The Certificate of Good Standing for this entity is appended as **ATTACHMENT-1A.**

ATTACHMENT-3

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(Continued iv)

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person who is related (as defined in Part 1130.140). If the related person is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

The Applicant, McAllister Nursing & Rehab Properties, LLC (Owner) and McAllister Nursing & Rehab, LLC (Operator), d/b/a McAllister Nursing & Rehabilitation is located at 18300 South Laverone Avenue in Tinley Park, Planning Area 7-E. Per the definition of "related person" as defined in Part 1130.140 there are three individuals with interest greater than 5% related to the operating entity. These persons are listed along with the respective amount of interest are provided below. Furthermore and also in accordance with the definition of "related person", one of the persons with interest in the Subject facility has interest in a second licensed nursing care facility. This information is provided under **ATTACHMENT-3A**. Other than the persons and facilities identified herein, there are no other related persons to either co-Applicant or relationships to the facility.

McAllister Nursing & Rehab Properties, LLC. (Owner)

Jay Orlinshy	10%
Donna Atkin	40%
Helen Lacek*	10%
Joel Atkin	40%

McAllister Nursing & Rehab, LLC (Licensee)

Jay Orlinsky	10%
Helen Lacek*	10%
Donna Atkin	80%

*Ms. Lacek is also identified as having interest is Oakridge Nursing & Rehab Ctr.

ATTACHMENT-4



- Who Regulates Nursing Homes?
- A Listing of Illinois Nursing Homes
- How to Select a Nursing Home
- Centers for Medicare and Medicaid Services Nursing Home Database
- Quarterly Reports of Nursing Home Violation
- Illinois Law on Advance Directives
- Nursing Homes with No Certification Deficiencies
- Nursing Home Care Act
- Illinois Health Care Worker Registry
- Centers for Medicare and Medicaid Services Nursing Home Quality Initiative

Ownership Information

MCALLISTER NURSING AND REHAB
 18300 S. LAVERGNE
 TINLEY PARK IL 60477
 ADMINISTRATOR: ELISHA ATKIN
 TELEPHONE: 708-798-2272

Licensee Name:
 MCALLISTER NURSING AND REHAB LLC

Persons with 5 percent or greater interest in licensee:

Name	% of Ownership
<u>JAYORLINSKY</u>	10.00
<u>DONNARATKIN</u>	80.00
<u>HELENLACEK</u>	10.00

Ownership Type:
 LIMITED LIABILITY CO

Click on individual's name to see other ownership interests.

Index

General

- [Facility Information](#)
- [Ownership information](#)

Surveys

Administration

- [Staffing](#)
- [Admission Restrictions](#)
- [Admissions & Discharges](#)
- [Licensed Beds / Beds in use](#)

Residents

- [Primary Diagnosis](#)
- [Age Gender & Level of Care](#)
- [Racial / Ethnic Groups](#)

Patient Days

- [Level of Care](#)
- [Payment Source](#)
- [Private Payment Rates](#)



- Who Regulates Nursing Homes?
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- Nursing Home Care Act
- Illinois Health Care Worker Registry
- Centers for Medicare and Medicaid Services Nursing Home Quality Initiative

Ownership Information

MCALLISTER NURSING AND REHAB

18300 S. LAVERGNE
TINLEY PARK IL 60477

ADMINISTRATOR ELISHA ATKIN
TELEPHONE 708-798-2272

HELEN LACEK
has ownership interest in the following long term care entities

Facility	Percentage Owned
<u>OAKRIDGE NURSING & REHAB CTR</u>	50.00

- Index**
- General
- Facility Information
- Ownership Information
- Surveys
- Administration**
- Staffing
- Admission Restrictions
- Admissions & Discharges
- Licensed Beds / Beds in use
- Residents**
- Primary Diagnosis
- Age, Gender & Level of Care
- Racial / Ethnic Groups
- Patient Days**
- Level of Care
- Payment Source
- Private Payment Rates



- Who Regulates Nursing Homes?
- A Listing of Illinois Nursing Homes
- How to Select a Nursing Home
- Centers for Medicare and Medicaid Services Nursing Home Database
- Quarterly Reports of Nursing Home Violation
- Illinois Law on Advance Directives
- Nursing Homes with No Certification Deficiencies
- Nursing Home Care Act
- Illinois Health Care Worker Registry
- Centers for Medicare and Medicaid Services Nursing Home Quality Initiative

Ownership Information

MCALLISTER NURSING AND REHAB

18300 S. LAVERGNE
TINLEY PARK IL 60477

ADMINISTRATOR ELISHA ATKIN
TELEPHONE 708-798-2272

JAY ORLINSKY
has ownership interest in the following long term care entities

Facility	Percentage Owned

Index

[General](#)

[Facility Information](#)

[Ownership Information](#)

[Surveys](#)

Administration

[Staffing](#)

[Admission Restrictions](#)

[Admissions & Discharges](#)

[Licensed Beds / Beds in use](#)

Residents

[Primary Diagnosis](#)

[Age Gender & Level of Care](#)

[Racial / Ethnic Groups](#)

Patient Days

[Level of Care](#)

[Payment Source](#)

[Private Payment Rates](#)





- Who Regulates Nursing Homes?
- A Listing of Illinois Nursing Homes
- How to Select a Nursing Home
- Centers for Medicare and Medicaid Services Nursing Home Database
- Quarterly Reports of Nursing Home Violation
- Illinois Law on Advance Directives
- Nursing Homes with No Certification Deficiencies
- Nursing Home Care Act
- Illinois Health Care Worker Registry
- Centers for Medicare and Medicaid Services Nursing Home Quality Initiative

Ownership Information

MCALLISTER NURSING AND REHAB

18300 S. LAVERGNE
TINLEY PARK IL 60477

ADMINISTRATOR ELISHA ATKIN
TELEPHONE 708-798-2272

DONNA R ATKIN
has ownership interest in the following long term care entities

Facility	Percentage Owned

Index

General

- [Facility Information](#)
- [Ownership Information](#)

Surveys

Administration

- [Staffing](#)
- [Admission Restrictions](#)
- [Admissions & Discharges](#)
- [Licensed Beds / Beds in use](#)

Residents

- [Primary Diagnosis](#)
- [Age Gender & Level of Care](#)
- [Racial / Ethnic Groups](#)

Patient Days

- [Level of Care](#)
- [Payment Source](#)
- [Private Payment Rates](#)

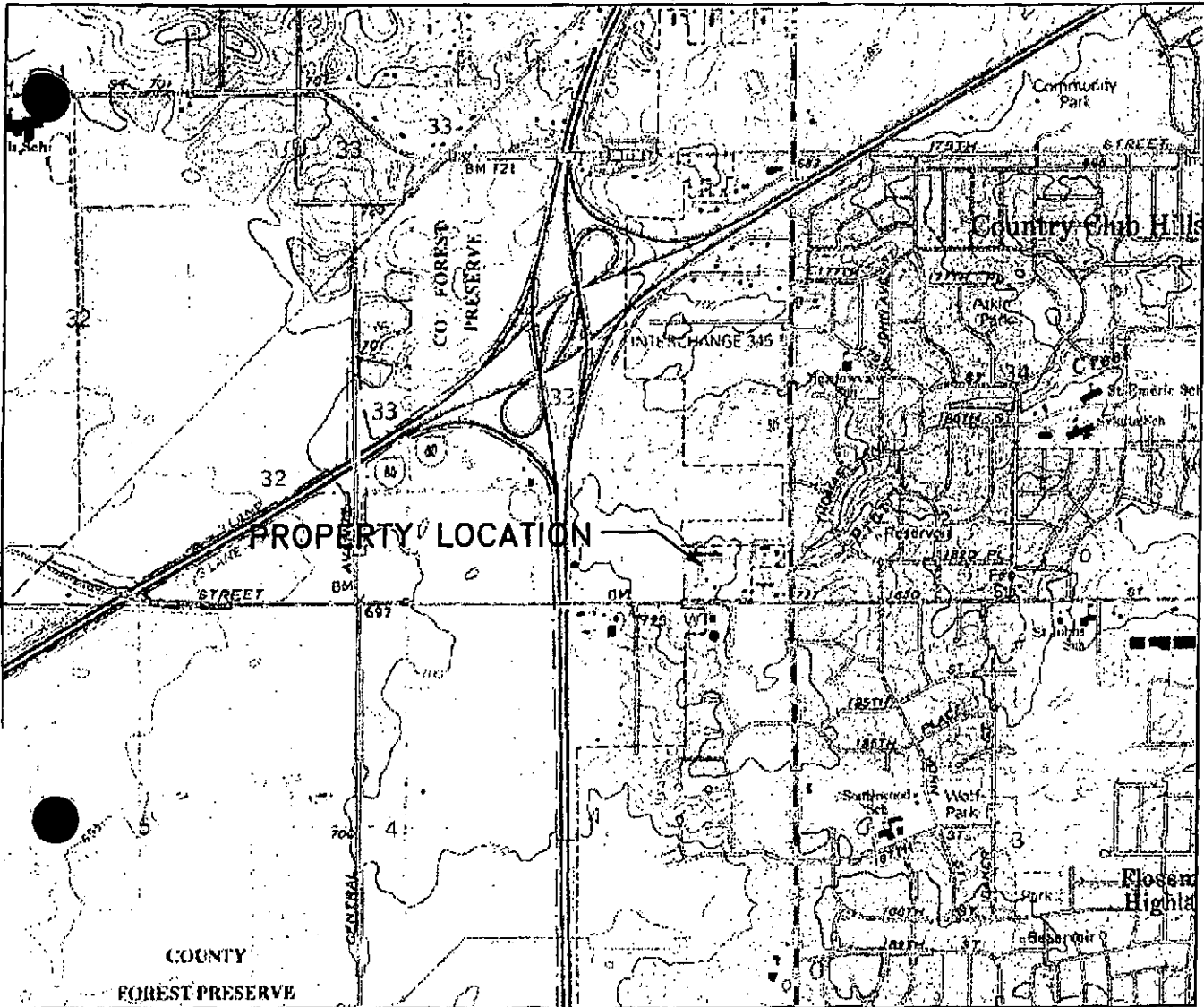
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
(Continued v)

Flood Plain Requirements

Provide documentation regarding compliance with the requirements of the Flood Plain requirements of Executive Order #5, 2006.

Appended as ATTACHMENT-4A, is the Special Flood Hazard Area Determination from the Illinois State Water Survey. This survey found that the property is not located in a Special Flood Hazard Area or a shaded Zone X flood zone.

ATTACHMENT-4



SCALE IN FEET

1" = 2000'

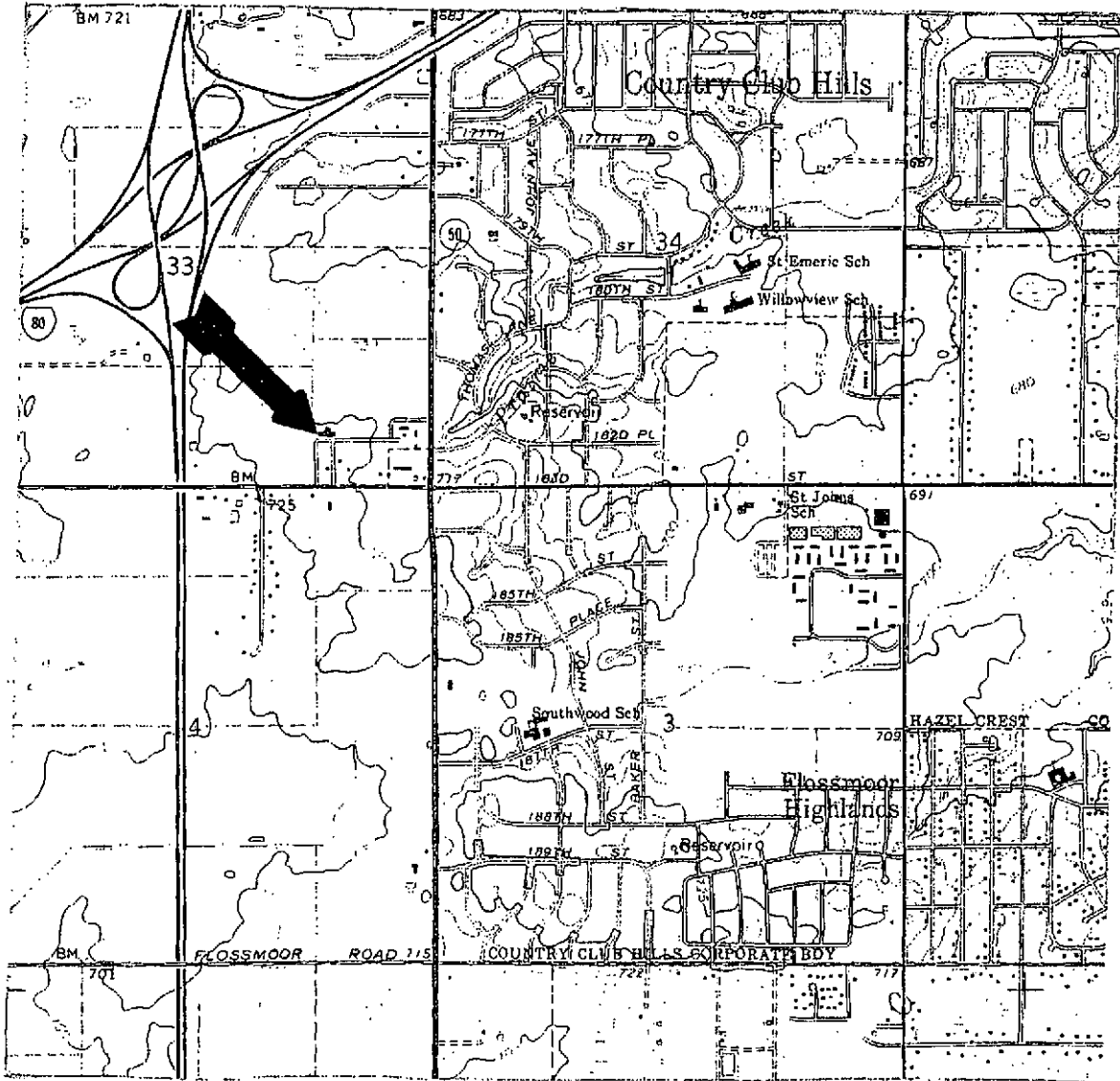


CONTOUR INTERVAL 10 FEET
NATIONAL GEODETIC VERTICAL DATUM



QUADRANGLE LOCATION

<p>Northern Environmental SM Hydrologists · Engineers · Surveyors · Scientists</p> <p>REVERE DRIVE, SUITE H, NORTHBROOK, ILLINOIS Phone: 888-680-8101 Fax 847-562-8352</p>	<p>PROPERTY LOCATION & LOCAL TOPOGRAPHY</p>
<p>CONSIN ▲ MICHIGAN ▲ ILLINOIS ▲ IOWA</p> <p>ON DATE: 08/15/07 THIS DRAWING AND ALL INFORMATION CONTAINED THEREON IS THE PROPERTY OF NORTHERN ENVIRONMENTAL INCORPORATED AND SHALL NOT BE COPIED OR USED EXCEPT FOR THE PURPOSE FOR WHICH IT IS EXPRESSLY FURNISHED.</p> <p>BY: DMS</p> <p>IN DATE: 00/00/00</p>	<p>McALLISTER NURSING HOME 18300 S. LaVERGNE COUNTRY CLUB HILLS, ILLINOIS 60478</p> <p>PROJECT NUMBER: MNH 05-3300-0825</p> <p>FIGURE 1</p>



N ↑

LOCATION MAP

SOURCE: (U.S.G.S. Harvey, ILL. Quad; 1963

Photorevised 1973; Scale 1:24,000)

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION.
(Continued vi)

Historic Resources Preservation Act Requirements

Provide documentation regarding compliance with the requirements of the Historical Resources Preservation Act.

Appended as ATTACHMENT-5A is a letter from Anne E. Haaker, Deputy State Historic Preservation Officer from the Illinois Historic Preservation Agency stating "no historic, architectural or archaeological sites exist within the project area".

ATTACHMENT-5



**Illinois Historic
Preservation Agency**

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Cook County

Country Club Hills

Demolition and New Construction, McAllister Nursing & Rehabilitation

18300 S. LaVergne Ave.

IHPA Log #010040811

April 21, 2011

Gina Kniery

Charles H. Foley & Associates, Inc.

1638 S. MacArthur Blvd.

Springfield, IL 62704

Dear Ms. Kniery:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker

Deputy State Historic

Preservation Officer

ATTACHMENT-5A

ATTACHMENT-7 PROJECT COST ITEMIZATION

MISCELLANEOUS PROJECT COSTS

Preplanning Costs	
Pre Design Studies	\$22,600
Preliminary CON Fees	\$10,000
Accounting & Marketing Studies	\$6,500

 Total \$38,500

Site Survey	
Topographic Survey and Site Plan	\$8,600
Subsoil Drilling and Testing	\$6,600

 Total \$13,200

Site Preparation	
General Earth Work	\$65,000
Utility Relocations	\$80,000
Demolition	\$10,000

 Total \$165,000

Off Site Work	
Street Work and Access Signs	\$35,000

 Total \$35,000

Consulting and Fees	
Con Application Fees	\$50,000
Legal Fees	\$19,000
CON Application Preparation	\$50,000
Accounting	\$10,000
Development Consultant	\$80,000

 Total \$209,000

Other Costs To Be Capitalized	
Taxes During Construction	\$25,000
Insurance During Construction	\$10,000
Title And Recording	\$5,000
Cost Certification Audit	\$7,500

 Total \$47,500

P.2	PROJECT CONSTRUCTION AND EXPENDITURES SCHEDULE	
	<u>DATE</u>	<u>% OF FUNDS EXPENDED</u>
	NOV 2011	CON APPROVAL
	APR 2012	BEGIN CONSTRUCTION
	JUL 2012	25%
	NOV 2012	50%
	DEC 2012	MID POINT OF CONSTRUCTION
	APR 2013	75%
	JUL 2013	90%
	AUG 2013	100%
	SEP 2013	FIRST ADMISSION
	FEB 2014	FINAL COST REPORT
	SEP 2014	REACHING 90% OCCUPANCY
	2015	FIRST FULL YEAR AT 90%

C. Start Up Costs

CATEGORY B?	YES
SUPPLEMENTAL / OVERTIME PERSONNEL	\$30,000
MOVING COSTS	\$10,000
ADVERTISING AND PROMOTION	\$51,000
CLASSIFIED ADVERTISING	\$10,000
SUPPLIES	\$15,000
TRAINING	\$15,000
TOTAL	\$131,000

	Quantity	Price	Sum Total
<u>Resident Rooms</u>			
UCXT 35" x 80"	180	\$1,546.40	\$278,352.00
Prevamatt Deluxe Mattress 35" x 80"	180	\$172.55	\$31,059.00
UCXT 42" x 80"	20	\$1,758.40	\$35,168.00
Prevamatt Deluxe Mattress 42" x 80"	20	\$206.55	\$4,131.00
CSC4190	200	\$232.05	\$46,410.00
TWA11__	200	\$292.40	\$58,480.00
TWA10__	200	\$198.05	\$39,610.00
TWW03	200	\$495.55	\$99,110.00
OBT200	200	\$78.20	\$15,640.00
YFTBEDSPREAD	200	\$47.56	\$9,512.00
YFTCUBICLE	172	\$261.49	\$44,976.28
YFTVALANCE/BLIND	114	\$410.39	\$46,784.46
		\$5,699.59	\$709,232.74

1st Floor

Exam Room

YHT4002	1	\$379.67	\$379.67
DNC4175	2	\$164.90	\$329.80
YHT2113	1	\$226.67	\$226.67
YHTD-24	1	\$208.25	\$208.25
YHTD-EP	1	\$61.63	\$61.63
YHTB-18-1D	1	\$406.58	\$406.58

Employee Lounge

T84242-G1	3	\$146.20	\$438.60
YEMPINLEG	3	\$294.67	\$884.00
YMT563-G1	12	\$97.31	\$1,167.73

Receiving Office

YOSNAPTYP4	1	\$544.21	\$544.21
YOSNAPTYP5	1	\$630.03	\$630.03
YOS5500	1	\$134.30	\$134.30
DNC4175-G3	2	\$164.90	\$329.80

South End Lounge

CSC9101	6	\$515.95	\$3,095.70
CT7503	1	\$107.10	\$107.10

South End Piano Lounge

CSC9101	6	\$515.95	\$3,095.70
CT7503	1	\$107.10	\$107.10

Dentist/Podiatrist Office

YAHE9W585	1	\$536.92	\$536.92
YHTD-24	1	\$208.25	\$208.25
YHTD-EP	1	\$61.63	\$61.63
YHTB-18-1D	1	\$406.58	\$406.58
DNC4175	2	\$164.90	\$329.80
YHT2113	1	\$226.67	\$226.67

Dialysis Waiting Room

CT852	1	CT852	\$109.65
DNC4175	4	\$164.90	\$659.60

Physical Therapy Waiting Area

DNC4175	6	\$164.90	\$989.40
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Physical Therapy Offices (2)

YOSNAPTYP4	1	\$544.21	\$544.21
YOSNAPTYP5	1	\$630.03	\$630.03
YOS5500	1	\$134.30	\$134.30
DNC4175-G3	2	\$164.90	\$329.80

Reception			
YOSNAPTYP19	1	\$851.33	\$851.33
YOSNAPTYP4	1	\$544.21	\$544.21
YOS5500	2	\$134.30	\$268.60
Inservice Room			
YOS9642RT3	1	\$321.30	\$321.30
YOSWD923	12	\$1,744.20	\$1,744.20
YOSNAPTYP5	1	\$630.03	\$630.03
Chapel/Multi-Purpose Room			
YMT570-AR-G3	37	\$134.17	\$4,964.38
YAH5L800	1	\$494.42	\$494.42
Ice Cream Parlor			
T84200-g1	5	\$146.20	\$731.00
DTB430	5	\$67.15	\$335.75
YMT567-AR-G1	25	\$150.62	\$3,765.50
Patio			
YWD280136	7	\$198.90	\$1,392.30
YWD3M0001	28	\$184.11	\$5,155.08
YWD3MW001	28	\$71.91	\$2,013.48
YMD77W210	7	\$210.12	\$1,470.84
Beauty Salon			
DNC4175-G1	4	\$155.50	\$622.00
CT7504	1	\$124.20	\$124.20
YOS5500	2	\$134.30	\$268.60
YAEIM-71	1	\$807.50	\$807.50
YAELC-248A	2	\$977.50	\$1,955.00
YAELC-264	2	\$705.50	\$1,411.00
YAE1990G	3	\$281.92	\$845.75
YAELC-266	3	\$477.42	\$1,432.25
YAE2100-522-503c	2	\$488.75	\$977.50
Family Dining			
YHK637-75-200	1	\$559.58	\$559.58
YHK637-75-415	10	\$195.50	\$1,955.00
YHK637-75-900	1	\$855.67	\$855.67
YHK637-75-415	2	\$195.50	\$391.00
YHK637-80-113	1	\$247.92	\$247.92
YUT26268	1	\$133.17	\$133.17
Bookkeeping			
YOSNAPTYP4	3	\$544.21	\$1,632.64
YOS5500	3	\$134.30	\$402.90
DNC4175-G3	3	\$164.90	\$494.70
Administrators Office			
YOSNAPTYP4	1	\$544.21	\$544.21
YOSNAPTYP5	1	\$630.03	\$630.03
T83600-G1/DTB436	1	\$118.15	\$118.15
YOS5500	1	\$134.30	\$134.30
DNC4175-G3	6	\$164.90	\$989.40
YOSCREDENZ	1	\$455.60	\$455.60
YUT60085	1	\$161.50	\$161.50
Therapy Apartment			
YHK637-90-250	1	\$701.25	\$701.25
YWGHC404QBM	1	\$935.00	\$935.00
YHK637-80-113	1	\$247.92	\$247.92
YUT29815-1	1	\$69.42	\$69.42
YHK637-75-203	1	\$325.83	\$325.83
YHK637-75-400	4	\$195.50	\$782.00
Offices			

YOSNAPTYP4	1	\$544.21	\$544.21
YOS5500	1	\$134.30	\$134.30
DNC4175-G3	2	\$164.90	\$329.80
YOSNAPTYP5	1	\$630.03	\$630.03
		\$27,336.97	\$64,845.46

Second Floor

<i>Dining Room</i>			
T84242-G1	19	\$219.30	\$4,166.70
YEMPINLEG	19	\$294.67	\$5,598.67
RCH4526-G3	76	\$364.65	\$27,713.40
YFTVALANCE/BLINDS	21	\$348.84	\$7,325.64
YFTSHIPPING	1	\$5,659.00	\$5,659.00
YFTINSTALL	1	\$29,660.00	\$29,660.00
<i>Exam Room</i>			
YHT4002	1	\$379.67	\$379.67
DNC4175	2	\$164.90	\$329.80
YHT2113	1	\$226.67	\$226.67
YHTD-24	1	\$208.25	\$208.25
YHTD-EP	1	\$61.63	\$61.63
YHTB-18-1D	1	\$406.58	\$406.58
<i>Nurses Lounge</i>			
T84242-G1	1	\$146.20	\$146.20
YEMPINLEG	1	\$294.67	\$294.67
YMT563-G1	4	\$97.31	\$389.24
<i>Nurses Station</i>			
YOS5500	4	\$134.30	\$537.20
<i>Med Room</i>			
YHSE9W635	1	\$247.90	\$247.90
<i>Nurses Office</i>			
YOSNAPTYP4	1	\$544.21	\$544.21
<i>Lounge/Activity Room</i>			
YUT26278	1	\$103.42	\$103.42
DNC4175-G3	8	\$164.90	\$1,319.20
DT442	2	\$156.40	\$312.80
CSL7112-G3	1	\$539.75	\$539.75
CSC7112-G3	2	\$415.65	\$831.30
YHK277-55-459	1	\$544.00	\$544.00
		\$41,382.87	\$87,545.90

Third Floor

<i>Dining Room</i>			
T84242-G1	19	\$219.30	\$4,166.70
YEMPINLEG	19	\$294.67	\$5,598.67
RCH4526-G3	76	\$364.65	\$27,713.40
<i>Exam Room</i>			
YHT4002	1	\$379.67	\$379.67
DNC4175	2	\$164.90	\$329.80
YHT2113	1	\$226.67	\$226.67
YHTD-24	1	\$208.25	\$208.25
YHTD-EP	1	\$61.63	\$61.63
YHTB-18-1D	1	\$406.58	\$406.58
<i>Nurses Lounge</i>			
T84242-G1	1	\$146.20	\$146.20
YEMPINLEG	1	\$294.67	\$294.67
YMT563-G1	4	\$97.31	\$389.24
<i>Nurses Station</i>			

YOS5500	4	\$134.30	\$537.20
Med Room			
YHSE9W635	1	\$247.90	\$247.90
Nurses Office			
YOSNAPTYP4	1	\$544.21	\$544.21
Lounge/Activity Room			
YUT26278	1	\$103.42	\$103.42
DNC4175-G3	8	\$164.90	\$1,319.20
DT442	2	\$156.40	\$312.80
CSL7112-G3	1	\$539.75	\$539.75
CSC7112-G3	2	\$415.65	\$831.30
YHK277-55-459	1	\$544.00	\$544.00
		\$5,715.03	\$44,901.26

Fourth Floor

Dining Room			
T84242-G1	14	\$219.30	\$3,070.20
YEMPINLEG	14	\$294.67	\$4,125.33
RCH4526-G3	56	\$364.65	\$20,420.40
Exam Room			
YHT4002	1	\$379.67	\$379.67
DNC4175	2	\$164.90	\$329.80
YHT2113	1	\$226.67	\$226.67
YHTD-24	1	\$208.25	\$208.25
YHTD-EP	1	\$61.63	\$61.63
YHTB-18-1D	1	\$406.58	\$406.58
Nurses Lounge			
T84242-G1	1	\$146.20	\$146.20
YEMPINLEG	1	\$294.67	\$294.67
YMT563-G1	4	\$97.31	\$389.24
Nurses Station			
YOS5500	4	\$134.30	\$537.20
Med Room			
YHSE9W635	1	\$247.90	\$247.90
Nurses Office			
YOSNAPTYP4	1	\$544.21	\$544.21
Lounge/Activity Room			
YUT26278	1	\$103.42	\$103.42
DNC4175-G3	8	\$164.90	\$1,319.20
DT442	2	\$156.40	\$312.80
CSL7112-G3	1	\$539.75	\$539.75
CSC7112-G3	2	\$415.65	\$831.30
YHK277-55-459	1	\$544.00	\$544.00
Patio			
YWD280136	6	\$198.90	\$1,193.40
YWD3M001	24	\$184.11	\$4,418.64
YWD3MW001	24	\$71.91	\$1,725.84
YWD77W210	6	\$210.12	\$1,260.72
		\$5,715.03	\$43,637.02

Basement

Maintenance Office			
YOSNAPTYP4	1	\$544.21	\$544.21
YOS5500	1	\$134.30	\$134.30
DNC4175-G3	2	\$164.90	\$329.80
Laundry Room			
YMT563-G1	1	\$97.31	\$97.30

Clean Linen Room
YMT563-G1

1

\$97.31
\$1,038.03

\$97.31
\$1,202.92

Patient Handling

HOY-PRESENCE
HOY-PRESENCEWSC
HOY-ELEVATE
HOY-JOURNEY

1
1
1
1

\$3,573.60
\$2,839.20
\$3,160.00
\$2,040.00
\$11,612.80

\$3,573.60
\$2,839.20
\$3,160.00
\$2,040.00
\$11,612.80

MISCELLANEOUS/CONTINGENCY

1

\$100,000.00

\$100,000.00

\$198,500.32

\$1,062,978.10

Freight
Install

TBD
\$28,100.00

\$1,091,078.10

Start-Up Costs

Supplemental/Overtime Personnel	\$30,000
Movings Costs	\$10,000
Advertising and Promotion	\$51,000
Classified Advertising	\$10,000
Supplies	\$15,000
Training	<u>\$15,000</u>
Total	\$131,000

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS**

Criterion 1110.230 - Project Purpose, Background and Alternatives

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, certification and accreditation identification numbers, if applicable.

In addition to the subject facility, McAllister Nursing & Rehab, the only other related facility is Oakridge Nursing and Rehab Ctr. There are no other facilities owned or operated by the Applicant nor are there any other related facilities. A copy of both facility licenses are appended as **ATTACHMENT-10A**.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

Appended as **ATTACHMENT-10B** is a notarized letter from the Applicant advising that no Adverse Action has been taken against the Applicant or against any health care facility owned or operated by the Applicant, directly or indirectly, within three years preceding the filing of this application.

3. Authorization permitting HFPB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFPB.

Appended as **ATTACHMENT-10C** is a letter from the Applicant entity authorizing access to any documents necessary to verify the information submitted herein.

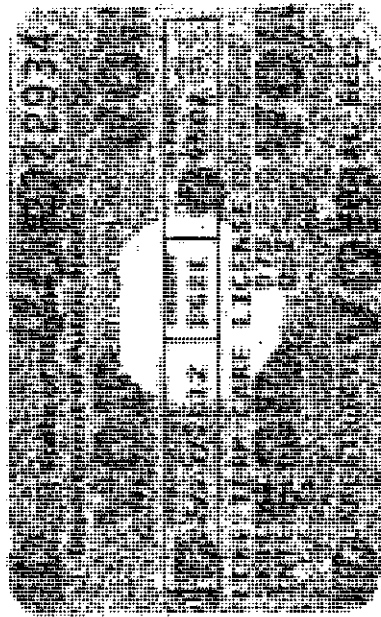
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

It should be noted that this item is not germane as this Applicant has not submitted any other application during this calendar year.

ATTACHMENT-10

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

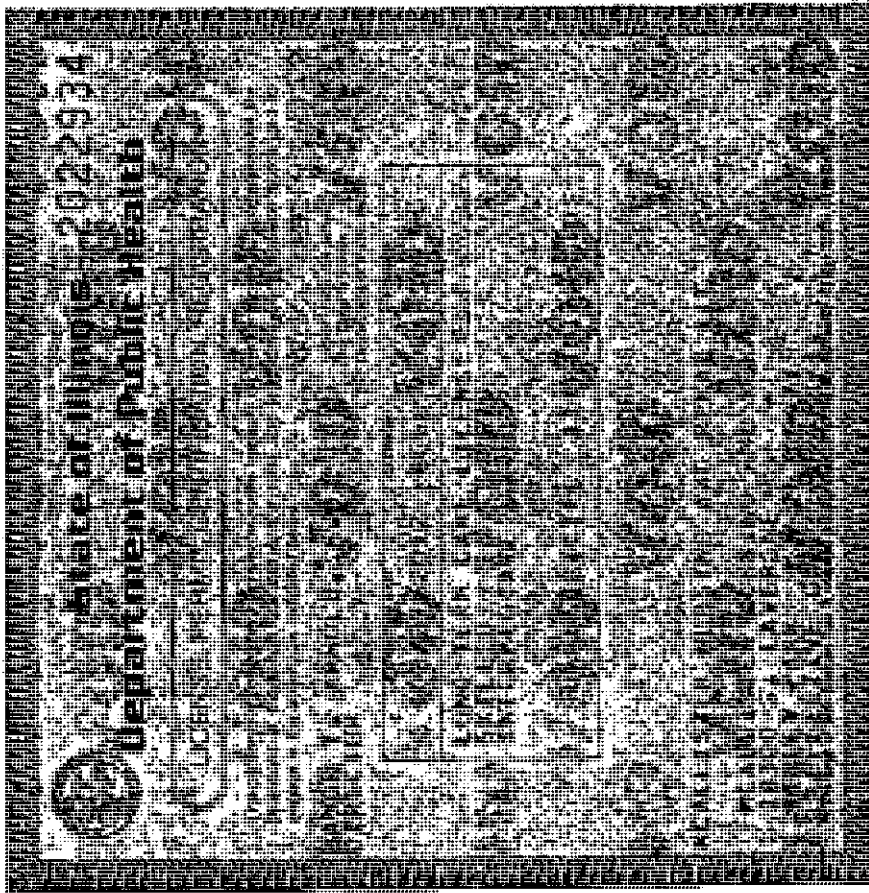
REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION →



02/01/11

MCALLISTER NURSING AND REHAB
18300 S. LAVERGNE
NINLEY PARK IL 60477

FEE RECEIPT NO.



← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION →

State of Illinois 2038961
 Department of Public Health
 LICENSE, PERMIT, CERTIFICATION, REGISTRATION

EXPIRATION DATE	CATEGORY	ID NUMBER
03/13/2013	BGHE	0049965

LUNG TERM CARE LICENSE
 SKILLED 05B
 INTERMEDIATE 015

UNRESTRICTED 073 TOTAL BEDS

05/25/11
 OAKRIDGE NURSING & REHAB CTR
 323 OAKRIDGE AVENUE
 HILLSIDE IL 60162

FEE RECEIPT NO.

State of Illinois 2038961
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

DANON J. ARNOLD, M.D.
 DIRECTOR

Issued under the authority of
 The State of Illinois
 Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
03/13/2013	BGHE	0049965

LUNG TERM CARE LICENSE
 SKILLED 05B
 INTERMEDIATE 015

UNRESTRICTED 073 TOTAL BEDS

**BUSINESS ADDRESS
 LICENSEE**

OAKRIDGE NURSING & REHAB CENTER, LLC
 OAKRIDGE NURSING & REHAB CTR
 323 OAKRIDGE AVENUE
 HILLSIDE IL 60162
 EFFECTIVE DATE: 03/14/11

The fees of this license has a colored background. Printed by authority of the State of Illinois • 407 •



McAllister
Nursing & Rehabilitation

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

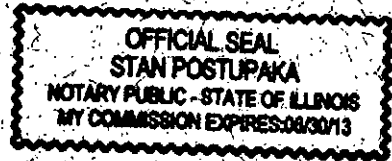
Please be advised that no Adverse action @ as defined under 1110.230.a)3)B has been taken against the applicant or against any health care facility owned or operated by the Applicant, directly or indirectly, within three years preceding the filing of the Certificate of Need Application.

Sincerely,

Elisha Atkin
Administrator

Subscribed and sworn to me
this 7 day of JULY, 2011

Stan Postupaka
Notary Public





McAllister
Nursing & Rehabilitation

May 27, 2011

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery,

I hereby authorize the Health Facilities Planning Board and the Illinois Department of Public Health (IDPH) access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. I further authorize the Illinois Department of Public Health to obtain any additional documentation or information that said agency deems necessary for the review of this application as it pertains to 1110.230.a.3)C.

Sincerely,

Elisha Atkin
Administrator

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued ii)**

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.

This project is for the major modernization of an existing nursing home in which 84.7% of the 2009 and 2010 admissions originated from within the zip code areas that comprise the 30-minute travel time. As the Subject facility is existing and will remain located within the 7-E Planning Area, this project will maintain the health care and wellbeing of the market area population already served.

2. Define the planning area or market area, or other, per the applicant's definition.

The primary market area is a 30-minute travel time area which consists of the zip code areas provided herein and a secondary market that is consistent with the 7-E Planning Area..

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

The Planning Board has identified a need for Long-Term nursing care services in the 7-E Planning Area. This single-story facility was originally constructed in 1964 with additions in 1978 and also in 1998. Based on the narrow lot, one of the major problems within the facility is the total length of the corridor is over 600 feet. Another major concern is that over 30% of the rooms are either three or four bed ward rooms with and without shared toilets. This makes the promotion of the facility very difficult in order to compete in today's market. There are only two private rooms in the facility. As more private rooms are needed for isolation, it becomes necessary to convert existing double rooms to private. Presently, a total of 3 double rooms are utilized as private rooms which affects the overall occupancy rate of the facility.

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued iii)**

PURPOSE OF PROJECT (Continued ii)

4. Cite the sources of the information provided as documentation.
 - A) Patient origin data for CY 2009 - 2010 for McAllister Nursing & Rehab (ATTACHMENT-11A);
 - B) MapPoint Map identifying area facilities and Zip Code areas (ATTACHMENT-11B).
 - C) Update to the Inventory of Health Care Facilities and Services and Need Determinations (2008 LTC Services)(ATTACHMENT-11C); and
 - D) Department of Health & Human Services Centers for Medicare & Medicaid Services Statement of Deficiencies and Plan of Correction (ATTACHMENT-11D).
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

As a modernization project, this application will address the negative issues that are inherent to a building that opened in 1964. The proposed replacement will provide for a more efficient and less institutional physical plant environment for the existing residents of McAllister Nursing & Rehab as well as for the community. Additional real estate is being purchased which will provide for a more functional building layout. Moreover, this project is addressing the outstanding need for additional nursing beds within the 7-E Planning Area.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.

The Applicant's goal is to complete the project in the timeframes outlined within this application and to reach and maintain a 90% or greater utilization rate by the second full year of operation.

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued iv)**

PURPOSE OF PROJECT (Continued iii)

For projects involving modernization, describe the conditions being upgraded. For facility projects, include statements of age and condition and regulatory citations. For equipment being replaced, include repair and maintenance records.

Appended as ATTACHMENT-11E is a report prepared by Arthur P. Salk, Architect (Salk & Associates, LLC) in cooperation with Skender Construction describing the existing condition and how the building complies with current standards, the potential cost to bring the entire building up to current standards to include current life safety codes, as compared to the scope of the project as being proposed. Appended as ATTACHMENT-11D are copies of the facility's Health & Human Services Centers for Medicare & Medicaid Services Statement of Deficiencies. The initial nursing home was constructed in 1967 (almost 45 years old) with a second addition in 1973 (37 years old) and a final phase added in 1995 (16 years old). The culmination of these additions is a single story building with a partial basement which is "approximately 600 ft. long or twice the length of a football field" (Arther P. Salk, AIA Emeritus NCARB, September 16, 2011 letter to the Health Facilities and Services Review Board (ATTACHMENT-11E)). There are significant numbers of ward rooms with some shared bath rooms. The construction of the building was typical for the period with cinder block construction which limits the Applicant's ability to rehab the existing building in an efficient, cost effective and appealing manner.

ATTACHMENT-11

McAllister Nursing Rehab
 Patient Origin Analysis
 2009 2010

ZIP Code	# of residents	Residents within 30-min
34607	1	0
49057	1	0
60126	1	0
60141	1	0
60162	1	0
60163	1	0
60164	1	0
60169	1	0
60401	1	1
60406	1	1
60409	4	4
60411	3	3
60415	1	1
60417	1	1
60419	2	2
60423	6	6
60425	1	1
60426	4	4
60429	10	10
60430	4	4
60439	1	1
60441	1	1
60443	10	10
60446	1	0
60448	1	1
60451	3	3
60452	7	7
60455	1	1
60459	2	2
60461	2	2
60462	8	8
60463	1	1
60465	2	2
60466	5	5
60467	1	1
60471	2	2
60473	1	1
60475	3	3
60477	15	15
60478	12	12
60487	1	1
60490	1	0
60491	1	1
60525	1	1
60602	1	0
60612	1	0
60617	2	2
60619	3	3
60620	3	3
60628	4	4
60629	1	1
60633	2	2
60634	1	0
60640	1	0
60643	3	3
60653	1	0
60655	1	1
60657	1	0
60803	2	2
60805	1	1
60827	1	1
60901	1	0
60950	2	2
64128	1	0
	162	144
Unknown	8	
	170	84.7%

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: JAN. 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 2009-JAN. 2011</u>
M.W.	COUNTRY CLUB HILLS, 60478	10
C.B.	CHICAGO, 60620	14
E.C.	MATTESON, 60443	702
W.H.	CHICAGO, 60653	17
K.H.	PARK FOREST, 60466	7
S. U. H.	ORLAND PARK, 60462	30
R.K.	MOKENA, 60448	31
F.M.	RIVERDALE, 60827	7
D.S.	MATTESON, 60443	90
H.T.	COUNTRY CLUB HILLS, 60478	46
W.S.	CHICAGO, 60628	2
TOTAL:12		956 TOTAL DAYS

MONTH/YR: FEB. 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 2009- JAN. 2011</u>
J.D.	CHICAGO, 60643	77
L.D.	CHICAGO, 60619	17
J.E.	CHICAGO, 60657	685
R.P.	HAZEL CREST, 60429	78
B.T.	UNKNOWN	668
TOTAL:5		1525 TOTAL DAYS

MONTH/YR: MARCH 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 2009-JAN.2011</u>
M.B	HAZEL CREST, 60429	588
S.D.	ELMHURST, 60126	81
D.H.	HARVEY, 60426	3
I.J.	MIDLOTHIAN, 60445	697
P.P.	OAK FOREST, 60452	10
J.R.	ORLAND PARK, 60462	40
S.S.	BERKELEY, 60163	3
L.S.	ORLAND PARK, 60462	333
TOTAL:8		1755 total days

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: APRIL 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN.2009-JAN. 2011</u>
B.B.	CHICAGO HEIGHTS, 60411	195
D.C.	GLENWOOD, 60425	7
I.C.	CHICAGO, 60620	659
S.F.	OAK FOREST, 60452	649
M.H.	CHICAGO, 60633	618
I.H.	HAZEL CREST, 60429	10
O.N.	MATTESON, 60443	484
C.R.	TINLEY PARK, 60477	15
R.S.	CRETE, 60401	486
R.T.	HAZEL CRÉST, 60429	4
TOTAL:10		3127 TOTAL DAYS

MONTH/YR: MAY 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 2009-JAN.2011</u>
M.B.	HARTFORD, MI. 49057	83
E.E.	HOMWOOD, 60430	55
R.H.	TINLEY PARK, 60477	568
J.K.	RIGHTON PARK, 60411	14
C.T.	TINLEY PARK, 60477	46
R.W.	FRANKFORT, 60423	29
TOTAL:6		795 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: JUNE 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
S.B.	MANTENO, 60950	21
T.B.	DIXMOOR, 60406	14
J.C.	TINLEY PARK, 60477	234
F.W.	FRANKFORT, 60423	529
TOTAL:4		798 TOTAL DAYS

MONTH/YR: JULY 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
C.L.	CALUMET CITY, 60409	7
J.N.	HOMER GLEN, 60491	1
V.P.	OAK FOREST, 60452	22
C.W.	CHICAGO, 60655	6
B.W.	MATTESON, 60443	99
TOTAL:5		135 TOTAL DAYS

MONTH/YR: AUGUST 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN 09-JAN.2011</u>
B.D.	TINLEY PARK, 60477	20
A.H.	BURBANK, 60459	155
M.K.	COUNTRY CLUB HILLS, 60478	533
F.L.	MIDLOTHIAN, 60445	7
B.P.	LOCKPORT, 60441	458
W.W.	UNIVERSITY PARK, 60466	267
M.W.	MATTESON, 60443	424
J.D.	HAZEL CREST, 60429	71
TOTAL:8		1935 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: SEPT 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
A.A.	ORLAND PARK, 60462	164
C.B.	ALSIP, 60803	469
M.M.	PALOS HILLS, 60465	58
H.P.	LEMONT, 60439	3
D.A.	HAZEL CREST, 60429	486
B.S.	COUNTRY CLUB HILLS, 60478	312
TOTAL:6		1492 TOTAL DAYS

MONTH/YR: OCT 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
L.B.	CHICAGO, 60620	449
C.D.	CHICAGO, 60628	471
J.S.	MATTESON, 60443	85
TOTAL:3		1005 TOTAL DAYS

MONTH/YR: NOV 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN.09-JAN.2011</u>
F.A.	FRANKFORT, 60423	8
L.D.	OAK FOREST, 60452	17
K.D.	RIGHTON PARK, 60471	392
S.J.	HARVEY, 60426	20
V.L.	HAZEL CREST, 60429	25
A.T.	CALUMET CITY, 60409	451
M.B.	RIGHTON PARK, 60471	442
TOTAL:7		1355 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: DEC. 09

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN.09-JAN.2011</u>
G.B.	TINLEY PARK, 60477	132
V.C.	EVERGREEN PARK, 60805	414
C.H.	PARK FOREST, 60466	306
W.I.	HOMWOOD, 60430	422
A.J.	TINLEY PARK, 60477	21
J.L.	SOUTH HOLLAND, 60473	122
TOTAL:6		1417 TOTAL DAYS

MONTH/YR: JAN. 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
W.B.	CHICAGO, 60628	62
L.D.	CHICAGO, 60619	376
G.D.	DOLTON, 60419	36
J.P.	MIDLOTHIAN, 60445	21
C.T.	HAZEL CREST, 60429	119
TOTAL:5		614 TOTAL DAYS

MONTH/YR: FEB. 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
D.A.	STEGER, 60475	1
D.B.	TINLEY PARK, 60477	308
M.C.	TINLEY PARK, 60477	205
C.B.	MATTESON, 60443	1
A.G.	PALOS HEIGHTS, 60463	11
H.G.	HAZEL CREST, 60429	59
S.K.	PALOS HILLS, 60465	39
V.L.	PARK FOREST, 60466	19
D.R.	MATTESON, 60443	300
M.T.	MANTENO, 60950	96
C.W.	CHICAGO, 60619	6
W.W.	HARVEY,60426	10
TOTAL:12		1055 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: MARCH 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
M.B.	COUNTRY CLUB HILLS, 60477	7
P.C.	CHICAGO, 60617	46
W.D.	BURBANK, 60459	320
B.E.	NEW LENOX, 60451	322
D.E.	NEW LENOX, 60451	322
J.G.	TINLEY PARK, 60477	51
J.I.	HOMWOOD, 60430	208
R.L.	NEW LENOX, 60451	1
A.O.	OLYMPIA FIELDS, 60461	2
A.T.	HINES, 60141	297
TOTAL:10		1576 TOTAL DAYS

MONTH/YR: APRIL 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
B.B.	COUNTRY CLUB HILLS, 60478	53
A.H.	KANSAS CITY, MO. 64128	273
E.H.	HAZEL CREST, 60429	40
J.R.	CHICAGO, 60629	26
M.W.	CALUMET CITY, 60409	31
TOTAL:5		423 TOTAL DAYS

MONTH/YR: MAY 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN.09-JAN.2011</u>
E.H.	COUNTRY CLUB HILLS, 60478	93
J.P.	DOLTON, 60419	30
L.P.	OLYMPIA FIELDS, 60461	38
O.S.	CHICAGO, 60643	151
E.S.	TINLEY PARK, 60477	169
C.J.	BROOKSVILLE, FL. 34607	231
TOTAL:6		712 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: JUNE 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN.2011</u>
R.K.	BRIDGEVIEW, 60455	130
D.K.	FRANKFORT, 60423	19
R.M.	CHICAGO RIDGE, 60415	90
J.M.	COUNTRY CLUB HILLS, 60478	2
M.K.	STEGER, 60475	49
TOTAL:5		290 TOTAL DAYS

MONTH/YR: JULY 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
G.B.	CRETE, 60417	23
F.C.	HILLSIDE, 60162	41
V.E.	HOMewood, 60430	68
H.F.	ORLAND PARK, 60467	49
W.M.	CHICAGO, 60612	41
W.M.	PARK FOREST, 60466	20
M.M.	NORTH LAKE, 60164	30
J.O.	CHICAGO, 60634	41
P.P.	COUNTRY CLUB HILLS, 60478	211
N.R.	CALUMET CITY, 60409	43
C.W.	CHICAGO, 60525	41
J.W.	HILLSIDE, 60490	41
TOTAL:12		649 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: AUG. 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
S.B.	TINLEY PARK, 60487	101
N.G.	OAK FOREST, 60452	174
J.G.	CHICAGO, 60640	35
R.M.	FRANKFORT, 60423	184
E.W.	SAUK VILLAGE, 60411	86
D.W.	MARKHAM, 60426	175
TOTAL:6		755 TOTAL DAYS

MONTH/YR: SEPT. 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
J.H.	KANKAKEE, 60901	120
R.K.	COUNTRY CLUB HILLS, 60478	134
P.M.	BURNHAM, 60633	124
C.M.	CHICAGO, 60643	58
K.S.	ALSIP, 60803	132
TOTAL:5		568 TOTAL DAYS

MONTH/YR: OCT. 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
Z.B.	ORLAND PARK, 60462	117
M.B.	OAK FOREST, 60452	118
L.M.	OAK FOREST, 60452	105
L.R.	UNKNOWN	110
E.S.	ORLAND PARK, 60462	12
M.T.	COUNTRY CLUB HILLS, 60478	31
TOTAL:6		493 TOTAL DAYS

ADMISSIONS REPORT
JAN. 2009-JAN. 2011

MONTH/YR: NOV 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
W.B.	ORLAND PARK, 60462	87
B.C.	UNKNOWN	15
E.E.	STEGER, 60475	2
W.J.	COUNTRY CLUB HILLS, 60478	28
J.L.	TINLEY PARK, 60477	18
E.M.	CHICAGO, 60602	22
P.S.	TINLEY PARK, 60477	70
R.S.	ROMEDEVILLE, 60446	73
TOTAL:8		315 TOTAL DAYS

MONTH/YR: DEC 2010

<u>RESIDENT</u>	<u>COMMUNITY ORIGINATED</u>	<u>TOTAL PATIENT DAYS</u> <u>JAN. 09-JAN. 2011</u>
L.C.	MATTESON, 60443	60
B.F.	CHICAGO, 60617	41
J.H.	FRANKFORT, 60423	38
L.K.	HOFFMAN ESTATES, 60169	31
G.M.	MATTESON, 60443	49
S.S.	ORLAND PARK, 60462	60
C.S.	TINLEY PARK, 60477	23
J.W.	TINLEY PARK, 60477	1
E.N.	CHICAGO, 60628	30
H.R.	MIDLOTHIAN, 60445	21
TOTAL:10		354 TOTAL DAYS

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 10/21/2011

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION	
CHANGES TO GENERAL LONG-TERM CARE					
Health Service Area 001					
Stephcnson	P-11-064	10/11/2011	FREEPORT MEMORIAL HOSPITAL/SNU, FREEPORT	Permit issued to discontinue the 26 nursing care bed unit.	New
	P-11-064	10/11/2011	FREEPORT MEMORIAL HOSPITAL/SNU, FREEPORT	Project completed.	New
Health Service Area 002					
Bureau/Putnam	Closure	06/10/2011	ORCHARD VIEW REHAB & HEALTHCAR, PRINCETON	Facility closed 06-10-2011, 123 nursing care beds removed from inventory.	New
	P-11-065	10/11/2011	MANOR COURT OF PRINCETON, PRINCETON	Permit issued to modernize facility. Will convert all 22 sheltered care beds to nursing care and add an additional 27 nursing care beds, total now 125 nursing care beds.	New
Fulton	Closure	07/29/2011	ASTORIA GARDEN & REHAB. CTR., ASTORIA	Facility closed 07-29-2011, 57 nursing care beds removed from inventory.	New
Knox	Bed Change	09/09/2011	KNOX COUNTY NURSING HOME, KNOXVILLE	Added 15 nursing care beds, total now 169 nursing care beds.	New
LaSalle	Name Change	10/01/2011	HERITAGE HEALTH-PERU, PERU	Name changed from Heritage Manor - Peru.	New
	Name Change	10/01/2011	HERITAGE HEALTH-STREATOR, STREATOR	Name changed from Heritage Manor - Streator.	New
	Name Change	10/01/2011	HERITAGE HEALTH-MENDOTA, MENDOTA	Name changed from Heritage Manor - Mendota.	New
	Name Change	10/01/2011	HERITAGE HEALTH-LASALLE, LASALLE	Name changed from Heritage Manor - Lasalle.	New
Peoria	Name Change	10/01/2011	HERITAGE HEALTH-CHILlicothe, CHILlicothe	Name changed from Heritage Manor - Chillicothe.	New
	P-11-063	10/11/2011	PROCTOR MEMORIAL HOSPITAL, PEORIA	Permit issued to discontinue 15 nursing care beds, total now 15 nursing care beds. Completion date will be 12-31-2011.	New
Woodford	Bed Change	02/01/2011	APOSTOLIC CHRISTIAN HOME, ROANOKE	Discontinued one nursing care bed, total now 60 nursing care beds.	New
	Name Change	02/01/2011	APOSTOLIC CHRISTIAN HOME, ROANOKE	Name changed from Apostolic - Roanoke.	New
	Name Change	10/01/2011	HERITAGE HEALTH-MINONK, MINONK	Name changed from Heritage Manor - Minonk.	New
	Name Change	10/01/2011	HERITAGE HEALTH-EL PASO, EL PASO	Name changed from Heritage Manor - El Paso.	New
Health Service Area 003					
Brown/Schuyler	Name Change	10/01/2011	HERITAGE HEALTH-MT. STERLING, MOUNT STERLING	Name changed from Heritage Manor - Mt Sterling.	New
	P-11-056	10/11/2011	SARAH CULBERTSON MEMORIAL HOSP, RUSHVILLE	Permit issued to discontinue the 29 nursing care bed unit.	New
	P-11-056	10/11/2011	SARAH CULBERTSON MEMORIAL HOSP, RUSHVILLE	Project completed.	New
Christian	Name Change	10/01/2011	HERITAGE HEALTH-PANA, PANA	Name changed from Heritage Manor - Pana.	New
Hancock	Closure	08/22/2011	HANCOCK COUNTY NURSING HOME, CARTHAGE	Facility closed 08-22-2011, 57 nursing care beds removed from inventory.	New
Macoupin	Name Change	10/01/2011	HERITAGE HEALTH-STAUTON, STAUNTON	Name changed from Heritage Manor - Staunton.	New
	Name Change	10/01/2011	HERITAGE HEALTH-GILLESPIE, GILLESPIE	Name changed from Heritage Manor - Gillespie.	New
	Name Change	10/01/2011	HERITAGE HEALTH-CARLINVILLE, CARLINVILLE	Name changed from Heritage Manor - Carlville.	New
Mcnead	Closure	07/08/2011	MENARD CONVALESCENT CENTER, PETERSBURG	Facility closed 07-08-2011, 86 nursing care beds removed from inventory.	New
Montgomery	Name Change	10/01/2011	HERITAGE HEALTH-LITCHFIELD, LITCHFIELD	Name changed from Heritage Manor - Litchfield.	New
Morgan/Scott	Closure	08/26/2011	CARE CENTER OF JACKSONVILLE, JACKSONVILLE	Facility closed 08-26-2011, 93 nursing care beds removed from inventory.	New
	Name Change	10/01/2011	HERITAGE HEALTH-JACKSONVILLE, JACKSONVILLE	Name changed from Barton W. Stone - Jacksonville.	New
Sangamon	Name Change	10/01/2011	HERITAGE HEALTH-SPRINGFIELD, SPRINGFIELD	Name changed from Heritage Manor - Springfield.	New
Health Service Area 004					
Ford	Name Change	10/01/2011	HERITAGE HEALTH-GIBSON CITY, GIBSON CITY	Name changed from Heritage Manor - Gibson City.	New

LONG-TERM CARE FACILITY UPDATES

09/16/2011 - 10/21/2011

PLANNING AREA	ACTION	EFFECTIVE DATE	FACILITY	DESCRIPTION	
Livingston	Name Change	10/01/2011	HERITAGE HEALTH-DWIGHT, DWIGHT	Name changed from Heritage Manor - Dwight.	New
McLean	Name Change	10/01/2011	HERITAGE HEALTH-NORMAL, NORMAL	Name changed from Heritage Manor - Normal.	New
	Name Change	10/01/2011	HERITAGE HEALTH-BLOOMINGTON, BLOOMINGTON	Name changed from Heritage Manor - Bloomington.	New
Macon	Name Change	10/01/2011	HERITAGE HEALTH-MOUNT ZION, MOUNT ZION	Name changed from Heritage Manor - Mount Zion.	New
Health Service Area 006					
Planning Area 6-A	Closure	05/06/2011	WINCREST NURSING CENTER, CHICAGO	Facility closed 05-06-2011, 82 nursing care beds removed from inventory.	New
	CHOW	10/01/2011	CHALET LIVING & REHAB CENTER, CHICAGO	Change of ownership occurred.	New
	Name Change	10/01/2011	CHALET LIVING & REHAB CENTER, CHICAGO	Name changed from Sherwin Manor Nursing Center.	New
Planning Area 6-C	Bed Change	09/26/2011	WASHINGTON & JANE SMITH COMM., CHICAGO	Discontinued two nursing care beds, total now 101 nursing care beds.	New
Health Service Area 007					
Planning Area 7-A	Bed Change	09/08/2011	MOORINGS HEALTH CENTER, THE, ARLINGTON HTS	Discontinued 23 sheltered care beds, total now 116 nursing care beds and 44 sheltered care beds.	New
Planning Area 7-C	P-11-055	10/11/2011	TRANS. CARE CTR OF NAPERVILLE, NAPERVILLE	Permit issued to establish a 120 bed nursing care facility.	New
Health Service Area 008					
Kane	Closure	03/01/2011	FOX RIVER PAVILION, AURORA	Facility closed 03-01-2011, 99 nursing care beds removed from inventory.	New
	Name Change	10/01/2011	HERITAGE HEALTH-ELGIN, ELGIN	Name changed from Heritage Manor - Elgin.	New
Lake	Closure	03/11/2011	HELIA HEALTHCARE OF ZION, ZION	Facility closed 03-11-2011, 116 nursing care beds removed from inventory.	New

CHANGES TO SPECIALIZED LONG-TERM CARE

Health Service Area 005					
Williamson	Closure	04/18/2011	INDEPENDENCE PLACE, HERRIN	Facility closed 04-18-2011, 16 ICF/DD beds removed from inventory.	New
Health Service Area 6-9					
Kane	Name Change	06/09/2011	BETHESDA LUTHERAN - MONTGOMERY, AURORA	Name changed from Bethesda Lutheran Home-Montgomery.	New

LONG-TERM CARE BED INVENTORY UPDATES

09/16/2011 - 10/21/2011

LONG-TERM CARE GENERAL NURSING BED NEED

PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
HEALTH SERVICE AREA 001			
Boone	305	279	26
Carroll	187	170	17
DeKalb	757	742	15
Jo Daviess	231	155	76
Lec	299	342	(43)
Ogle	599	535	64
Stephenson	665	637	28
Whiteside	717	822	(105)
Winnebago	2,399	2,463	(64)
HEALTH SERVICE AREA 002			
Bureau/Putnam	429	373	56
Fulton	523	615	(92)
Henderson/Warren	245	217	28
Knox	823	980	(157)
LaSalle	1,364	1,419	(55)
McDonough	379	376	3
Marshall/Stark	346	427	(81)
Peoria	1,760	1,721	39
Tazewell	1,516	1,293	223
Woodford	655	593	62
HEALTH SERVICE AREA 003			
Adams	1,188	1,495	(307)
Brown/Schuyler	183	186	(3)
Calhoun/Pike	301	337	(36)
Cass	186	150	36
Christian	412	472	(60)
Greene	154	119	35
Hancock	190	184	6
Jersey	411	369	42
Logan	502	468	34
Macoupin	686	744	(58)
Mason	143	164	(21)
Menard	230	106	124
Montgomery	567	490	77
Morgan/Scott	573	561	12
Sangamon	1,344	1,254	90
HEALTH SERVICE AREA 004			
Champaign	1,037	908	129
Clark	290	255	35
Coles/Cumberland	759	939	(180)
DeWitt	219	190	29
Douglas	238	233	5
Edgar	260	299	(39)
Ford	240	427	(187)
Iroquois	461	486	(25)
Livingston	494	550	(56)
McLean	1,306	1,118	188
Macon	1,331	1,231	100
Moultrie	318	369	(51)
Piatt	160	160	0
Shelby	264	265	(1)
Vermilion	692	773	(81)
HEALTH SERVICE AREA 005			
Alexander/Pulaski	124	83	41
Bond	172	198	(26)
Clay	133	209	(76)
Crawford	246	220	26
Edwards/Wabash	175	139	36
Effingham	490	432	58
Fayette	255	261	(6)
Franklin	442	390	52
Gallatin/Hamilton/Saline	684	663	21
Hardin/Pope	95	113	(18)
Jackson	376	427	(51)
Jasper	82	82	0
Jefferson	424	346	78
Johnson/Massac	338	312	(26)
Lawrence	325	360	(35)
Marion	862	605	257

LONG-TERM CARE BED INVENTORY UPDATES

09/16/2011 - 10/21/2011

LONG-TERM CARE GENERAL NURSING BED NEED

PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
Perry	207	210	(3)
Randolph	580	492	88
Richland	360	309	51
Union	351	293	58
Washington	172	263	(91)
Wayne	133	169	(36)
White	354	355	(1)
Williamson	600	543	57
HEALTH SERVICE AREA 006			
Planning Area 6-A	5,963	7,218	(1,255)
Planning Area 6-B	4,252	4,178	74
Planning Area 6-C	5,209	5,037	172
HEALTH SERVICE AREA 007			
Planning Area 7-A	4,482	3,330	1,152
Planning Area 7-B	7,180	7,039	81
Planning Area 7-C	6,867	6,106	761
Planning Area 7-D	2,519	2,904	(385)
Planning Area 7-E	9,328	8,989	339
HEALTH SERVICE AREA 008			
Kane	3,322	2,894	428
Lake	5,275	4,709	566
McHenry	1,501	1,032	469
HEALTH SERVICE AREA 009			
Grundy	260	265	(5)
Kankakee	1,290	1,368	(78)
Kendall	219	185	34
Will	3,479	2,810	669
HEALTH SERVICE AREA 010			
Henry	452	518	(66)
Mercer	222	186	36
Rock Island	1,243	1,326	(83)
HEALTH SERVICE AREA 011			
Clinton	432	406	26
Madison	2,048	2,199	(151)
Monroe	435	324	111
St.Clair	2,102	2,294	(192)
LONG-TERM CARE ICF/DD 16 BED NEED			
PLANNING AREA	CALCULATED BED NEED	APPROVED BEDS	ADDITIONAL BEDS NEEDED OR EXCESS BEDS ()
HSA 1	268	360	(92)
HSA 2	268	333	(65)
HSA 3	230	383	(153)
HSA 4	322	334	(12)
HSA 5	255	671	(416)
HSA 6,7,8 & 9	3,429	1,133	2,296
HSA 10	82	40	42
HSA 11	220	384	(164)



Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

August 28, 2009

BY CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Elisha Atkin, Administrator
McAllister Nursing & Rehb.
18300 S. Lavergne Avenue
Tinley Park, Illinois 60477

Reference: Provider#: 145967/0049502
Survey Date: 08/13/09
Survey Type: LSC Annual Certification
First LSC Revisit to
Temporary Waiver
Requests from Annual
12/06/07, 07/30/08, and
02/04/09

Dear Ms. Atkin:

On 12/06/07, 07/30/08, and 02/04/09, Life Safety Code (LSC) surveys were conducted at your facility by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in Medicare and/or Medicaid programs. Deficiencies were identified and remedies imposed, proposed or recommended in an 'Initial Notices'.

After review of Plans of Correction (POCs) related to those deficiencies and receipt of a credible "Allegation of Compliance", Department staff conducted a revisit. At the time of the revisit, it was determined that all previous LSC deficiencies had been corrected. A copy of the "Post-Certification Revisit Report" (CMS-2567B) is enclosed.

Based on Administrative Review by Department staff, **K56 was deleted from the Statement of Deficiencies; no other changes were made to the Statement of Deficiencies.**

If you have any questions concerning this letter, please notify this office at (217) 782-5180 or, for the hearing impaired the Department's TTY number at 1-800-547-0466.

Sincerely,


Richard L. Dees, Chief
Bureau of Long Term Care

Attachments

cc: State Medicaid Agency
Joel Atkin, Registered Agent
File (3)

LPOC/revised0108/as/TP

Improving public health, one community at a time

ATTACHMENT-11D

2. Address actions the facility will take to assure that no other examples of the deficiency exist in other parts of the building. Cited deficiencies may not identify all locations where a condition may occur. It is the facility's responsibility to review its building to assure that similar conditions do not exist in other areas;
3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure those solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the quality assurance system; and
5. Include a specific date when corrective action will be completed not later than 09/20/09 for any deficient at Level "D" or higher. Effective July 1, 2005, per direction received from the Regional Office of the Centers for Medicare & Medicaid Services (CMS), a provider will be allowed three (3) months for completion of corrective actions for LSC deficiencies. No LSC revisit will occur until after the latest POC date provided.

*****See the ORANGE attachment that further explains POC requirements for Life Safety Code*****

Further, in accordance with the State Operations Manual (Sections 7304D and 7316), the facility must submit POCs to the Department within ten (10) calendar days after receipt of the CMS-2567. Therefore, our Department cannot grant an extension of the time for which the POC is to be submitted.

Failure to submit a POC which includes the above-listed components and in the mandated timeframes will result in our Department imposing or recommending immediate imposition of remedies and/or termination from the Medicare and/or Medicaid programs.

In some cases, while certain provisions of the LSC might not be met but the facility provides a reasonable degree of fire safety, an Annual Waiver may be requested with proper justification. The Annual Waiver justification must include facility fire safety characteristics to support granting of the waiver would not adversely affect patient health and safety and would impose an unreasonable hardship on the facility. For those cases of unreasonable hardship an actual estimate from a licensed contractor or consulting firm in support of the statement of estimated cost must be submitted. The Annual Waiver request must provide specific information described in the State Operations Manual (Section 2480) and must be signed and dated by the facility's representative. **One (1) Annual Waiver request form (Enclosure #4) must be completed, signed and dated for each K tag/deficiency. Only Plans of Correction (POCs) or Annual Waivers will be accepted and reviewed for deficiencies at Levels "B" and/or "C".**

The Regional CMS Office has authorized our Department to review and issue notice of our approval of Temporary Waivers up to six (12) months duration from the survey cycle date for Medicare/Medicaid certified nursing homes. The Temporary Waiver response/request must address increased fire safety awareness as required by the State Operation Manual (Section 7410F1) to be deemed acceptable. You will be notified of Department approval of the request following review of all POC documents. Temporary Waivers for more than six (12) months from the survey cycle date will be forwarded to CMS for review. Notification of CMS approval or denial of these requests will be issued by our Department when received from CMS. The Temporary Waiver request form must be completed, signed and dated by the facility's representative. **One (1) Temporary Waiver request form (Enclosure #4A) must be completed, signed and dated for each K tag/deficiency. Temporary Waiver requests will not be accepted or reviewed for deficiencies at Levels "B" and/or "C".** [NOTE: The survey cycle date is included in the information reference block on the first page of the "Initial Notice" accompanying the LSC Statement of Deficiencies.] If any deficiency cited on the Annual LSC survey has a previously requested Temporary Waiver on file, the POC response submitted for that deficiency for the Annual survey cannot exceed the date previously requested.

CMS has final authority to approve or deny all Waiver or FSES requests.

If the facility is subject to a LSC Federal Monitoring Survey (FMS), that survey will in most instances become part of an existing enforcement cycle. No revisit activity for the Annual LSC will occur until our office has received authorization from the Regional CMS Office to conduct a revisit for the FMS survey. The Regional CMS Office has final authority for review and approval of POCs, Waiver requests and FSES requests for a LSC FMS. All inquiries regarding Denial of Payments for New Admissions (DOPNA) in these cases should be made to the CMS Illinois Principal Program Representative.

Before a revisit will be scheduled, the facility must provide to the Department an acceptable POC for all deficiencies. An acceptable POC will also serve as the facility's allegation of compliance, thereby signifying the facility attests it will be in substantial compliance with all federal certification requirements. Based upon the acceptable POC, a revisit will be conducted to verify compliance.

SUBMISSION OF EVIDENCE IN LIEU OF AN ONSITE FOLLOW-UP REVISIT

Based upon the scope and severity level of the LSC deficiencies cited, the facility may be considered eligible to submit evidence in lieu of an onsite revisit. This evidence must be submitted within thirty days of the survey exit date, should be clearly separated by tag number, and should show that the facility has:

1. Put into place systemic changes as identified in its Plan of Correction to ensure that the deficient practices will not recur, and
2. Initiated a program to monitor the continued effectiveness of its Plan of Correction.

Evidence of correction should include documentation such as copies of written policies and procedures, completed (i.e., filled out) monitoring sheets, outline of in-service programs, in-service attendance sheets, quality assurance monitoring reports, committee minutes, licenses or other credentials, invoices, receipts, photographs or other credible evidence. If the evidence that the facility submits is determined by the Department to show correction of the deficiencies, an on-site health revisit will not be conducted. **If the evidence does not prove correction, or is not submitted in a timely manner, an on-site revisit will be scheduled. All information submitted as evidence will be reviewed by the Architect that conducted the Annual Survey.**

PLEASE SUBMIT THE ABOVE EVIDENCE WITHIN 30 DAYS OF THE LSC SURVEY EXIT DATE.

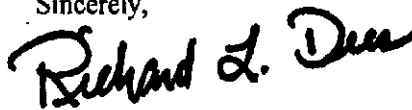
The facility may request an "Informal Dispute Resolution" (IDR) to challenge any deficiency that renders the facility not in substantial compliance (Level "D" or above). The facility may only question whether or not a deficiency existed at the time of the survey, not the scope/severity or any recommended or imposed remedies. **The IDR process will not delay the effective date of any enforcement action!** If the facility requests an IDR without submitting an acceptable POC and the Department's decision, as a result of the process, does not result in the deletion of the deficiency, our Department will then proceed to impose or recommend immediate imposition of remedies, to include termination from the Medicare and/or Medicaid programs. The provider is allowed one (1) opportunity for IDR. (See Enclosure #3).

Please submit all documents or other materials relating to this survey to:

Illinois Department of Public Health
Division of Long-Term Care, Field Operations
Quality Review Section; Attention: Jon Siegel
525 West Jefferson, Fifth Floor
Springfield, Illinois 62761-0001

If you have questions concerning this notice, please contact my staff at the above address or telephone (217) 782-5180. You may also telephone the Department's TTY number (hearing impaired use only) at 1-800-547-0466.

Sincerely,

A handwritten signature in cursive script that reads "Richard L. Dees".

Richard L. Dees, Chief
Bureau of Long Term Care

Enclosures

cc: State Medicaid Agency
IL Department on Aging
Joel Aktin, Registered Agent
File (3)
G2/ddb/012408/as/TP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/13/2009
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{K 000}	<p>INITIAL COMMENTS</p> <p>AN ANNUAL LIFE SAFETY CODE CERTIFICATION SURVEY WAS CONDUCTED AT "McALLISTER NURSING HOME" TO DETERMINE COMPLIANCE WITH TITLE 42 CODE OF FEDERAL REGULATIONS PART 483.70(a) FOR LONG TERM CARE FACILITIES(LIFE SAFETY FROM FIRE) AND WITH THE 2000 EDITION (EXISTING SECTION) OF THE LIFE SAFETY CODE OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA 101).</p> <p>BUILDING 0303: ONE STORY; PARTIAL BASEMENT; CONSTRUCTION TYPE III(000); FULLY SPRINKLERED.</p> <p>THE FACILITY HAS A CAPACITY OF 111 BEDS.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/13/2009
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{K 000}	<p>INITIAL COMMENTS</p> <p>AN ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0203: ONE STORY BUILDING WITH NO BASEMENT WAS DETERMINED TO BE A TYPE 111[200] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTION.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED.</p> <p>THE FACILITY HAS A CAPACITY OF 111 BEDS.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/13/2009
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{K 000}	<p>INITIAL COMMENTS</p> <p>A FIRST REVISIT TO THE TEMPORARY WAIVER TO THE ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0103: ONE STORY BUILDING WITH TWO PARTIAL BASEMENTS WAS DETERMINED TO BE A TYPE II (222) CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS AND SPACES OPEN TO THE CORRIDORS.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED, WITH THE EXCEPTION OF EAVES FOR BUILDING 0103.</p> <p>The facility has a capacity of 113 beds with a census of 89 at the time of the survey.</p> <p>The requirement at 42 CFR 483.70(a) is met.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/13/2009
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 387 TINLEY PARK, IL, 60477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A FIRST REVISIT TO THE TEMPORARY WAIVER TO THE ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0103: ONE STORY BUILDING WITH TWO PARTIAL BASEMENTS WAS DETERMINED TO BE A TYPE II (222) CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS AND SPACES OPEN TO THE CORRIDORS.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED, WITH THE EXCEPTION OF EAVES FOR BUILDING 0103.</p> <p>The facility has a capacity of 113 beds with a census of 89 at the time of the survey.</p> <p>The requirement at 42 CFR 483.70(a) is met.</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ATTACHMENT-11D

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2009
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/04/2009
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>AN INTERIM MF-1 TO THE TEMPORARY WAIVER TO THE ANNUAL LIFE SAFETY CODE[LSC] CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME/BUILDING 0303 WAS FOUND IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION [NFPA] 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE BASED ON TEMPORARY WAIVER.</p> <p>THE FACILITY IS DIVIDED INTO THREE BUILDINGS, EACH BEING BUILT AT A DIFFERENT TIME AND IN TWO DIFFERENT CONSTRUCTION TYPES.</p> <p>BUILDING 0303 IS A ONE STORY WITH PARTIAL BASEMENT. IT IS DETERMINED TO BE OF CONSTRUCTION TYPE III[200]. THE BUILDING IS FULLY SPRINKLERED. THE BUILDING HAS A COMPLETE SMOKE DETECTOR SYSTEM THAT IS TIED TO THE FIRE ALARM SYSTEM[FAS]. RESIDENT SLEEPING ROOM DOORS ARE TIED TO THE FIRE ALARM SYSTEM VIA SMOKE DETECTORS.</p> <p>THE REQUIREMENT AT 42 CFR SUBPART 483.70(a) IS MET AS EVIDENCED BY:</p>	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED R 02/04/2009
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE. POB 367 TINLEY PARK, IL 60477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>AN INTERIM MF-1 TO THE TEMPORARY WAIVER TO THE ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE BASED ON TEMPORARY WAIVER.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0203: ONE STORY BUILDING WITH NO BASEMENT WAS DETERMINED TO BE A TYPE 111[200] CONSTRUCTION. THE FACILITY IS TIED TO THE FACILITY'S AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTION. THIS BUILDING CONTAINS NO SLEEPING ROOMS.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED.</p> <p>THE FACILITY HAS A CAPACITY OF 111 BEDS WITH A CENSUS OF 80 AT THE TIME OF THE SURVEY.</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>AN INTERIM MF-1 TO THE TEMPORARY WAIVER TO THE ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED February 04, 2009 BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE BASED ON TEMPORARY WAIVER.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0103: ONE STORY BUILDING WITH TWO PARTIAL BASEMENTS WAS DETERMINED TO BE A TYPE II(222) CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS AND SPACES OPEN TO THE CORRIDORS.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED, WITH THE EXCEPTION OF THE EAVES FOR BUILDING 0103.</p>	{K 000}		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011 SS=F	Continued From page 1 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE A TWO [2] HOUR FIRE RATED SEPARATION BETWEEN NONCONFORMING BUILDINGS AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 19.1.1.4.1 AND 19.1.1.4.2. THIS DEFICIENT PRACTICE COULD ALLOW A FIRE OF A STRONGER MAGNITUDE TO SPREAD TO THE BUILDING WITH A VARYING SYSTEM OF FIRE PROTECTION. THE FINDING IS: ON AUGUST 13, 2009 AT APPROXIMATELY 11:35 AM, WHILE IN THE COMPANY OF E-2[DIRECTOR OF MAINTENANCE/PRIVATE CORPORATION] AND E-3[FACILITY MAINTENANCE], THE TWO HOUR FIRE RATED CROSS CORRIDOR DOORS BETWEEN BUILDINGS 0103 AND 0303 WERE OBSERVED BEING UNABLE TO CLOSE TO SMOKE/FIRE TIGHT. E-2 AND E-3 CONCURRED WITH THE FINDING.	K 011		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 2</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE A MEANS TO KEEP A CORRIDOR DOOR CLOSED TO SMOKE SEEPAGE AS REQUIRED BY NFPA 101, 2000 EDITION, SECTION 19.3.6.3. THIS DEFICIENT PRACTICE COULD RESULT IN THE SPREAD OF SMOKE TO ONE SMOKE ZONE CONTAINING THE ACTIVITY/ DINING ROOM WITH APPROXIMATELY 5 RESIDENTS AND UNKNOWN NUMBERS OF STAFF AND VISITORS AT THE TIME OF THE SURVEY. THE FINDING IS:</p> <p>ON AUGUST 13, 2009 AT APPROXIMATELY</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477	
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K 018	Continued From page 3 12:15 PM, WHILE IN THE COMPANY OF E-2 AND E-3, THE CORRIDOR DOOR TO THE SMOKING LOUNGE WAS OBSERVED LACKING ANY FORM OF LATCHING DEVICE TO HOLD IT IN A CLOSED POSITION AND PREVENT THE SPREAD OF SMOKE.	K 018		
K 022 SS=E	E-2 AND E-3 CONCURRED WITH THE FINDING. NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE EXIT SIGNAGE TO INDICATE THE DIRECTION OF THE EXIT PATH WHENEVER UNCLEAR AS REQUIRED BY NFPA 101, 2000 EDITION, SECTION 7.10.1.4. THIS DEFICIENT PRACTICE COULD EFFECT 7 RESIDENTS ON THE DAY OF THE SURVEY, PLUS UNTOLD NUMBERS OF EMPLOYEES AND VISITORS. THE FINDING IS: ON AUGUST 13, 2009 AT APPROXIMATELY 11:24 AM, WHILE IN THE COMPANY OF E-2	K 022		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477		
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K 022	Continued From page 4 AND E-3 , IT WAS OBSERVED THAT AN EXIT SIGN WAS MISSING FROM EXIT #7. THIS EXIT CORRIDOR LAID AT A 90 DEGREE ANGLE TO THE PRIMARY EXIT CORRIDOR.	K 022			
K 038 SS=E	E-2 AND E-3 CONCURRED WITH THE FINDING. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038			
K 046 SS=F	This STANDARD is not met as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: BASED ON MAINTENANCE RECORD REVIEW AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE EMERGENCY LIGHTING FOR THE GENERATOR SETS AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 7.9 AND 19.2.9.1. THIS DEFICIENT PRACTICE COULD RENDER THE GENERATORS IRREPARABLE IF NO EMERGENCY LIGHT SOURCE WERE MADE AVAILABLE WITH WHICH TO REPAIR A GENERATOR FAILING UNDER EMERGENCY OPERATION. THIS DEFICIENT PRACTICE WOULD EFFECT ALL 89 RESIDENTS AND AN UNTOLD NUMBER OF	K 046			

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K 046	<p>Continued From page 5</p> <p>STAFF AND VISITORS IN AN EMERGENCY WERE THE GENERATOR(S) TO FAIL. THE FINDING IS:</p> <p>ON AUGUST 13, 2009 AT APPROXIMATELY 3:30 PM, WHILE IN THE COMPANY OF E-2 AND E-3, IT WAS LEARNED THAT NO PROVISION FOR EMERGENCY LIGHTING FOR EMERGENCY REPAIR OF THE THREE[3] GENERATORS HAD BEEN MADE TO DATE. REVIEW OF EMERGENCY LIGHTING RECORDS SUBSTANTIATED THIS.</p> <p>E-2 AND E-3 CONCURRED WITH THE FINDING.</p>	K 046		
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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K 000	INITIAL COMMENTS AN ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE. THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS. BUILDING 0203: ONE STORY BUILDING WITH NO BASEMENT WAS DETERMINED TO BE A TYPE 111[200] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTION IN THE PRIMARY SPACE. BUILDING 0203 IS SOLELY FOR DINING. THERE IS NO SLEEPING IN THIS BUILDING. THE BUILDING IS TOTALLY SPRINKLERED.. THE FACILITY HAS A CAPACITY OF 113 BEDS WITH A CENSUS OF 89 AT THE TIME OF THE SURVEY. THE REQUIREMENT AT 42 CFR SUBPART 483.70(a) IS NOT MET AS EVIDENCED BY:	K 000		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the	K 022		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 022	Continued From page 1 occupants. 7.10.1.4	K 022			
K 046 SS=F	<p>This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE EXIT SIGNAGE TO INDICATE THE DIRECTION OF THE EXIT PATH WHENEVER UNCLEAR AS REQUIRED BY NFPA 101, 2000 EDITION, SECTION 7.10.1.4. THIS DEFICIENT PRACTICE COULD EFFECT 4 RESIDENTS ON THE DAY OF THE SURVEY, PLUS UNTOLD NUMBERS OF EMPLOYEES AND VISITORS. THE FINDING IS:</p> <p>ON AUGUST 13, 2009 AT APPROXIMATELY 1:50 PM, WHILE IN THE COMPANY OF E-1, E-2 AND E-3, IT WAS OBSERVED THAT AN EXIT SIGN WAS MISSING FROM THE BUILDING 0203/DINING ROOM ADDITION DIRECTLY TO THE EXTERIOR OF THE BUILDING.</p> <p>E-1, E-2 AND E-3 CONCURRED WITH THE FINDING.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p>	K 046			

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K 046	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: BASED ON MAINTENANCE RECORD REVIEW AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE EMERGENCY LIGHTING FOR THE GENERATOR SETS AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 7.9 AND 19.2.9.1. THIS DEFICIENT PRACTICE COULD RENDER THE GENERATORS IRREPARABLE IF NO EMERGENCY LIGHT SOURCE WERE MADE AVAILABLE WITH WHICH TO REPAIR A GENERATOR FAILING UNDER EMERGENCY OPERATION. THIS DEFICIENT PRACTICE WOULD EFFECT ALL 89 RESIDENTS AND AN UNTOLD NUMBER OF STAFF AND VISITORS IN AN EMERGENCY WERE THE GENERATOR(S) TO FAIL. THE FINDING IS:</p> <p>ON AUGUST 13, 2009 AT APPROXIMATELY 3:30 PM, WHILE IN THE COMPANY OF E-2 AND E-3, IT WAS LEARNED THAT NO PROVISION FOR EMERGENCY LIGHTING FOR EMERGENCY REPAIR OF THE THREE[3] GENERATORS HAD BEEN MADE TO DATE. REVIEW OF EMERGENCY LIGHTING RECORDS SUBSTANTIATED THIS.</p> <p>E-2 AND E-3 CONCURRED WITH THE FINDING.</p>	K 046			

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 387 TINLEY PARK, IL 60477	
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K 000	INITIAL COMMENTS AN ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE. THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS. BUILDING 0303: ONE STORY BUILDING WITH ONE PARTIAL BASEMENT WAS DETERMINED TO BE A TYPE 111[200] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS AND SPACES OPEN TO THE CORRIDORS AND INTER-CONNECTED TO THE RESIDENT SLEEPING ROOM DOORS. THE BUILDING IS TOTALLY SPRINKLERED. THE FACILITY HAS A CAPACITY OF 113 BEDS WITH A CENSUS OF 89 AT THE TIME OF THE SURVEY. THE REQUIREMENT AT 42 CFR SUBPART 483.70(a) IS NOT MET AS EVIDENCED BY: NFPA 101 LIFE SAFETY CODE STANDARD	K 000		
K 011 SS=F	If the building has a common wall with a nonconforming building, the common wall is a fire	K 011		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2009
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 1 barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE A TWO [2] HOUR FIRE RATED SEPARATION BETWEEN NONCONFORMING BUILDINGS AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 19.1.1.4.1 AND 19.1.1.4.2. THIS DEFICIENT PRACTICE COULD ALLOW A FIRE OF A STRONGER MAGNITUDE TO SPREAD TO THE BUILDING WITH A VARYING SYSTEM OF FIRE PROTECTION. THE FINDING IS: ON AUGUST 13, 2009 AT APPROXIMATELY 11:35 AM, WHILE IN THE COMPANY OF E-2[DIRECTOR OF MAINTENANCE/PRIVATE CORPORATION] AND E-3[FACILITY MAINTENANCE], THE TWO HOUR FIRE RATED CROSS CORRIDOR DOORS BETWEEN BUILDINGS 0103 AND 0303 WERE OBSERVED BEING UNABLE TO CLOSE TO SMOKE/FIRE TIGHT. E-2 AND E-3 CONCURRED WITH THE FINDING.	K 011		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2009
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 046	Continued From page 2 This STANDARD is not met as evidenced by: BASED ON MAINTENANCE RECORD REVIEW AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE EMERGENCY LIGHTING FOR THE GENERATOR SETS AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 7.9 AND 19.2.9.1. THIS DEFICIENT PRACTICE COULD RENDER THE GENERATORS IRREPARABLE IF NO EMERGENCY LIGHT SOURCE WERE MADE AVAILABLE WITH WHICH TO REPAIR A GENERATOR FAILING UNDER EMERGENCY OPERATION. THIS DEFICIENT PRACTICE WOULD EFFECT ALL 89 RESIDENTS AND AN UNTOLD NUMBER OF STAFF AND VISITORS IN AN EMERGENCY WERE THE GENERATOR[S] TO FAIL. THE FINDING IS: ON AUGUST 13, 2009 AT APPROXIMATELY 3:30 PM, WHILE IN THE COMPANY OF E-2 AND E-3, IT WAS LEARNED THAT NO PROVISION FOR EMERGENCY LIGHTING FOR EMERGENCY REPAIR OF THE THREE[3] GENERATORS HAD BEEN MADE TO DATE. REVIEW OF EMERGENCY LIGHTING RECORDS SUBSTANTIATED THIS. E-2 AND E-3 CONCURRED WITH THE FINDING.	K 046		
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RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item document a timetable with milestone dates of major activities to correct the deficiency that can be monitored on any follow up visit. (If additional space is required, use additional page)

PROVISION NUMBER **PROVIDER JUSTIFICATION FOR REQUESTING TEMPORARY WAIVER**

K84

K-

NAME OF FACILITY:

PROVIDER #:

TEMPORARY WAIVER EXPIRATION DATE:

FIRE AUTHORITY OFFICIAL

RECOMMEND WAIVER

(Initials)

DO NOT RECOMMEND WAIVER

SURVEYOR RECOMMENDATIONS ATTACHED

YES NO

Provider Representative Signature:

Date:

Fire Authority Official Signature

Title

Office

Date

Illinois Department of
**PUBLIC
HEALTH**

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us
April 15, 2010

BY CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Elisha Atkin, Administrator
McAllister Nursing & Rehb
18300 S. Laverne Ave.
Tinley Park, Illinois 60477

Reference: Provider #: 145967/0049502
Cycle Date: 04/02/10
Survey Date: 04/02/10
Survey Type: Annual Life Safety Code
Highest S/S: "E", K18

Dear Ms. Atkin:

On 04/02/10, an Annual Life Safety Code (LSC) inspection was conducted at the above-named facility by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare and/or Medicaid programs. As a result of that survey, the facility was determined to not be in "Substantial Compliance" with regulatory requirements as found in Title 42, Code of Federal Regulations. A "Statement of Deficiencies," (Form CMS-2567) is enclosed.

Based on the LSC deficiencies, the following remedies are proposed:

- Denial of Payment for New Admissions three (3) months from the LSC survey date; and
- Termination from the Medicare and/or Medicaid programs six (6) months from the LSC survey date.

The facility must submit a Plan of Correction (POC) for all deficiencies at "B" Level or higher; Level "A" deficiencies must be corrected, but do not require a written POC. All required POCs must be submitted to the Department within ten (10) calendar days after receipt of the written "Statement of Deficiencies." The POC cannot be submitted on the CMS-2567, but on separate sheets of paper which are attached to the first page of the CMS-2567. The first page of the CMS-2567 must be returned with the facility representative's signature and date. The POC is not to be used to dispute a deficiency or to make comments about the survey process. Information disputing a deficiency may be provided through the informal dispute resolution (IDR) process on the enclosed form, and, if necessary, separate sheets of paper; comments about the survey process may be provided on the enclosed Provider Feedback Survey. In order for a POC to be acceptable, it must:

1. Address corrective actions taken and/or how the deficiency will be corrected;
2. Address actions the facility will take to assure that no other examples of the deficiency exist in other parts of the building. Cited deficiencies may not identify all locations where a condition may occur. It is the facility's responsibility to review its building to assure that similar conditions do not exist in other areas;

3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plan to monitor its performance to make sure those solutions is sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the quality assurance system; and
5. Include a specific date when corrective action will be completed not later than 05/17/10 for any deficiency at Level "D" or higher.

*****See the ORANGE attachment that further explains POC requirements for Life Safety Code*****

Further, in accordance with the State Operations Manual (Sections 7304D and 7316), the facility must submit POCs to the Department within ten (10) calendar days after receipt of the CMS-2567. Therefore, our Department cannot grant an extension of the time for which the POC is to be submitted.

Failure to submit a POC which includes the above-listed components and in the mandated timeframes will result in our Department imposing or recommending immediate imposition of remedies and/or termination from the Medicare and/or Medicaid programs.

In some cases, while certain provisions of the LSC might not be met but the facility provides a reasonable degree of fire safety, an Annual Waiver may be requested with proper justification. The Annual Waiver justification must include facility fire safety characteristics to support granting of the waiver would not adversely affect patient health and safety and would impose an unreasonable hardship on the facility. **For those cases of unreasonable hardship an actual estimate from a licensed contractor or consulting firm in support of the statement of estimated cost must be submitted along with justification to support how this is a financial hardship. Details of how resident safety will be protected if the deficiency is not corrected must also be included in the waiver request.** The Annual Waiver request must provide specific information described in the State Operations Manual (Section 2480) and must be signed and dated by the facility's representative. One (1) Annual Waiver request form (Enclosure #4) must be completed, signed and dated for each K tag/deficiency. Only Plans of Correction (POCs) or Annual Waivers will be accepted and reviewed for deficiencies at Levels "B" and/or "C". Notification of CMS approval or denial of Annual Waiver requests will be issued by our Department when received from the Regional Office of the Centers for Medicare and Medicaid Services (CMS).

The Regional CMS Office has authorized our Department to review and issue notice of our approval of Temporary Waivers up to 12 months duration from the survey cycle date for Medicare/Medicaid certified nursing homes. The Temporary Waiver response/request must address increased fire safety awareness as required by the State Operation Manual (Section 7410F1) to be deemed acceptable. **The Temporary Waiver request must include benchmarking correction to justify the date of completion, financial information to justify the waiver request and safeguards for residents in the facility until the end of the waiver period. If corrective actions include modifications to the sprinkler system and/or fire alarm system or building exit access, the Licensure Plan/Review Unit must be consulted prior to modification to determine the need for project plan submission to ensure Code compliance.** You will be notified of Department approval of the request following review of all POC documents. Temporary Waivers for more than 12 months from the survey cycle date will be forwarded to CMS for review. Notification of CMS approval or denial of these requests will be issued by our Department when received from CMS. The Temporary Waiver request form must be completed, signed and dated by the facility's representative. One (1) Temporary Waiver request form (Enclosure #4A) must be completed, signed and dated for each K tag/deficiency. Temporary Waiver requests will not be accepted or reviewed for deficiencies at Levels "B" and/or "C". If any deficiency cited on the Annual LSC survey has a previously requested Temporary Waiver on file, the POC response submitted for that deficiency for the Annual survey cannot exceed the date previously requested. **[NOTE: The survey cycle date is included in the information reference block on the first page of the "Initial Notice" accompanying the LSC Statement of Deficiencies.]**

PLEASE SUBMIT THE ABOVE EVIDENCE WITHIN 30 DAYS OF THE LSC SURVEY EXIT DATE.

The facility may request an "Informal Dispute Resolution" (IDR) to challenge any deficiency that renders the facility not in substantial compliance (Level "D" or above). The facility may only question whether or not a deficiency existed at the time of the survey, not the scope/severity or any recommended or imposed remedies. **The IDR process will not delay the effective date of any enforcement action!** If the facility requests an IDR without submitting an acceptable POC and the Department's decision, as a result of the process, does not result in the deletion of the deficiency, our Department will then proceed to impose or recommend immediate imposition of remedies, to include termination from the Medicare and/or Medicaid programs. The provider is allowed one (1) opportunity for IDR. (See Enclosure #3)

Please submit all documents or other materials relating to this survey to:

Illinois Department of Public Health
Division of Long-Term Care, Field Operations
Quality Review Section; Attention: Jon Siegel
525 West Jefferson, Fifth Floor
Springfield, Illinois 62761-0001

If you have questions concerning this notice, please contact my staff at the above address or telephone (217) 782-5180. You may also telephone the Department's TTY number (hearing impaired use only) at 1-800-547-0466.

Sincerely,

Richard L. Dees

Richard L. Dees, Chief
Bureau of Long-Term Care

- 217
785-4200

Enclosures

cc: State Medicaid Agency
IL Department on Aging
Joel Atkin, Registered Agent
File (3)

LISC/after 03152010/as/TP

Effective March 15, 2010, if a deficiency is to be addressed through a Fire Safety Evaluation System (FSES) the provider is responsible for completion of the FSES to include Table of Alternates. The FSES must be submitted within ten (10) calendar days after receipt of the written "Statement of Deficiencies" (CMS-2567) along with the POC. CMS will not allow Temporary Waivers to allow time to conduct the FSES. An inability to submit the FSES will not delay the effective date of any enforcement action. (Enclosure #5)

Informal dispute resolution (IDR) information must be submitted within ten (10) calendar days after receipt of the CMS-2567.

Annual Waivers may not be used in conjunction with the Fire Safety Evaluation System (FSES) to achieve compliance.

CMS has the final authority to approve or deny all Annual and Temporary Waiver and FSES requests.

If the facility is subject to a LSC Federal Monitoring Survey (FMS), that survey will in most instances become part of an existing enforcement cycle. No revisit activity for the Annual LSC will occur until our office has received authorization from the Regional CMS Office to conduct a revisit for the FMS survey. The Regional CMS Office has final authority for review and approval of POCs, Waiver requests and FSES requests for the LSC FMS. All inquiries regarding Denial of Payments for New Admissions (DOPNA) in these cases should be made to the CMS Illinois Principal Program Representative.

Before a revisit will be scheduled, the facility must provide to the Department an acceptable POC for all deficiencies. An acceptable POC will also serve as the facility's allegation of compliance, thereby signifying the facility attests it will be in substantial compliance with all federal certification requirements. Based upon the acceptable POC, a revisit will be conducted to verify compliance.

SUBMISSION OF EVIDENCE IN LIEU OF AN ONSITE FOLLOW-UP REVISIT

Based upon the scope and severity level of the LSC deficiencies cited, the facility may be considered eligible to submit evidence in lieu of an onsite revisit. This evidence must be submitted within thirty days of the survey exit date, should be clearly separated by tag number, and should show that the facility has:

1. Put into place systemic changes as identified in its Plan of Correction to ensure that the deficient practices will not recur, and;
2. Initiated a program to monitor the continued effectiveness of its Plan of Correction.

Evidence of correction should include documentation such as copies of written policies and procedures, completed (i.e., filled out) monitoring sheets, outline of in-service programs, in-service attendance sheets, quality assurance monitoring reports, committee minutes, licenses or other credentials, invoices, receipts, photographs or other credible evidence. If the evidence that the facility submits is determined by the Department to show correction of the deficiencies, an on-site health revisit will not be conducted. If the evidence does not prove correction, or is not submitted in a timely manner, an on-site revisit will be scheduled. Evidence will be reviewed during revisit activity (not during POC review) by the Architect that conducted the Annual survey. All evidence submitted for review must be legible. Please be aware that copies of photographs sent via facsimile generally are not legible and may result in a request for other documents.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2010
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS SURVEY, McALLISTER NURSING HOME WAS FOUND NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE. THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0103: ONE STORY BUILDING WITH TWO PARTIAL BASEMENTS WAS DETERMINED TO BE A TYPE 111[211] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS AND SPACES OPEN TO THE CORRIDORS. THE BUILDING IS TOTALLY SPRINKLERED WITH THE EXCEPTION OF THE EAVES FOR BUILDING 0103. THE FACILITY HAS A CAPACITY OF 111 BEDS WITH A CENSUS OF 96 AT THE TIME OF THE SURVEY. THE REQUIREMENT AT 42 CFR SUBPART 483.70(a) IS NOT MET AS EVIDENCED BY: NFPA 101 LIFE SAFETY CODE STANDARD	K 000		
K 018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Guadalupe Yllaga* TITLE *Asst Adm* (X6) DATE *4/23/10*

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ATTACHMENT - 11D

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 1</p> <p>required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO ENSURE THAT ALL CORRIDOR DOORS WERE PROVIDED BY A MEANS OF CLOSURE PROVIDING A SMOKE RESISTING CONDITION. AS REQUIRED BY NFPA 101, 20000 EDITION, SECTION 19.3.6.3. THIS DEFICIENT PRACTICE COULD EFFECT APPROXIMATELY 11 RESIDENTS IN FIRE ALARM ZONE #07 AND AN UNKNOWN NUMBER OF STAFF AND VISITORS IN THE EVENT OF A FIRE. THE FINDING IS:</p> <p>ON April 02, 2010 AT APPROXIMATELY 1:45 PM, WHILE IN THE COMPANY OF E-1[DIRECTOR OF MAINTENANCE], THE DOOR TO THE SMOKING ROOM WAS NOTED TO LACK A LATCH TO SECURE CLOSURE. THIS DOOR OPENS ONTO THE MAIN EGRESS ACCESS CORRIDOR.</p>	K 018		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2	K 018		
K 067 SS=E	E-1 CONCURRED WITH THE FINDING. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE A DUCTED AIR SYSTEM THAT PROTECTED THE RESIDENT ROOMS FROM AIR EXCHANGE WITH THE EXIT CORRIDOR AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 19.5.2.1, 9.2, NFPA 90A AND 19.6.2.2. THIS DEFICIENT PRACTICE COULD EFFECT APPROXIMATELY 28 RESIDENTS AND INNUMERABLE STAFF AND VISITORS IN FIRE ALARM ZONE #5. THE FINDING IS: ON April 02, 2010 AT APPROXIMATELY 12:10 PM, WHILE IN THE COMPANY OF E-1, IT WAS OBSERVED THAT TWO DUCTS PASSED THROUGH THE OUTSIDE WALL OF THE BUILDING THROUGH THE CORRIDOR WALL INTO THE CORRIDOR CEILING. THIS DUCTING WAS NOT INSULATED AND NO DAMPER WAS IN PLACE AT ANY POINT OF SMOKE CONTROL. THE DUCTS WERE FEEDING FROM AND TO AIR UNITS AT THE GROUND LEVEL OUTSIDE OF THE BEDROOM WINDOW. E-1 CONCURRED WITH THE FINDING.	K 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>MAIN BUILDING 01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2010
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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K 000	<p>INITIAL COMMENTS</p> <p>AN ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS: BUILDING 0203: ONE STORY BUILDING WITH NO BASEMENT WAS DETERMINED TO BE A TYPE 111[200] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTION.</p> <p>THE BUILDING IS TOTALLY SPRINKLERED.</p> <p>THE FACILITY HAS A CAPACITY OF 111 BEDS WITH A CENSUS OF 96 AT THE TIME OF THE SURVEY.</p>	K 000		
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by:</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 038	<p>Continued From page 1</p> <p>BASED ON OBSERVATION AND STAFF INTERVIEW, THE FACILITY FAILED TO PROVIDE READILY ACCESSIBLE EXIT PASSAGE AT ALL TIMES AS REQUIRED BY NFPA 101, 2000 EDITION, SECTIONS 7.1 AND 19.2.1. THIS DEFICIENT PRACTICE COULD EFFECT ALL 4 RESIDENTS SEEN IN THE DINING ROOM[S] IN ADDITION TO NUMEROUS STAFF AND VISITORS IN THE FIRE ALARM ZONE #12. THE FINDING IS AS FOLLOWS:</p> <p>ON April 02, 2010 AT APPROXIMATELY 2:00 PM, WHILE IN THE COMPANY OF E-1, IT WAS OBSERVED THAT THE EXIT DOOR TO THE OUTSIDE FROM BUILDING 0203 WAS LOCKED AND COVERED AS WELL AS SIGNED TO NOT USE.</p> <p>E-1 CONCURRED WITH THE FINDINGS.</p>	K 038		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2010
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>AN ANNUAL LIFE SAFETY CODE (LSC) CERTIFICATION SURVEY WAS CONDUCTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. AT THIS SURVEY, McALLISTER NURSING HOME WAS FOUND NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS FOR PARTICIPATION IN MEDICARE/MEDICAID AT 42 CFR SUBPART 483.70(a), LIFE SAFETY FROM FIRE, AND THE 2000 EDITION OF THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101, LIFE SAFETY CODE, CHAPTER 19 EXISTING HEALTH CARE.</p> <p>THE FACILITY WAS SURVEYED AS THREE SEPARATE BUILDINGS. BUILDING 0303: ONE STORY BUILDING WITH A PARTIAL BASEMENT WAS DETERMINED TO BE A TYPE 111[000] CONSTRUCTION. THE FACILITY HAS AN AUTOMATIC FIRE ALARM SYSTEM WITH SMOKE DETECTORS AT CORRIDORS, SPACES OPEN TO THE CORRIDORS AND RESIDENT ROOMS[TIED TO THE DOOR CLOSURES].</p> <p>THE BUILDING IS TOTALLY SPRINKLERED..</p> <p>THE FACILITY HAS A CAPACITY OF 111 BEDS WITH A CENSUS OF 96 AT THE TIME OF THE SURVEY.</p> <p>THE REQUIREMENT AT 42 CFR SUBPART 483.70(a) IS NOT MET AS EVIDENCED BY:</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Illinois Department of

PUBLIC HEALTH

Pat Quinn, Governor

Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

February 23, 2011

BY CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Elisha Atkin, Administrator
McAllister Nsg & Rehb
18300 S Lavergne Avenue
Tinley Park, Illinois 60477

Reference: Provider #: 145967/0049502
Cycle Date: 01/27/11
Survey Date: 01/27/11
Survey Type: Annual Life Safety Code
Highest S/S: "F", K52

Dear Administrator:

On 01/27/11, an Annual Life Safety Code (LSC) inspection was conducted at the above-named facility by staff of the Illinois Department of Public Health to determine compliance with federal certification requirements for nursing homes participating in the Medicare and/or Medicaid programs. As a result of that survey, the facility was determined to not be in "Substantial Compliance" with regulatory requirements as found in Title 42, Code of Federal Regulations. A "Statement of Deficiencies," (Form CMS-2567) is enclosed.

Based on the LSC deficiencies, the following remedies are proposed:

- Denial of Payment for New Admissions three (3) months from the LSC survey date; and
- Termination from the Medicare and/or /Medicaid programs six (6) months from the LSC survey date.

The facility must submit a Plan of Correction (POC) for all deficiencies at "B" Level or higher; Level "A" deficiencies must be corrected, but do not require a written POC. All required POCs must be submitted to the Department within ten (10) calendar days after receipt of the written "Statement of Deficiencies." The POC cannot be submitted on the CMS-2567, but on separate sheets of paper which are attached to the first page of the CMS-2567. The first page of the CMS-2567 must be returned with the facility representative's signature and date. The POC is not to be used to dispute a deficiency or to make comments about the survey process. Information disputing a deficiency may be provided through the informal dispute resolution (IDR) process on the enclosed form, and, if necessary, separate sheets of paper; comments about the survey process may be provided on the enclosed Provider Feedback Survey. In order for a POC to be acceptable, it must:

1. Address corrective actions taken and/or how the deficiency will be corrected;
2. Address actions the facility will take to assure that no other examples of the deficiency exist in other parts of the building. Cited deficiencies may not identify all locations where a condition may occur. It is the facility's responsibility to review its building to assure similar conditions do not exist in other areas;

3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plan to monitor its performance to make sure those solutions is sustained
The facility must develop a plan for ensuring that correction is achieved and sustained. This Sustained must be implemented, and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the quality assurance system; and
5. Include a specific date when corrective action will be completed not later than 03/13/11 for any deficiency at Level "D" or higher.

See the ORANGE attachment that further explains POC requirements for Life Safety Code

Further, in accordance with the State Operations Manual (Sections 7304D and 7316), the facility must submit POCs to the Department within ten (10) calendar days after receipt of the CMS-2567. Therefore, our Department cannot grant an extension of the time for which the POC is to be submitted.

Failure to submit a POC which includes the above-listed components and in the mandated timeframes will result in our Department imposing or recommending immediate imposition of remedies and/or termination from the Medicare and/or Medicaid programs.

In some cases, while certain provisions of the LSC might not be met but the facility provides a reasonable degree of fire safety, an Annual Waiver may be requested with proper justification. The Annual Waiver justification must include facility fire safety characteristics to support granting of the waiver would not adversely affect patient health and safety and would impose an unreasonable hardship on the facility. For those cases of unreasonable hardship an actual estimate from a licensed contractor or consulting firm in support of the statement of estimated cost must be submitted along with justification to support how this is a financial hardship. Details of how resident safety will be protected if the deficiency is not corrected must also be included in the waiver request. The Annual Waiver request must provide specific information described in the State Operations Manual (Section 2480) and must be signed and dated by the facility's representative. One (1) Annual Waiver request form (Enclosure #4) must be completed, signed and dated for each K tag/deficiency. Only Plans of Correction (POCs) or Annual Waivers will be accepted and reviewed for deficiencies at Levels "B" and/or "C". Notification of CMS approval or denial of Annual Waiver requests will be issued by our Department when received from the Regional Office of the Centers for Medicare and Medicaid Services (CMS).

The Regional CMS Office has authorized our Department to review and issue notice of our approval of Temporary Waivers up to 12 months duration from the survey cycle date for Medicare/Medicaid certified nursing homes. The Temporary Waiver response/request must address increased fire safety awareness as required by the State Operation Manual (Section 7410F1) to be deemed acceptable. The Temporary Waiver request must include benchmarking correction to justify the date of completion, financial information to justify the waiver request and safeguards for residents in the facility until the end of the waiver period. If corrective actions include modifications to the sprinkler system and/or fire alarm system or building exit access, the Licensure Plan/Review Unit must be consulted prior to modification to determine the need for project plan submission to ensure Code compliance. You will be notified of Department approval of the request following review of all POC documents. Temporary Waivers for more than 12 months from the survey cycle date will be forwarded to CMS for review. Notification of CMS approval or denial of these requests will be issued by our Department when received from CMS. The Temporary Waiver request form must be completed, signed and dated by the facility's representative. One (1) Temporary Waiver request form (Enclosure #4A) must be completed, signed and dated for each

K tag/deficiency. Temporary Waiver requests will not be accepted or reviewed for deficiencies at Levels "B" and/or "C".

If any deficiency cited on the Annual LSC survey has a previously requested Temporary Waiver on file, the POC response submitted for that deficiency for the Annual survey cannot exceed the date previously requested. [NOTE: The survey cycle date is included in the information reference block on the first page of the "Initial Notice" accompanying the LSC Statement of Deficiencies.]

Effective March 15, 2010, if a deficiency is to be addressed through a Fire Safety Evaluation System (FSES) the provider is responsible for completion of the FSES to include Table of Alternates. The FSES must be submitted within ten (10) calendar days after receipt of the written "Statement of Deficiencies" (CMS-2567) along with the POC. CMS will not allow Temporary Waivers to allow time to conduct the FSES. An inability to submit the FSES will not delay the effective date of any enforcement action. (Enclosure #5)

Informal dispute resolution (IDR) information must be submitted within ten (10) calendar days after receipt of the CMS-2567.

Annual Waivers may not be used in conjunction with the Fire Safety Evaluation System (FSES) to achieve compliance.

CMS has the final authority to approve or deny all Annual and Temporary Waiver and FSES requests.

If the facility is subject to a LSC Federal Monitoring Survey (FMS), that survey will in most instances become part of an existing enforcement cycle. No revisit activity for the Annual LSC will occur until our office has received authorization from the Regional CMS Office to conduct a revisit for the FMS survey. The Regional CMS Office has final authority for review and approval of POCs, Waiver requests and FSES requests for the LSC FMS. All inquiries regarding Denial of Payments for New Admissions (DOPNA) in these cases should be made to the CMS Illinois Principal Program Representative.

Before a revisit will be scheduled, the facility must provide to the Department an acceptable POC for all deficiencies. An acceptable POC will also serve as the facility's allegation of compliance, thereby signifying the facility attests it will be in substantial compliance with all federal certification requirements. Based upon the acceptable POC, a revisit will be conducted to verify compliance.

SUBMISSION OF EVIDENCE IN LIEU OF AN ONSITE FOLLOW-UP REVISIT

Based upon the scope and severity level of the LSC deficiencies cited, the facility may be considered eligible to submit evidence in lieu of an onsite revisit. This evidence must be submitted within thirty days of the survey exit date, should be clearly separated by tag number, and should show that the facility has:

1. Put into place systemic changes as identified in its Plan of Correction to ensure that the deficient practices will not recur, and;
2. Initiated a program to monitor the continued effectiveness of its Plan of Correction.

Evidence of correction should include documentation such as copies of written policies and procedures, completed (i.e., filled out) monitoring sheets, outline of in-service programs, in-service attendance sheets, quality assurance monitoring reports, committee minutes, licenses or other credentials, invoices, receipts, photographs or other credible evidence. If the evidence that the facility submits is determined by the Department to show correction of the deficiencies, an on-site health revisit will not be conducted. If the evidence does not prove correction, or is not submitted in a timely manner, an on-site revisit will be scheduled. Evidence will be reviewed during revisit activity (not during POC review) by the Architect that conducted the Annual survey. All evidence submitted for review must be legible. Please be aware that copies of photographs sent via facsimile generally are not legible and may result in a request for other documents.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 1</p> <p>minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that corridor doors were able to resist the passage of smoke, having no impediment to the closing of the door to a latched position when needed, as required by NFPA 101, 2000 Edition, Section 19.3.6.3. This deficient practice could effect 50 residents located in two smoke zones in addition to numerous staff and visitors in Building 0103 in the event of a fire. The finding is:</p> <p>On January 27, 2011 between 1:30 and 2:00 PM, while in the company of E-1(Director of Maintenance) and E-2(Director of Housekeeping), it was observed that the privacy curtains for the resident bed proximal to the corridor door are developing a pattern of blocking the bedroom doors in Zones #2 and 5 upon closure of the door. This was specifically noted for Rooms #115 and 114. Other doors were tested and the some condition occurred.</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
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K 018	Continued From page 2	K 018		
K 046 SS=C	E-1 and E-2 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046		
	<u>This STANDARD is not met as evidenced by:</u> Based on record review, the facility failed to ensure that the emergency lighting source for the repair of the emergency generator was tested for a capacity of 90 minutes operation time on an annual basis as required by NFPA 101, 2000 Edition, Sections 7.9 and 19.2.9.1. This deficient practice could result in loss of any light to repair a generator during a loss of usual power, effecting all 98 residents and untold numbers of staff and visitors. The finding is: On January 27, 2011 at approximately 11:40 AM, review of the testing records from the facility for all battery operated emergency lighting devices was found to not include any record of having tested the emergency light maintained for the emergency generator.			
K 052 SS=F	E-1 and E-2 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3	K 052		
K 062 SS=F	<p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that the Fire Alarm System was properly protected with a smoke detector proximal to its' location, as required by NFPA 101, 2000 Edition, Section 9.6.1.4 and NFPA 70 and 72. This deficient practice could cause a lack of warning if the Fire Control Panel became endangered, possibly effecting residents in the 0102 building, or approximately 17 residents and an unknown number of staff and visitors. The finding is:</p> <p>On January 27, 2011, at approximately 1:10 PM, while in the company of E-1 and E-2, the fire panel located in a room immediately across from the central Nursing Station in Building 0103 was observed to be lacking a smoke detector.</p> <p>E-1 and E-2 concurred with the finding.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Fire Suppression System was</p>	K 062		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 maintained so as to be ready for immediate use in an emergency situation as required by NFPA 101, 2000 Edition, Section 19.7.6 and 4.6.12 and NFPA 25, Section 9.75 and 8.3. This deficient practice could effect any of the five smoke zones (serving resident needs) in any of the three buildings, each containing approximately 20 residents on the day of the survey. The finding is: On January 27, 2011 at approximately 10:25 AM, review of facility fire Suppression System records did not locate any records showing that the fire pump had been churmed on a weekly basis.	K 062		
K 067 SS=F	E-1 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Heating, Ventilating and Air Conditioning Systems ([HVAC's]) components were properly maintained to ensure that fire dampers properly responded in the event of fire, as is required by NFPA 90A, 1999, Section 3-4.7. This deficient practice could effect any one of eight smoke zones containing approximately 30 residents each in addition to numerous staff and visitors. The finding is: On January 27, 2011 at approximately 12:05 PM,	K 067		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 5 review of Fire Alarm System/HVAC component records from service contractors' failed to locate any report reflecting a four-year periodic evaluation/functional test of fire dampers for any of the buildings.	K 067		
K 144 SS=F	E-1, E-2 and E-3(Chief Executive Officer) concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on review of documentation provided by the facility, there was a failure to ensure that the emergency generator was inspected each week and exercised under load one time per month, as required by NFPA 110, Section 8.4.2 and NFPA 99 Section 3.4.4.1. This deficient practice could result in no available emergency generator back-up available in the event of a power loss, effecting all 98 residents and unknown numbers of staff and visitors. The finding is: On January 27, 2011 at approximately 11:15 AM, review of the documentation for the weekly and monthly inspection/exercise of the emergency generator could not locate any recorded information as regards:	K 144		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 6 time for load transfer (monthly) amount of load transferred (monthly) function of components fluid levels observation of critical components functioning	K 144		
K 146 SS=F	E-1 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the emergency generator performed for a 90 minute period/was capable of providing for the emergency life safety system(s) for a 90 minute period of time, as required by NFPA 99, Section 3.6. This deficient practice could result in a total loss of power to essential systems in an emergency situation, effecting 98 residents and an unknown number of staff and visitors. The findings are: On January 27, 2011 at approximately 11:10 AM, review of the facility's documentation for maintenance of the generator system could not locate any record of the emergency generator having been exercised for a period of 90 minutes in the last 12 month period. E-1 concurred with the finding.	K 146		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>1133 IN BUILDING 01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER MCCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477
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PLEASE SUBMIT THE ABOVE EVIDENCE WITHIN 30 DAYS OF THE LSC SURVEY EXIT DATE.

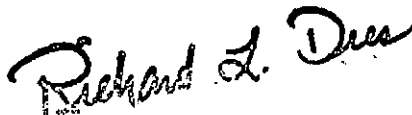
The facility may request an "Informal Dispute Resolution" (IDR) to challenge any deficiency that renders the facility not in substantial compliance (Level "D" or above). The facility may only question whether or not a deficiency existed at the time of the survey, not the scope/severity or any recommended or imposed remedies. **The IDR process will not delay the effective date of any enforcement action!** If the facility requests an IDR without submitting an acceptable POC and the Department's decision, as a result of the process, does not result in the deletion of the deficiency, our Department will then proceed to impose or recommend immediate imposition of remedies, to include termination from the Medicare and/or Medicaid programs. The provider is allowed one (1) opportunity for IDR. (See Enclosure #3)

Please submit all documents or other materials relating to this survey to:

Illinois Department of Public Health
Division of Long-Term Care, Field Operations
Quality Review Section; Attention: Jon Siegel
525 West Jefferson, Fifth Floor
Springfield, Illinois 62761-0001

If you have questions concerning this notice, please contact my staff at the above address or telephone (217) 782-5180. You may also telephone the Department's TTY number (hearing impaired use only) at 1-800-547-0466.

Sincerely,



Richard L. Dees, Chief
Bureau of Long-Term Care

Enclosures

cc: State Medicaid Agency
IL Department on Aging
Joel Atkin, Registered Agent
File (3)

LISC/after 03152010/ns/DM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 1 requirements of NFPA 70 and 72. 9.6.1.4	K 052		
K 062 SS=F	<p>This STANDARD is not met as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Fire Suppression System was maintained so as to be ready for immediate use in an emergency situation as required by NFPA 101, 2000 Edition, Section 19.7.6 and 4.6.12 and NFPA 25, Section 9.75 and 8.3. This deficient practice could effect any of the five smoke zones (serving resident needs) in any of the three buildings, each containing approximately 20 residents on the day of the survey. The finding is:</p> <p>On January 27, 2011 at approximately 10:25 AM, review of facility fire Suppression System records did not locate any records showing that the fire pump had been churned on a weekly basis.</p> <p>E-1 concurred with the finding.</p>	K 062		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
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K 067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Heating, Ventilating and Air Conditioning Systems ([HVAC's]) components were properly maintained to ensure that fire dampers properly responded in the event of fire, as is required by NFPA 90A, 1999, Section 3-4.7. This deficient practice could effect any one of eight smoke zones containing approximately 30 residents each in addition to numerous staff and visitors. The finding is:</p> <p>On January 27, 2011 at approximately 12:05 PM, review of Fire Alarm System/HVAC component records from service contractors' failed to locate any report reflecting a four-year periodic evaluation/functional test of fire dampers for any of the buildings.</p> <p>E-1, E-2 and E-3(Chief Executive Officer) concurred with the finding.</p>	K 067		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of documentation provided by the facility, there was a failure to ensure that the emergency generator was inspected each week and exercised under load one time per month, as required by NFPA 110, Section 8.4.2 and NFPA 99 Section 3.4.4.1. This deficient practice could result in no available emergency generator back-up available in the event of a power loss, effecting all 98 residents and unknown numbers of staff and visitors. The finding is: On January 27, 2011 at approximately 11:15 AM, review of the documentation for the weekly and monthly inspection/exercise of the emergency generator could not locate any recorded information as regards: <ul style="list-style-type: none"> . time for load transfer (monthly) . amount of load transferred (monthly) . function of components . fluid levels . observation of critical components functioning 	K 144		
K 146 SS=F	E-1 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1	K 146		

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K 146	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the emergency generator performed for a 90 minute period/was capable of providing for the emergency life safety system(s) for a 90 minute period of time, as required by NFPA 99, Section 3.6. This deficient practice could result in a total loss of power to essential systems in an emergency situation, effecting all 98 residents and numerous staff and visitors. The findings are: On January 27, 2011 at approximately 11:10 AM, review of the facility's documentation for maintenance of the generator system could not locate any record of the emergency generator having been exercised for a period of 90 minutes in the last 12 month period. E-1 concurred with the finding.	K 146			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145967	(X2) MULTIPLE CONSTRUCTION A. BUILDING NO. 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 1	K 062		
K 067 SS=F	<p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Fire Suppression System was maintained so as to be ready for immediate use in an emergency situation as required by NFPA 101, 2000 Edition, Section 19.7.6 and 4.6.12 and NFPA 25, Section 9.75 and 8.3. This deficient practice could effect any of the five smoke zones (serving resident needs) in any of the three buildings, each containing approximately 20 residents on the day of the survey. The finding is:</p> <p>On January 27, 2011 at approximately 10:25 AM, review of facility fire Suppression System records did not locate any records showing that the fire pump had been churned on a weekly basis.</p> <p>E-1 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the Heating, Ventilating and Air Conditioning Systems ([HVAC's]) components were properly maintained to ensure that fire dampers properly responded in the event of fire, as is required by NFPA 90A, 1999, Section 3-4.7.</p>	K 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145987	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 19300 S. LAVERGNE AVE TINLEY PARK, IL 60477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 067	Continued From page 2 This deficient practice could effect any one of eight smoke zones containing approximately 30 residents each in addition to numerous staff and visitors. The finding is: On January 27, 2011 at approximately 12:05 PM, review of Fire Alarm System/HVAC component records from service contractors failed to locate any report reflecting a four-year periodic evaluation/functional test of fire dampers for any of the buildings. E-1, E-2 and E-3(Chief Executive Officer) concurred with the finding.	K 067			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on review of documentation provided by the facility, there was a failure to ensure that the emergency generator was inspected each week and exercised under load one time per month, as required by NFPA 110, Section 8.4.2 and NFPA 99 Section 3.4.4.1. This deficient practice could result in no available emergency generator back-up available in the event of a power loss, effecting all 98 residents and unknown numbers of staff and visitors. The finding is:	K 144			

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 19300 S. LAVERGNE AVE TINLEY PARK, IL 60477
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K 144	Continued From page 3 On January 27, 2011 at approximately 11:15 AM, review of the documentation for the weekly and monthly inspection/exercise of the emergency generator could not locate any recorded information as regards: <ul style="list-style-type: none"> . time for load transfer (monthly) . amount of load transferred (monthly) . function of components . fluid levels . observation of critical components functioning 	K 144		
K 146 SS=F	E-1 concurred with the finding. NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that the emergency generator performed for a 90 minute period/was capable of providing for the emergency life safety system(s) for a 90 minute period of time, as required by NFPA 99, Section 3.6. This deficient practice could result in a total loss of power to essential systems in an emergency situation, effecting all 98 residents and numerous staff and visitors. The findings are: On January 27, 2011 at approximately 11:10 AM, review of the facility's documentation for	K 146		

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NAME OF PROVIDER OR SUPPLIER MCALLISTER NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 18300 S. LAVERGNE AVE TINLEY PARK, IL 60477
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K 146	Continued From page 4 maintenance of the generator system could not locate any record of the emergency generator having been exercised for a period of 90 minutes in the last 12 month period. E-1 concurred with the finding.	K 146		

SALK & ASSOCIATES LLC
CONSULTANTS

ARTHUR P. SALK

630 DUNDEE ROAD, SUITE 120
NORTHBROOK, ILLINOIS 60062

TEL 847.828.4313
FAX 847.480.7882
E-MAIL ASALK@SALKASSOCLLC.COM

November 10, 2011

Attn: Michael Constantino
Health Facilities and Services Renew Board
Supervisor, Project Review Section
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: McAllister Nursing Home

Dear Mr. Constantino:

The purpose of this letter is to explain why the McAllister Nursing Home should be replaced with a new facility.

The following descriptive material of the facility, the attached schematic floor plan of the existing facility, survey analysis, and costs will confirm the facility should be replaced.

Due to the fact that it was constructed in three phases on a narrow site, the ultimate result was a design which did nothing to augment the delivery of appropriate nursing care. The initial nursing home was constructed in 1967, the first addition to the east of the original building in 1974 with the last addition to the west in 1995. The total length of the one story with partial basements is approximately 600 ft. long or twice the length of a football field. The main 8-ft. corridor is over 500 feet from end to end. The kitchen located in the first addition to the east is 350 feet from the west addition dining room.

The original building and first addition are constructed of masonry wall bearing with an exposed precast concrete roof. Most interior partitions are painted concrete block. The bed lights are connected with wire mold attached to the surface of the walls.

The construction of the last addition is masonry wall bearing and wood trussed roof. Interior walls are steel stud and drywall.

Of the total licensed beds; there are 4-four bedrooms without toilets, 4-two bedrooms with small shared toilets, and 13-three bedrooms, one without a toilet. Since the home is currently licensed for 111 beds, over fifty percent of the beds are in three and four bedrooms.

Asbestos was observed on piping and under the floor tile in the original building. Therefore, asbestos abatement will be required prior to any remodeling. That portion of the facility will have to be vacated during the abatement period.

Mechanical Systems, especially in the 1967 and 1974 buildings are at the end of useful life. I counted at least six old air conditioned condensing units being repaired at the time of my walk-thru on May 3, 2011.

Please refer to the attached schematic floor plan of the existing structure.

On August 31, 2011, a site inspection was made to evaluate the extent of construction required to bring the facility into compliance to the applicable codes and basic physical plant deficiencies.

Assisting me were Keith Tyschper, AIA, LEED. AP. of Harley Ellis Devereaux Architects, Donnell P.D. LEEDS. AP, of the Martin Peterson Co., and Joe Wilock of Jolen Electric. Skender Construction provided the consolidated proposed construction budget.

Attached are documents that reflect our collaborative effort to describe the work and costs relating to any consideration to rehabilitate the existing facility.

The licensed capacity would have to be reduced from one hundred eleven (111) beds to ninety-six (96) beds in order to comply with applicable codes, rules and regulations. IDPH Rules and Regulations for existing nursing homes require that if the cost of remodeling of any existing nursing home exceeds fifty percent (50%) of the replacement cost, then the facility must meet the standards for new construction.

The construction budget is estimated to be \$12,473,487.00 or \$112,373.00 per bed. The construction budget for a new one hundred eleven (111) bed replacement facility is estimated to be \$13,841,000 or \$124,693.00 per bed.

The construction budget for the proposed new facility is \$20,868,326.00 or \$104,341.00 per bed.

If rehabilitation is contemplated, due to the magnitude of the construction and the asbestos removal, a significant number of patients would have to be relocated. As previously stated, the existing facility with corridors in excess of six hundred feet long is inappropriate for any healthcare related facility.

In conclusion, it is my professional opinion that the existing structure should be demolished. The patients, their families, future clientele and the community would be better served by the proposed new nursing home.

Sincerely,



Arthur Phillip Salk, AIA Emeritus NCARB
License 001.003766

APS/rb

ATTACHMENT-11E



CORPORATE OFFICE
200 W. Madison, Suite 1300
Chicago, IL 60606
Tel: 312.781.0265
Fax: 312.781.0279
www.skender.com

Mr. Art Salk
Salk and Associates
630 Dundee Road
Northbrook, IL 60062

Re: McAllister Nursing Home Code Compliance Costs

Dear Art,

This letter is in response to your request to survey, analyze, and provide costs to bring the existing McAllister Nursing Home in Country Club Hills, IL into compliance with applicable codes.

Harley Ellis Devereaux Architects provided a report with the deficiencies of the building and we have provided an estimate of repair costs. Please note that these options are not feasible and would come with great inconvenience in disruption to the facility. Costs of temporary protection were not included in this estimate and are separated below.

Jolen Electric analyzed the existing electrical systems and have provided an estimate to complete work associated with the same.

Martin Petersen Company analyzed the existing mechanical systems and have provided an estimate to complete work associated with the same.

To perform the work associated with these various reports, to bring the building into compliance as detailed, we propose the following budget:

- Harley Ellis Devereaux Recommendations - \$5,865,500
- Jolen Electric Recommendations - \$941,680
- MPC Recommendations - \$2,657,000
- Contingency (15%) - \$1,419,627
- General Conditions/Requirements - \$870,705
- Temporary Construction - \$125,000
- Profit and Overhead - \$593,975

TOTAL PROPOSED BUDGET: \$12,473,487



CORPORATE OFFICE
200 W. Madison, Suite 1300
Chicago, IL 60606
Tel 312.781.0265
Fax 312.781.0279
www.skender.com

We appreciate the opportunity to present this proposal to you and look forward to discussing it further with you.

Let me know if you have any questions.

Regards,

A handwritten signature in black ink, appearing to read 'B. Simons', is written over a horizontal line.

Brian Simons
Project Manager
Skender Construction

Encl. Jolen Report and Estimate
MPC Report and Estimate
Harley Ellis Devereaux Report

cc. File



September 7, 2011 DRAFT

RE: McAllister Nursing Home
#2011-40038-000

401 West Superior
Chicago, Illinois
60654-3430 | USA

t 312.951.8883

f 312.951.1718

harley@hedeveaux.com

A. Life Safety [Per NFPA Life Safety Code 2000 (LSC)]

The existing building contains design elements that may have been permissible at the time of initial construction, but are no longer permitted. The following observations of the building's current conditions are not intended to suggest that the safety of the residents is being compromised, but instead identify the changes to life safety requirements and public health regulations since the building and subsequent additions were built.

- 1. **Corridor Fire Doors:** The Life Safety Code requires pairs of corridor doors to swing opposite from one another to allow egress from either side. In at least five locations in the corridor, doors were observed that swing against the direction of egress. This condition grandfathered into acceptance (LSC 19.2.2.5.3), but may contribute to difficulties in evacuating residents in the event of an emergency.

A remedy of the existing condition would include the construction of new fire walls around the frames from the floor to the structure above (LSC 8.2.2.2) to eliminate door swing encroachment on other means of egress. At many of these doors, neither the door slab nor the frame is labeled to identify the required fire rating. We estimate the cost of this work to replace the doors and walls and fire alarm system activated hold opens will be \$ 65,000.

- 2. **Egress through Living/Dining Rooms:** In some locations, it was observed that the means of egress passes through secondary common spaces (i.e. Dining Room and Solarium/Open Office Area). Currently, it is not permissible to pass from an egress corridor through a room in the way to an exit (LSC 10.2.5.9). The estimate to create a corridor is \$ 55,000.

- 3. In at least (2) locations, means of egress doors are encroached upon by other doors swinging into the corridor. The remedy for this condition would require the relocation of doors at the walls in which they are located, and would also include the reconfiguration of rooms (LSC Chapter 7). The estimate to remedy this issue is \$ 25,000.

- 4. The current code requires that resident room doors, as doors off of an exit passageway, may remain open provided an automatic release device is provided. This requirement is waived per Chapter 19 (LSC 18.2.2.2.6, 19.2.2.2.6 and 19.3.6.3.4). The installation of these devices at every resident room door is estimated to be \$ 225,000.

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5. The building has a dead-end corridor permissible as an existing building per LSC 19.2.5.10; however, otherwise not permitted per 18.2.5.10. An estimate for new corridor construction is estimated at \$ 55,000.
6. Not all exits discharge with access to a public way (LSC 7.7.1). Some locations would need new paving to provide a connection to perimeter walls. This work is anticipated to cost \$ 32,500.
7. The original 1964 building has evidence of asbestos floor tile and pipe insulation. Encapsulation is not possible considering a complete renovation to bring the facility in line with current IDPH regulations. Walls and existing construction would need to be removed that would disturb the existing finishes. Asbestos abatement would be required. The cost to do such work is estimated to be \$ 175,000.

B. IDPH Section 300 Administrative Requirements (IDPH 300)

1. **Bathing Suites:** The building can support 111 residents. Currently, it has 4 bathing suites or a ratio of nearly 1:28. Current regulations limit this ratio to 1:10 (IDPH 300, 2860 [f] [3]). The cost to add an additional (7) bathing suites is estimated to be in excess of \$ 350,000.
2. **Toilet Rooms:** None of the resident rooms, with the exception of (4), have direct access to a toilet room without going into the common corridor. Current regulations stipulate that each room must have direct access to a toilet without having to enter the corridor (IDPH 300, 2860 [b] [3]). Providing an accessible toilet room in each residential room would reduce the size of the rooms, making some of them non-compliant for the current number of occupants. Other rooms may need to be deleted entirely and would decrease the number of building residents.

Approximately 35 toilet rooms would need to be constructed as part of a rehabilitation. Since existing waste piping sizes within the building and the municipal system are unknown, it is anticipated that the waste system would require replacement to accommodate the additional fixture units. The cost to create the toilet rooms and replace existing, and install new plumbing piping is estimated to be \$ 3,500,000.

3. An extensive renovation would require the building to comply with current accessibility codes, specifically the Americans with Disabilities Act and the Illinois Accessibility Code. This would include, but is not limited to, the following:
 - Construction of new accessible bathrooms as noted above. - Incl Above
 - Construction of new accessible tub rooms to replace all existing. - \$250,000
 - Elimination of any non-compliant thresholds or changes of elevation or flooring - \$50,000



4. **Obsolescence:**

1. Current Wanderguard System is obsolete and parts can no longer be obtained to repair or enhance the existing system. A new system should be provided at an estimated cost of \$ 150,000.
2. Energy Efficiency: Windows in the original 1964 building still remain. Both the window and exterior walls are not thermally insulated in accordance with current energy standard guidelines (ASHRAE 90.1). The cost to replace approximately 75 percent of all windows is estimated to be \$ 128,000.
3. Furthermore, the original building is anticipated to be either not insulated or minimally insulated, contributing to heat loss and mechanical inefficiencies. The cost of furring, insulation and finishing the exterior perimeter halls is estimated at \$ 250,000.
4. Many required fire-rated doors and frames are not labeled. In order to ensure code compliance, the doors and frames should be replaced with the appropriately rated door. The cost to replace these doors is estimated to be \$ 250,000.
5. The current one-story plan has three (3) nurses' stations; however, just one (1) remotely located nurses' lounge and restroom. The cost to provide additional lounge areas in proximity to the stations and toilet rooms is anticipated to be \$ 125,000.
6. A dining room addition has a floor system that appears to have been constructed of wood floor joists over a crawl space. There is evidence of settlement of the subfloor evident through continuous lines of cracked tiles. The cost to repair the floor support system, subfloor and finishes in this 600 SF space is approximately \$ 180,000.

JOLEN ELECTRIC AND COMMUNICATIONS, INC.

Certified WBE Contractor with the State of Illinois and the City of Chicago
E-mail: info@jolenelectric.net

McAllister Nursing Home -- Electrical Assessment

Overview

Jolen Electric and Communications, Inc. inspected/assessed the McAllister Nursing home on Thursday, September 1, 2011. The purpose of our visit was as follows:

- Determine the status of the existing electrical systems.
- Identify any code violations / pressing items.
- Provide budget pricing to upgrade the electrical system.

The one story building is made up of three (3) distinct sections, the original building (built in 1964), the East addition (1978) and the West addition (1995). The West addition is in relatively good shape. The electrical systems in the Original building and East addition, however, need replacement.

All budgets provided in this report are for the Electrical alone. HVAC, structural, architectural, cutting, patching and roofing costs are not included.

Scope of Work

Jolen Electric performed a visual inspection of the Electrical Systems found on this property in order to provide a written property assessment to identify deficiencies that we deemed material. The primary purpose of the property assessment is to enhance the client's knowledge about the property to improve decision making for buying, selling, maintaining or improving the property.

Limitations

The property assessment shall not be construed to be technically exhaustive, identify all concealed or latent defects, deal with aesthetic concerns and cosmetic defects, determine the life expectancy of the Electrical systems, or include items not permanently installed.

ATTACHMENT-11E

References

- 2005 NEC Electrical
- Country Club Hill Electrical Code Addmends
- NFPA - 72

West Addition (1995) Observations:

- No AFCI breakers or dedicated circuits are present for receptacles in patient rooms.

Main Service:

The main electrical service is a 800amp 120 / 240 v (high leg) 3 phase 4 wire service.

Generator:

A 20 kva 120/240 v 3 phase 4 wire this generator powers up an emergency panel located in the basement of the West Addition. The emergency lighting, exit signs throughout the West Addition, and nurse call system are fed from this panel. This generator is Original from the West Addition (1995).

Nurse Call System:

The nurse call system has been updated.

Fire Alarm System:

The fire alarm system is updated and is tied into the existing (old) fire alarm panel in basement of East Addition.

Original Building (1965) and East Addition (1978) Observations:

- No AFCI breakers or dedicated circuits are present for receptacles in patient rooms.
- Not enough room in panels for dedicated AFCI circuits to be added.
- The electrical panels present are 100% full with no spare breaker spaces. If AFCI breakers were added in every unit, additional sub panels will need to be added to accommodate the added breakers. If additional sub panels are added, the original feeds going to existing panels will have to be upsized (pipe and wire) to accommodate added amperage needed.
- No GFI receptacles in Bathrooms.
- Smoke Detectors in patient rooms are battery operated ONLY, as per code they need to be 110v detectors w/battery back-up.
- No critical receptacles / dedicated circuits in patient rooms.
- No 3-way switching from patient beds to entry door for light in rooms.
- Panels are original in both the Original building (1965) and East addition (1978), and should be replaced with new interiors, breakers.
- All existing light fixtures and exit signs have magnetic ballast and do not comply with any energy codes and should be replaced.
- Copper wiring in the Original building (1965) is 46 years old, the East addition (1978) is 33 years old. It is recommend updating copper wiring after 50 years.

Main Switch Gear:

Original Building

The main electrical service is 400amp 120/208v 3 phase 4 wire and is from original building installation 46 years ago.

- The service is not large enough to accept any added panel feeders.
- Service must be changed with increased amperage or combined with East addition new service.

East Addition

This main electrical service is 800amp 120/208v 3 phase 4 wire and is from original building installation 33 years ago.

- The service is not large enough to accept added panel feeders.
- Service must be changed with increased amperage or combined with Original Addition new service.

Fire Pump:

The fire pump is located in East Addition's basement and is 225amp 3 phase 3 wire. This building was built in 1978 and all electrical wiring is copper and has reached 33 years of its 50 year life expectancy and should all be replaced in its entirety.

Generator:

There are two (2) generators in the East Addition.

- The generator located in the basement is not known to be working, although the wiring is still terminated at the generator.
- There is a newer 37.5 kva Generator located outside the stairway of the East Addition basement. This generator is the newer of the two. The age is of this generator is unknown, but I would guess around 15 to 18 years old. This generator powers up the emergency panel located in the basement of the East Addition. It feeds the emergency lighting, exit signs throughout the East additions and Original building, fire alarm panel and nurse call systems.

Nurse Call System:

- The nurse call system in a whole is not in good shape. The Nurse call annunciator panels is part of a Tektone system, but most of the other parts or devices are not the same manufacturer.
- The dome lights outside of patient room doors are too old to identify system. Many dome lenses missing and may not be available to replace.
- This original building was built in 1965 and all of the nurse call system wiring is predominantly copper and has reached 46 years of its 50 year life expectancy and should all be replaced in its entirety.

Fire Alarm System:

Fire alarm system is original in Original and East Additions and is a Gamewell system. All devices in public areas are as old as original system.

- Devices such as audio /visuals do not have proper decibel rating.
- Smoke detectors are spaced improperly.
- This original building was built in 1965 and all of the fire alarm system wiring is predominantly copper and has reached 46 years of its 50 year life expectancy and should all be replaced in its entirety.

Original and East Buildings

Total Cost\$759,050.00

Install AFCI receptacles with dedicated circuits in all 11 patient rooms in the West Addition, fed from new 225amp panel in hallway at training room.

Total Cost\$3,850.00

Install new 225amp panel fed from existing MSB in West building with new conduit and cable feeder.

Total Cost.....\$10,100.00

Nurse Call System

Total Cost.....\$168,680.00

TOTAL COST OF ABOVE.....\$941,680.00

A detailed description is in the attached proposal document.

JOLEN ELECTRIC

AND COMMUNICATIONS, INC.

Certified WBE Contractor with the State of Illinois and the City of Chicago
E-mail: info@jolenelectric.net

PROPOSAL

September 13, 2011

Budget cost to install the following electrical systems in the existing areas of the East Addition and the Original Addition.

Primary Electric Service Conduit and Cable:

Stub 2-4" conduits out 5' from primary section of ComEd transformer pad and stop ComEd is responsible for all primary cable and trenching.

Secondary Electric Service Conduit and Cable:

Furnish and install 7 - 4" conduits with 4 #600 mcm cables each from secondary section of ComEd transformer pad to new 2400amp 120/208 volt 3 phase 4 wire main switch gear located in the basement of the East addition.

Concrete Transformer Pad:

Furnish and install 1 6'-0" x 6'-6" ComEd transformer pad per ComEd specs and requirements pad to be located no more than 5' from exterior wall of East Addition at backside of new Main Switchgear.

Main Switchboard:

Furnish and install 1 new 2500amp 120/208 volt 3 phase 4 wire multi section switch board. Locate in basement of East Addition. This MSB will feed all new Panelboards, new HVAC equipment etc. in East and Original Additions.

Distribution Panelboards:

Install new Panelboards in all existing areas of Original and East additions for all new lighting and power feeds to unit bedrooms and public areas. These panelboards will be fed from new MSB in East Addition room basement. These new panelboards will also feed all new branch circuiting to units with new Arc Fault /GFI protection from panelboard AFCI and GFI breakers.

Panelboard Feeders :

Install all new conduit and cable from new MSB to new panelboards in Original and East additions.

Metering Cabinet:

Install new Instrumental metering for new Main Switch Gear, Install new metering for Fire Pump

Grounding Systems:

Install new Main Building Grounding junction box which will interface Main service MSB, Fire pump, Building steel, supplemental ground with new Water service to comply with NEC 2005.

Starters, Control Wiring, Disconnect Switches, HVAC:

Furnish and install all new starters. Disconnect switches for all new HVAC and mechanical equipment.

Conduit for Communications System:

Install 1 - 4" empty conduit for telephone and 1 - new 3" empty conduit for cable tv from new communications room in basement of Activity Room out to property line of site. Install all new empty conduits for telephone and cable to West, Original and East additions from communications room.

Receptacles, Devices, Switches and Special Outlets:

This contractor will furnish and install all devices such as receptacles, smoke detectors, AFCI receptacles, dedicated circuits for bedrooms, GFI receptacles and circuits for baths and switches and lighting fixtures in units to comply with code. All devices to be commercial grade 20amp. All new lighting fixtures to be energy efficient and comply with energy code.

Branch Circuit Conduit and Wiring:

All branch circuiting between devices as shown on electrical drawings. Minimum 1/2" conduit. Minimum wire #12.

Emergency and Exit Lighting Systems:

All Emergency, exit lighting systems and life safety systems to be fed from new 125amp emergency panel and fed from ATS #1 from emergency generator and MSB to comply with local codes.

Lighting Fixtures and Lamps:

Furnish and install all new lighting fixtures and lamps. All to be energy efficient and to comply with energy codes and with local codes.

Temporary Service:

Furnish and install temporary service. Feed to building for temporary power and lighting included in cost. 200amp temporary service maximum. Voltage to be determined by utility feed. Temporary power and lighting to be per minimum OSHA standards. General contractor trailer hook up included in cost. No temporary hook up of sub contractor trailers or equipment included in cost. No utility company coordination or fees included in cost. All utility company communication, correspondence and coordination is by others. All utility fees and charges are by others.

Fire Alarm System:

Furnish and install a complete new fire alarm system in East and Original Additions with all new conduit and wiring. All conduit to be a minimum 1/2" and all wire to be minimum #14. Design of Fire Alarm system with drawings, cuts and submittal of same to Local Fire Department is included in cost.

Jolen Electric and Communications, Inc. is not responsible for changes made to fire alarm system by City Fire Prevention Department during permit process, plan review, construction, on-site inspections or testing. Any changes made to fire alarm system may result in extra costs to contract.

This contractor will be present during programming, pre-test and testing between Affiliated Systems and City of Chicago Fire Prevention. All coordination of programming and testing between City of Chicago Fire Prevention, monitoring company and Jolen Electric and Communications, Inc. is by others. Jolen Electric and

Generator:

Furnish and install 1 – new 125 kw generator 120/208v 3 phase 4 wire, generator to feed new 125amp 120/208v 3 phase 4 wire panel in basement of East Addition and Fire Pump. Install 2 new ATS switches for same in basement ATS #1- 125amp to feed Emergency Panel and ATS #2 to feed Fire pump both ATS switches will also receive feeds from MSB normal source.

Fire Pump:

Fire Pump is existing and is 120/208 v 3 phase 3 wire. Fire pump will be fed from ATS #2 (emergency source) ComEd (normal source).

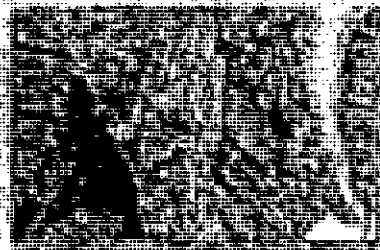
Nurse Call System:

Furnish and install a completely new nurse call system. System to include stations at bed side, bathroom pull cord stations, dome lights outside of each room and main annunciators at nurse stations (2).



McAllister
Nursing & Rehabilitation

Long in Tradition



First in Care

HVAC Assessment For:
McAllister Nursing Home
Country Club Hills, IL

Prepared By:

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ATTACHMENT-11E

Table of Contents

Overview.....Page 3

Scope of Work..... Page 3

Limitations..... Page 3

References.....Page 4

Original Building.....Page 4

 Observations.....Page 5

 Deficiencies.....Page 5

 Obsolescence.....Page 5

 Budget.....Page 5

East Addition.....Page 7

 Observations.....Page 6

 Deficiencies.....Page 6

 Obsolescence.....Page 6

 Budget.....Page 7

West Addition.....Page 7

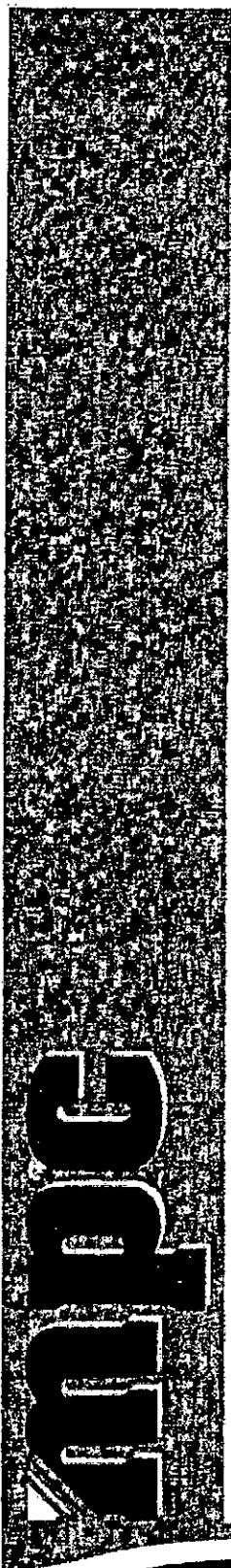
 Observations.....Page 7

 Deficiencies.....Page 7

 Obsolescence.....Page 7

 Budget.....Page 7

Budget Summary.....Page 8



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Overview

Martin Petersen Company inspected the McAllister Nursing home on Thursday August 31, 2011. The purpose of our visit was threefold.

- Determine the status of the existing mechanical systems.
- Identify any code violations / pressing items.
- Provide budget pricing to upgrade the mechanical system

The one story building is made up of (3) distinct sections, the original building (built in 1964), the East addition (1978), and the West addition (1995). The West addition is in relatively good shape. The Mechanical systems in the original building and East addition, however, have exceeded their design life and need replacement.

All budgets provided in this report are for the HVAC alone. Electrical, structural, architectural, cutting, patching, and roofing costs are not included.

Scope of Work

Martin Petersen Company performed a visual inspection of the HVAC systems found on this property in order to provide a written property assessment identifying deficiencies that we deemed material. The primary purpose of the property assessment is to enhance the client's knowledge about the property to improve decision making for buying, selling, maintaining, or improving the property

Limitations

The property assessment shall not be construed to be technically exhaustive, identify all concealed or latent defects, deal with aesthetic concerns and cosmetic defects, determine the life expectancy of the HVAC systems, or include items not permanently installed.

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References

A brief summary of code shortfalls are listed below. Complete descriptions follow.

IDPH Administrative Code – Sheltered Care Facilities

- Areas of nursing homes used by residents must be air conditioned – bedrooms are not air conditioned

International Code Council (ICC) - International Mechanical Code (IMC) 2006

- Inadequate Outdoor Ventilation – Nursing Home Patient Rooms 25 CFM/person
- Missing transfer air from hall to bathrooms – inadequate transfer path from the hall to the bathrooms
- Missing exhaust – Janitor Closets 2.0 CFM/SF or 75 CFM/sink
- Missing exhaust – Shower Room 2.0 CFM/SF
- Short exhaust – Smoking Lounge 2.0 CFM/SF
- Missing make up air – Clothes dryer exhaust > 200 CFM must have make up air
- Missing exhaust – Dishwashing appliances require 100 CFM per linear foot of hood length
- Missing make up air – Make up air shall be supplied during operation of the commercial kitchen exhaust
- Short combustion air – Combustion air (boiler rooms) 1 square inch per 2,000 BTUH

Original Building (1965)

Observations

The original building is served by a central heating plant located in the basement. Hot water is generated by (2) Weil Mclean boilers (376 MBH each) and (1) AO smith Boiler (420,000 MBH). Hot water is piped to individual room convectors. No individual room zoning is provided. Two ground-mounted packaged heating/cooling units provide heating, cooling, and ventilation to the central corridor. No cooling or ventilation is directed to the perimeter patient rooms. There is one dedicated heating / cooling unit providing ventilation to the activity/dining room. Exhaust for a limited number of bathrooms is provided by roof mounted fans.

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Deficiencies

- There is no cooling provided directly to the patient rooms. The only cooling provided is discharged into the hallway where it then may migrate into the patient rooms.
- There is no mechanical ventilation provided to the patient rooms. The patient source of ventilation is through operable windows.
- There is limited exhaust provided to the bathrooms & shower rooms. More than half have no exhaust at all. Because of a lack of transfer paths, the remaining exhaust grilles are not meeting code.
- There is no exhaust provided in the janitor / utility closets.
- The exhaust is not working in the barber shop.
- The smoking room has an undersized exhaust fan and no provisions for makeup air.
- There is no ventilation or make up air provided to the laundry room.

Obsolescence

- Boiler Plant – The HW boilers and equipment date back to the original construction, 46 years ago. The entire plant has exceeded its lifetime and should be replaced.
- Packaged Heating/cooling units are 20 years old. They have exceeded their expected life of 15 years. Replacement is recommended.
- Exhaust fans – Fans are inoperable, undersized, missing. The entire exhaust system needs to be upgraded.

Budget

- \$ 395,000 Upgrade boiler plant
- \$ 80,000 Replace central hallway heating/cooling units
- \$ 120,000 Update exhaust systems
- \$ 370,000 Provide ventilation system and cooling to individual patient rooms
- \$ 40,000 Provide ventilation to the laundry room
- \$1,005,000 TOTAL

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East Addition (1978)

Observations

The East Addition has a central heating plant located in the basement. Hot water is generated by (2) AO Smith boilers (536 MBH each). The hot water is piped to individual room convectors. No individual room zoning is provided. Two ground-mounted packaged heating/cooling units provide heating, cooling, and ventilation to the central corridor. No cooling or ventilation is provided to the perimeter patient rooms. Exhaust for a limited number of bathrooms is provided by roof mounted fans. There is a dedicated unit that provides heating, cooling and ventilation to the dining room. Another unit provides heating, cooling, and ventilation to the small dining room /patio. A furnace provides heating, cooling, and ventilation to the Solarium/Office. The kitchen has an exhaust hood with ansul fire suppression system over the grille. There is no makeup air provided for the kitchen hood exhaust so the kitchen is negative whenever the hood is running.

Deficiencies

- There is no cooling provided directly to the patient rooms. The only cooling is discharged into the hallway and migrates into the rooms.
- There is no mechanical ventilation provided to the patient rooms. The patient source of ventilation is through operable windows.
- There is limited exhaust provided to the bathrooms & shower rooms. More than half have no exhaust at all. Because of a lack of transfer paths, the remaining exhaust grilles are not meeting code.
- There is no exhaust provided in the janitor / utility closets.
- The combustion air to the boiler plant is undersized.
- There is no makeup air provided in the kitchen.
- There is no exhaust on the dishwasher unit.

Obsolescence

- Boiler Plant – The HW boilers and equipment in this room trace back to the original construction, 35 years ago. The entire plant has exceeded its lifetime and should be replaced.
- Packaged Heating/cooling units are 20 years old. They have exceeded their expected life of 15 years. Replacement is recommended.
- Exhaust fans – Fans are inoperable, undersized, missing. The entire exhaust system needs to be upgraded

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Budget

- \$ 310,000 Upgrade Boiler Plant
- \$ 140,000 Replace Central Core Heating/Cooling units
- \$ 120,000 Update Exhaust systems
- \$ 677,000 Provide Ventilation system and cooling to patient rooms
- \$ 65,000 Provide Make Up Air to the kitchen hood
- \$ 20,000 Provide Exhaust to the dishwasher
- **\$ 1,332,000 TOTAL**

West Addition (1995)

Observations

The West addition is heated, cooled, and ventilated by seven split system residential grade furnaces. Outside air and exhaust is ducted through the roof. The furnaces are original to the building. Three condensing units have failed and have been replaced.

Deficiencies

- Inadequate airflow - The residential grade equipment is unable to overcome the extensive ductwork and fittings. Air flow has been short since taking occupancy. Booster fans were added to overcome the excess static pressure.
- Condensing units are failing
- Booster fans are failing

Obsolescence

- The equipment is 16 years old. Expected life is 15 years for this grade of equipment. Replacement should be considered

Budget

- \$ 320,000 Replace seven furnaces with one packaged heat/cool unit with VAV zoning

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Budget Summary

Original Building	\$ 1,005,000
East Building	\$ 1,332,000
West Building	<u>\$ 320,000</u>
TOTAL HVAC	\$ 2,657,000

If you have any questions, please do not hesitate to call.

Sincerely,
Martin Petersen Company

John Donnell, PE, LEED AP
President
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**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued v)**

ALTERNATIVES

- 1) Document ALL of the alternatives to the proposed project:
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of cost, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation.

The alternatives to this project are limited due to the fact that this is an existing nursing care facility. Therefore, the alternatives are limited to: "Do Nothing", "Discontinuation of the Facility"; "Total Renovation of the Existing Building"; "Project as Proposed".

DO NOTHING

Issues of Cost:

The Applicant considered the alternative to "do nothing" and found that if the facility is not replaced it is at the point that significant modernization is necessary. This Applicant has owned the facility for only three years being acquired in 2008. According to the annual Cost Reports, in 2009 and 2010 the Applicant has spent approximately \$196,000 for capital improvements. This does not include operational maintenance budget items that in CY 2010 that \$236,568 had been expended (or an average of almost \$20,000/month. Therefore, at a minimum, the Applicant could expect to continue expending operational and capital cost of nearly \$30,000 each month (or \$334,568/year. The result of this alternative is reduced revenue from the continuing decline in utilization as the building continues to be less and less marketable.

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued vi)**

ALTERNATIVES (Continued ii)

Patient Access:

This alternative of "do nothing" does not improve accessibility. Currently, accessibility is limited in this facility due to marketability that stems from its physical plant's age, design and condition. The primary market area has already seen a net reduction of over 1,226 nursing beds in the 7E Planning Area. By not replacing beds that would also include an additional 89 beds, would further jeopardize the continued existence of McAllister Nursing & Rehab. This alternative could have the result of forcing area residents to look outside of the community and possibly the planning area for care through the promotion of an outdated traditional (institutional) environment.

Quality:

Quality of care is not an issue as is quality of life. However, there appears to be a direct correlation between the two. Specifically, if a provider improves the physical plant for the residents to a more modern and appealing setting, not only is the resident more satisfied to be there but the staff is also. A bright and modern environment provides a setting in which the staff and the residents are more relaxed and therefore, less frustrated and confrontational. This alternative of "do nothing" does not lend itself to creating a modern inviting environment as the existing building is institutional. This facility was originally constructed in 1964 with additions made in 1978 and also 1998. Because of the narrow lot size the facility's additions were made basically in a straight line thereby creating and approximate 600 foot long corridor which is almost twice the size of a football field. Obviously, this creates a lot of unnecessary travel time

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued vii)**

ALTERNATIVES (Continued iii)

for staff. As a result, there is not much further that can be done with this institutional space. Since this alternative does not do enough to improve the quality of life issues as it relates to the physical plant environment, this alternative does nothing to improve quality of care.

Financial Benefits:

This building is at the point that it needs to evolve to survive. It is not a question of need for nursing care services. It is a question of providing a desirable home for tomorrow's seniors in need of continual skilled nursing services. This alternative of "do nothing" does not address this issue. Therefore, the overall institutional appearance and ambiance will continue to have the effect of reducing admissions as the building continues to age to the point the home will not be able to survive. Therefore, this alternative has no financial benefits.

DISCONTINUATION OF McALLISTER NURSING & REHAB

Issues of Cost:

The alternative of "discontinuation of McAllister Nursing & Rehab" is the least expensive alternative in terms of capital cost although not without a cost. Specifically, the existing building was constructed based on the narrow lot thus creating a 600 long foot corridor creating a facility of institutional appearance. This function and purpose is contrary to current trends in the long-term care industry, which are to provide a less institutional and more homelike environment in a smaller group or neighborhood concept. Specifically, smaller autonomous households under the umbrella of a multi-household facility focusing on personalization of care and greater emphasis on rehabilitating residents to get them back to a more independent status.

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued viii)**

ALTERNATIVES (Continued iv)

In the layout and condition of the existing building, there is little use for the building; therefore, the most likely outcome of disposition would be to demolish the entire structure. Included in the proposed project cost is the total building demolition of \$150,000. Additional cost that are not readily known are the losses realized by the community in terms of real estate taxes (\$234,697 end of year 2010), a intangible resource of accessible nursing services, and all of the jobs that the facility currently provides (the facility has an operating expenses for nursing costs, employee welfare costs, housekeeping & plant costs, laundry and linen costs, and dietary costs that together total \$4,215,995 according to the 2010 Long Term Care Cost reports from the Department of Health Care and Family Services). Thus, this alternative would also be considered rather expensive without even giving consideration to accessibility to long-term care services. For all of the cited McAllister Nursing & Rehab costs refer to **ATTACHMENT-12A** for the facility's Medicaid Cost Report from the Illinois Department of Health Care and Family Services.

Patient Access:

This alternative is the most restrictive in terms of patient accessibility. In the months following new ownership in 2008, McAllister Nursing & Rehab experienced a utilization rate of 86.71% in 2010. During the twelve months ending July, 2011, the facility occupancy rate was 87.7%. To discontinue this facility would displace 35,546 patient days or nearly 98 residents in a Planning Area that shows a need for 339 beds. Therefore, this alternative would result in the 7-

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued ix)**

ALTERNATIVES (Continued v)

E Planning Area having a need for 450 beds instead of only a need for 250 additional long-term care nursing beds.

In addition several other facilities have admission restrictions which further hinder access to care. There are 47 facilities within the 30-minute drive time. Approximately one quarter of the beds have been identified as being inaccessible to general long-term skilled care patients as the beds are only licensed as ICF (Intermediate Care Facility) or having a large MI (Mentally Ill) population indicative of the facility being exclusively for MI's or having dedicated MI units or wings, or finally, some of the beds have no or have limited Medicaid Certification, thus, beds only for those who are most affluent. Please refer to the facilities chart appended as **ATTACHMENT-12B**. In recap, out of the 7,949 nursing care beds, 1,955 beds appear to present restrictive admissions to general geriatric long-term skilled patients.

Since the Applicant is proposing to have all 200 beds certified for both Medicare and Medicaid all beds will be licensed as Skilled. Unfortunately, there are those facilities that are only licensed for Intermediate Care and therefore cannot be certified for Medicare thus creating an additional access issue.

The latest Long-Term Care Bed Inventory Updates (dated October 21, 2011) there is an outstanding need for 339 additional beds within the 7E Planning Area. The alternative being considered to discontinue McAllister Nursing & Rehab would also further exacerbate the maldistribution of beds within the County. Since the initial publication of the Inventory of Health Care Facilities and Services and Need Determination in March 2008 there has been a net

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued x)**

ALTERNATIVES (Continued vi)

reduction of almost 1,300 beds within this planning area. Most evident is the recent discontinuation of 884 beds at Oak Forest Hospital with only 10 beds remaining. However, under Project No. 11-037 an application has been filed by this hospital for a total discontinuation which includes the remaining 10 beds. The Planning Area has also seen the closure of 249 beds at the Emerald Park Healthcare Center (April 9, 2008), the 30 beds at the Blue Island Nursing Home ((October 26, 2010) and 22 beds at Manor Care Oak Lawn (December 1, 2009)). In addition there is an unrecognized bed need situation that is created from the inclusion of those facilities that predominately serves the mental ill population. The Crestwood Terrace is licensed for 126 beds whereas over 82% of their population reported a primary diagnosis of mental illness; Riviera Care Center, licensed for 200 beds and reported over 73% of their population with a primary diagnosis of mental illness; Thornton Heights Terrace, licensed for 222 beds reported over 96 of their residents with a primary diagnosis of mental illness; and, Lydia Healthcare reported over 94% of their population with a primary diagnosis of mental illness within their 412 license beds. This accounts for a total of 960 beds in the planning area that are not readily available or accessible to the general geriatric population. Thus, the State has included these 960 nursing care beds (10.6% of licensed capacity) in the 8,989 7E Planning Area approved beds against a calculated bed need of 9,242 beds. Since these beds do not primarily serve the general geriatric population of the planning area and since most of these beds are not licensed for skilled care and all are not certified under the Medicare program they should recognized as "restrictive usage beds" and as not be accessible to the population that is

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xi)**

ALTERNATIVES (Continued vii)

intended to be served. This would ultimately increase the bed need for the planning area to as much as 2,294 additional beds. Again, for the full list of apparent restrictive admissions, please refer to **ATTACHMENT-12B**. Furthermore, primary documentation of this information in this chart is provided from the State's 2010 Annual Facility Questionnaire Form which is appended as **ATTACHMENT-12C** for all long-term care facilities listed.

Through the Certificate of Need process, accessibility has also been an indicator of need and typified through the ratio of nursing care beds to total population. The table included herein,

30-Minute				
Beds	7949	divided by	7,949	= 1 Bed
Population	2,171,418	divided by	7,949	= 273 Persons
Planning Area				
Beds	8,989	divided by	8,989	= 1 Bed
Population	917,000	divided by	8,989	= 102 Persons
State				
Beds	102312	divided by	102,312	= 1 Bed
Population	12,900,700	divided by	102,312	= 126 Persons
Source: 30-minute population derived from 2007 Microsoft Map-Point data. Planning Area and State population derived from the Inventory of Health Care Facilities and Services and Need Determinations, 13-Oct-2011 edition.				

illustrates that this particular service area, i.e., the 30-minute travel contour, has greatest number of persons per nursing bed. The State's rules for maldistribution allow for one and one half times the State's ratio before there are too many

beds in a given area. The 30-minute market contour does not need to utilize that allowance. The simple explanation of the ratio of beds to population chart provided herein is that the 30-minute market area has just over twice (2.2 times) the number of people per nursing home bed than the State does and over two and one half (2.7 times) the number of people per nursing bed than the 7-E Planning Area has. Therefore, to proceed with the alternative to discontinue the service

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xii)**

ALTERNATIVES (Continued viii)

could enhance the apparent maldistribution of population to beds. This item seems to illustrate that there is a need for improved accessibility which this project addresses but not this alternative.

Quality:

This alternative does not address quality, i.e., quality of life or quality of care. This alternative forces the displacement of existing residents to facilities either throughout the planning area.

Financial Benefits:

This alternative does not have any financial benefits as it presents a significant cost to the Applicant, the community and, most importantly, to the residents of Southern Cook County (7-E Planning Area) with no potential for a return.

Therefore, with significant issues of cost, patient access, and quality with no potential for financial or other benefits, this alternative was rejected.

TOTAL RENOVATION OF THE EXISTING BUILDING

Issues of Cost:

As this is not viable outcome to continued operations and for providing needed long-term nursing care services to its existing residents and to the community, the "do nothing" would result in the modernization of the existing facility. The Applicant's architect, Arthur P. Salk, AIA Emeritus NCARB, has reviewed the physical plant shortcomings and has outlined a modernization plan that would allow the Applicant to maintain its existing total licensed

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xiii)**

ALTERNATIVES (Continued ix)

capacity, add additional beds to reflect economies of scale and correct all physical plant and life safety code deficiencies. The most critical problem in renovating the existing building is that it cannot be accomplished by "piece milling" but rather all at once. The original footprint of the building is much too long (over 600 feet) for a single loaded corridor and is highly inefficient both architecturally and operationally. Presently, the extraordinary amount of staff workload created by the necessity to move residents horizontally over a long distance for dining and activities cause operational inefficiencies that need to be solved. The mechanical system need total replacement and as such are at the end of their life. Antiquated electrical and communications systems need replacement as well. Therefore, all residents would have to be displaced before renovation can even begin. It appears that the existing facility has far more liabilities than assets. Renovation would not only be difficult to achieve but the cost penalties would be severe, much of which would add no value to the finished project. The reason for this, according to the architect, is that "the original building and first addition are constructed of masonry wall bearing with an exposed precast concrete roof. Most interior partitions are painted concrete block." Refer to Salk & Associates letter appended as **ATTACHMENT-11E**. The architect letter along with the attached report from the subject facility's site inspection by Keith Tyschper, AIA of Harley Ellis Devereaux Architects, John Donnell, PE, LEED AP of Martin Peterson Co., Joe Wilock of Jolen Electric, and Skender Construction's construction budgeting. It should also be mentioned that once one area of the building undergoes major modernization, the entire building must be brought up to current codes. It is estimated that the building cost for

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xiv)**

ALTERNATIVES (Continued x)

modernization alone without any loan interest and issuance expense, furnishing, consulting and other fees, and preplanning costs could be \$12,473,487. This cost addresses the life safety issues, IDPH regulations, electrical system issues to include call systems, and HVAC system issues. What is not factored in is the loss of at least 15 beds from the licensed capacity and the resulting income from those beds. There is also an issue in only replacing the existing bed compliment. The apparent cost of replacing and constructing only 111 bed project is \$13,846,923 or \$124,693 per bed whereas the project as being proposed is projected to come in at \$104,341 per bed. Modernization is such a great expense with the loss of at least 15 beds and the Applicant would still end up with a 47 year old structure that would require continued and increasing cost to maintain. To replace only the existing capacity of 111 beds does not utilize economies-of-scale that are realized in the full proposed project and without the full complement of beds (200) it will be near impossible for the Applicant take on the additional cost of modernization or replacement without also increasing the revenue stream.

Patient Access:

At a time where other area facilities are closing, this alternative would not even ensure that accessibility to general long-term care is further eroded as the alternative to modernize requires the displacement of at least 15 resident beds. Furthermore, this alternative is not a long-term solution. Renovating a building that is 47 years old leaves the Applicant with a 47 year old building. There will be continued issues of maintenance cost and facility marketability as the

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xv)**

ALTERNATIVES (Continued xi)

institutional appearance would not be total erased. Therefore, this alternative does not improve accessibility nor does it even maintain accessibility as ultimately, this alternative would cause the closure of the facility in the not so distance future.

Quality:

The issue of quality is also addressed through this alternative, but at what cost? This project would allow for the Applicant to continue providing and caring for its residents and the care and resident housing would be in a renovated facility. However, due to the existing facility layout and design, the renovations cannot eliminate the institutional feel of the long corridors and the predominately multi occupancy room accommodations with shared bathroom facilities. As such, there are issues of quality of life for the residents that this alternative fails to address.

Financial Benefits:

This alternative has a total construction renovation cost of \$12,473,487. This cost is 1.77 times more on a per bed basis as compared to the construction cost of the proposed project on a per bed basis. Therefore, there doesn't appear to be any financial benefits to this alternative, thus, this alternative was regarded as not viable.

TOTAL REPLACEMENT FACILITY

Issues of Cost:

The proposed construction cost for the on-site replacement of 111-nursing beds is \$13,840,923 or \$124,693 per bed.

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xvi)**

ALTERNATIVES (Continued xii)

Patient Access:

This alternative allows for the least amount of disruption to the residents with the exception of the project as being proposed. This alternative along with the alternative of the project as being proposed allow the residents to remain in place until construction of the replacement facility is completed. The accessibility will never be lessened throughout this process.

Quality:

The issue of quality of care would have the same result as the proposed project. The only difference is the effect of having a new and modern physical plant environment would have on improving resident and staff quality of life. The replacement project will realize a building that is unencumbered by structural restraints allowing the physical plant to be totally designed around the programming. Therefore, realized quality of care and quality of life would appear to be ultimately improved.

Financial Benefits:

In these fiscally hard times, this represents the most expensive alternative, which if chosen, would appear to make the Applicant's financial and economic feasibility ratios completely out of range of those guidelines that are in place. This results in a project that would have a lower return on investment. Specifically, as stated in the letter from Salk & Associates (appended as ATTACHMENT-11E), this alternative has a per bed cost of \$124,693 whereas the proposed project has a per bed cost of \$104,341. This alternative is projected to cost 1.2 times or

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xvii)**

ALTERNATIVES (Continued xiii)

20 percent more than the project as being proposed. Each of the per bed cost are based upon construction budget of 111 beds compared to 200 beds. The lower financial feasibility coupled with the existing mortgage on the facility could affect the project in ultimately not meeting its debt service. Therefore, it would appear that the financial benefits of this project are not even neutral but, in fact, negative.

PROJECT AS PROPOSED

Issues of Cost:

This project has a new construction price of \$20,868,326 and a total project cost of \$24,910,942.

Patient Access:

The site with the project as being proposed allows for the construction and phasing of the project where residents and services to residents will be continuous if not increasing as portions of the projects get completed. This alternative provides for greater integration of a replacement facility on-site, with the community and to address the State's outstanding need for additional nursing care beds in the 30-minute travel time contour and in the 7-E Planning Area. This alternative is the only one that improves accessibility and not just maintains it.

Quality:

This alternative is able to utilize the best of the existing resources coupled with a new design to provide a quality place for care to be provided, a quality home for the existing residents, and a quality work environment for the existing employees of Ottawa Pavilion. The replacement home

ATTACHMENT-12

**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xviii)**

ALTERNATIVES (Continued xiv)

provides for state-of-the-art environment for specialized care for rehabilitation and general long-term care that is not available today. Although the physical plant does not determine quality, even the best staff would be hindered without it. This Applicant believes it has a proven track record of commitment to the community and its seniors through its incredible staff. Now it wants the opportunity to improve this track record with an equally impressive environment.

Financial Benefits:

In review of all the other alternatives of financial benefits: do nothing has no capital cost other than continued facility maintenance and would appear to ultimately result in the demise of McAllister Nursing & Rehab; Discontinuation has a cost of approximately \$150,000 in demolition costs and the negative benefit of over \$4.2 million to the community; the total renovation has a construction cost of over \$12.4 million (some 7.7% higher than the proposed project on a per bed basis) and does not eliminate the issue of continued maintenance, reduction in total beds and resulting income, nor the reduction of facility institutional feel, function and appearance; A 111-bed facility replacement has a cost of \$13,840,923 (nearly 20% higher than the proposed project on a per bed basis); and total replacement has a construction and contingency cost of just over \$24 million with best results in accessibility and quality. This alternative, the project as being proposed, solves all of the issues most return for the capital expenditure and least patient disruption. Specifically, it maintains the Applicant's commitment to the residents, the employees and the community. The project as proposed utilizes the best of

ATTACHMENT-12

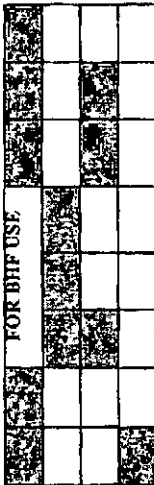
**SECTION III PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES
INFORMATION REQUIREMENTS (Continued xix)**

ALTERNATIVES (Continued xv)

the existing resources to minimize cost. Finally, this project does its part to ensure accessibility is not further eroded.

- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

The alternative of the "Project as Proposed" is based on the need for major modernization that will result in facility replacement and on the overwhelming growth of the projected senior population which is under-served as identified by. Therefore, this alternative is not based solely or in part on improved quality of care.



LL1

IMPORTANT NOTICE:
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 450-208. 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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049502

Facility Name: MCALLISTER NURSING AND REHAB

Address: 18300 S. LAVERGNE
 City: TINLEY PARK Zip Code: 60477

County: COOK

Telephone Number: (708) 798-2272 Fax #: (708) 798-2298

HFS ID Number:

Date of Initial License for Current Owners: 03/17/08

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
Charitable Corp.	Individual	State
Trust	Partnership	County
IRS Exemption Code	Corporation	Other
	"Sub-S" Corp.	
	Limited Liability Co.	
	Trust	
	Other	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA
Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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)	(Type or Print Name)	ELI ATKIN	(Date)
Paid Preparer	(Signed)	(Title)	ADMINISTRATOR	(Date)
	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)		
	(Print Name and Title)	BOB KAGDA	VICE PRESIDENT	(Date)
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124		
	(Telephone)	(847) 675-3585	Fax:	(847) 675-5777
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone #: (217) 782-1630				

STATE OF ILLINOIS

Facility Name & ID Number: MCALLISTER NURSING AND REHAB Report Period Beginning: 01/01/2010 Ending: 12/31/2010
 # 0049502 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 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

L. On what date did you start providing long term care at this location?
 Date started 12/01/08

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 12/01/08 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 79 and days of care provided 4,608

Medicare Intermediary ADMINISTRAR FEDERAL

IV. ACCOUNTING BASIS
 ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

III. STATISTICAL DATA

A. Licensee/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	Licensee Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
79	SKILLED (SNF)	79	28,835
	SKILLED Pediatric (SNF/PED)		
32	Intermediate (ICF)	32	11,680
	Intermediate/DD		
	Sheltered Care (SC)		
	ICF/DD 16 or Less		
111	TOTALS	111	40,515

B. Census-For the entire report period.

1	2	3			4	5
		Medicaid Recipient	Private Pay	Other		
Level of Care	Patient Days by Level of Care and Primary Source of Payment				Total	
8 SNF	14,528	3,868	6,806	25,202		
9 SNF/PED						
10 ICF	9,149	546	261	9,956		
11 ICF/DD						
12 SC						
13 DD 16 OR LESS						
14 TOTALS	23,677	4,414	7,067	35,158		

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.78%

Operating Expenses	Salary/Wage Costs Per General Ledger			Total	Reclassification	Reclassified Total	Adjustments	Adjusted Total	FOR BHF USE ONLY		
	1	2	3						4	5	6
A. General Services											
1 Dietary	206,218	19,131	297	225,646		225,646		225,646			
2 Food Purchase		182,316		182,316	(14,418)	167,898	(1,397)	166,501			
3 Housekeeping	3,343	3,049		6,392		6,392		6,392			
4 Laundry		239	100,227	100,466		100,466		100,466			
5 Heat and Other Utilities			111,285	111,285		111,285		111,285			
6 Maintenance	24,823	11,098	200,647	236,568		236,568		236,568			
7 Other (specify):*			10,817	10,817		10,817		10,817			
8 TOTAL General Services	234,384	215,833	423,273	873,490	(14,418)	859,072	(1,397)	857,675			
B. Health Care and Programs											
9 Medical Director			16,200	16,200		16,200		16,200			
10 Nursing and Medical Records	1,415,083	107,456	11,785	1,529,324		1,529,324		1,529,324			
10a Therapy	93,728	2,759	5,630	102,117		102,117		102,117			
11 Activities	99,558	5,271		104,829		104,829		104,829			
12 Social Services	11,630			11,630		11,630		11,630			
13 CNA Training											
14 Program Transportation			631	631		631		631			
15 Other (specify):*											
16 TOTAL Health Care and Programs	1,619,999	110,486	34,246	1,764,731		1,764,731		1,764,731			
C. General Administration											
17 Administrative	196,439		238,012	434,441		434,441		434,441			
18 Directors Fees											
19 Professional Services			90,917	90,917		90,917		90,917			
20 Dues, Fees, Subscriptions & Promotions			74,258	74,258		74,258	(66,660)	7,598			
21 Clerical & General Office Expenses	150,054	22,952	88,491	261,497		261,497	(35,250)	226,247			
22 Employee Benefits & Payroll Taxes			487,326	487,326	14,418	501,744	(70,299)	431,445			
23 Inservice Training & Education		1,522		1,522		1,522		1,522			
24 Travel and Seminar			785	785		785		785			
25 Other Admin, Staff Transportation			1,877	1,877		1,877		1,877			
26 Insurance-Prop.Liab.Malpractice			151,368	151,368		151,368		151,368			
27 Other (specify):*			73,783	73,783		73,783	(73,783)				
28 TOTAL General Administration	346,483	22,952	1,208,339	1,577,774	14,418	1,592,192	(245,992)	1,346,200			
TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,200,866	349,271	3,665,858	4,215,995		4,215,995	(247,389)	3,968,606			

* 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.

LINE	DIETARY	SCHED REF	TOTAL	LINE	NURSING	SCHED REF	TOTAL
1	DIETITIAN CONSULTANT	XVIII B 35-2	0	10	CONTRACT NURSING	XVIII C 53-2	
	REPAIRS & MAINTENANCE		297		LABORATORY & XRAY EXPENSE		0
3	HOUSEKEEPING		0		PURCHASED SERVICES		0
			0		PSYCHO-SOCIAL CONSULTANT	XVIII B -2	0
4	LAUNDRY		0		RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	EQUIPMENT REPAIRS & MAINTENANCE	4,227			MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
5	CONTRACTED LAUNDRY SERVICES	96,000	100,227		PHARMACY CONSULTANT	XVIII B 39-2	1,770
	HEAT & OTHER UTILITIES				UTILIZATION REVIEW FEES	XVIII B -2	0
	GAS HEAT	33,929			PHYSICIANS	XVIII B -2	0
	ELECTRICITY	56,792			PSYCHIATRIC	XVIII B -2	0
	WATER	17,202			RN CONSULTANT	XVIII B 38-2	4,700
	CABLE TV - LOBBY	3,362			NURSING PROGRAM CONSULTANT		1,444
		0	111,285	10a	DENTAL		3,871
6	MAINTENANCE				PHYSICAL THERAPY SERVICES		
	GROUPS MAINTENANCE	5,951			SPEECH THERAPY SERVICES		0
	PAINTING & DECORATING	499			OCCUPATIONAL THERAPY SERVICES		0
	BUILDING REPAIRS	10,726			REHABILITATION CONSULTANT	XVIII B -2	0
	MAINTENANCE TRAVEL	0			PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,800
	EQUIPMENT MAINTENANCE & REPAIR	17,882			OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	ELEVATOR MAINTENANCE & REPAIR	0			RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	2,830
	OUTSIDE LABOR	1,968			SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
	EXTERMINATING SERVICE	4,223					
	FIRE SERVICE	13,652			ACTIVITIES		5,630
	CONTRACTED BUILDING MAINT.	145,744		11	CABLE TV - PATIENT ROOMS		
		0			ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
		0					0
7	OTHER		200,847	12	SOCIAL SERVICES		
	SCAVENGER	9,913			SOCIAL REHABILITATION SERVICES		
	SECURITY SERVICE	904			SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
		0			SOCIAL WORKER	XVIII B 45-2	0
		0	10,817				0
9	MEDICAL DIRECTOR			13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,200		NURSE AIDE TRAINING COSTS	XIII	0
			16,200				0

LINE	SCHED REF	TOTAL	LINE	SCHED REF	TOTAL
14			22		
	PROGRAM TRANSPORTATION			EMPLOYEE BENEFITS & PAYROLL TAXES	
	PATIENT TRANSPORTATION	631		FICA TAXES	168,519
		0		UNEMPLOYMENT COMPENSATION	54,477
17				WORKERS COMPENSATION INSURANC	61,753
	ADMINISTRATIVE			HOSPITALIZATION INSURANCE	109,759
	MANAGEMENT FEES	238,012		EMPLOYEE BENEFITS - OTHER	3,469
18				EMPLOYEE PHYSICAL EXAMS	0
	DIRECTORS FEES	0		INSURANCE - EXECUTIVE LIFE	70,299
19				PENSION/PROFIT SHARING PLANS	19,050
	PROFESSIONAL SERVICES			CHICAGO HEAD TAX	0
	DATA PROCESSING	21,578		INSERVICE TRAINING & EDUCATION	487,326
	ADMINISTRATIVE CONSULTANTS	28,080	23	EDUCATION & SEMINARS	1,522
	PROFESSIONAL FEES	41,259		TRAVEL & SEMINARS	
		0		EDUCATION & SEMINARS	0
20				TRAVEL	785
	FEES, SUBSCRIPTIONS, PROMOTIONS	90,917		ADMIN. STAFF TRANSPORTATION	
	ENTERTAINMENT & MARKETING	913	24	TRANSPORTATION - STAFF	1,877
	ADV & PROMC-NON PATIENT RELATED	7,685		INSURANCE - PROP. LIAB & MALPRACTICE	151,368
	EMPLOYEE WANT ADS	972		GENERAL INSURANCE	
	CONTRIBUTIONS	58,062		OTHER	151,368
	DUES & SUBSCRIPTIONS	2,732		BAD DEBTS	73,783
	LICENSES & PERMITS	3,394			
	PUBLIC RELATIONS-PATIENT RELATED	0	25		
	ADVERTISING-YELLOW PAGES	0		ADMIN. STAFF TRANSPORTATION	
	TRUST FEES / FRANCHISE TAX / ETC	0		TRANSPORTATION - STAFF	1,877
	CONTRIBUTIONS - POLITICAL	0	26		
	HEALTH CARE WORKER BACKGROUND CHEC	500		INSURANCE - PROP. LIAB & MALPRACTICE	151,368
	PATIENT BACKGROUND CHECKS	0		GENERAL INSURANCE	
		74,258		OTHER	151,368
21			27		
	CLERICAL & GENERAL OFFICE EXPENSES			BAD DEBTS	73,783
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,261			
	EQUIPMENT REPAIR & MAINTENANCE	1,255		OTHER	151,368
	OUTSIDE CLERICAL SERVICES	0			
	PENALTIES / OVERDRAFT CHARGES	34,323			
	HOME OFFICE EXPENSE	0			
	THEFT & DAMAGE LOSS	0			
	TELEPHONE	49,652			
	MESSENGER SERVICE	0			
		88,491			

GRAND TOTAL COLUMN 3 OTHER

1,665,858

MCALLISTER NURSING AND REHAB
 SCHEDULES
 12/31/2010

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

TOTAL FOOD PURCHASE	182,316
LESS SALES TAX	(1,397)
NET FOOD	<u>180,919</u>
TOTAL PATIENT CENSUS	35,158
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	<u>105,474</u>
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	<u>9,125</u>
PATIENT MEALS	105,474
ADD EMPLOYEE MEALS	9,125
TOTAL MEALS/YEAR	<u>114,599</u>
NET FOOD	180,919
DIVIDE TOTAL MEALS/YEAR	<u>114,599</u>
COST PER MEAL	1.58
TIME EMPLOYEE MEALS	9,125
EMPLOYEE MEAL RECLASSIFICATION	<u>14,418</u>
	=====

STATE OF ILLINOIS

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		261,423	0	0	0	0	0	0	0	0	0	259,280
30 Depreciation	(2,143)	0	0	0	0	0	0	0	0	0	0	0
31 Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
32 Interest	(7,817)	189,297	0	0	0	0	0	0	0	0	0	181,780
33 Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0
34 Rent-Facility & Grounds	0	(505,884)	0	0	0	0	0	0	0	0	0	(505,884)
35 Rent-Equipment & Vehicles	(2,672)	0	0	0	0	0	0	0	0	0	0	(2,672)
36 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
37 TOTAL Ownership	(12,632)	(54,864)	0	0	0	0	0	0	0	0	0	(67,496)
Ancillary Expense												
E. Special Cost Centers												
38 Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
39 Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
40 Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
41 Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
42 Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
43 Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
44 TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL COST	(260,021)	(54,864)	0	0	0	0	0	0	0	0	0	(314,885)
45 (sum of lines 29, 37 & 44)												

Facility Name & ID Number MCALLISTER NURSING AND REHAB

VIL 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
JOEL ATKIN	44			MCALLISTER	TINLEY PARK	REAL ESTATE
DONNA ATKIN	5			PROPERTY, LLC	TINLEY PARK	MANAGEMENT
JAY ORLINSKY	7			INNOVATIVE		O/S CLERICAL
HELEN LACEK				HEALTHCARE		& THERAPY

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 Schedule V	2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Name of Related Organization	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
V	34	RENT	\$ 505,884		MCALLISTER PROPERTY, LLC	261,423	(505,884) 1
V	30	DEPRECIATION				174,896	261,423 2
V	32	INTEREST				14,701	174,896 3
V	32	AMORT LOAN COSTS					14,701 4
V	6						
V	7						
V	8						
V	9						
V	10						
V	11						
V	12						
V	13						
Total			\$ 505,884			\$ 451,020	\$ (54,864) 14

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

STATE OF ILLINOIS # 0049502 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

Facility Name & ID Number MCALLISTER NURSING AND REHAB

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

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

Name of Related Organization: MCALLISTER PROPERTY, LLC
 Street Address: 18300 S LAVERGNE
 City / State / Zip Code: TINLEY PARK, ILL 60477
 Phone Number: (708) 798-2272
 Fax Number: (708) 798-2298

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	DEPRECIATION	DIRECT COSTS	1	1	\$ 261,423	\$	1	\$ 261,423
2	INTEREST	DIRECT COSTS	1	1	174,896		1	174,896
3	AMORT LOAN COSTS	DIRECT COSTS	1	1	14,701		1	14,701
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25	TOTALS				\$ 451,020	\$		\$ 451,020

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
		A. Directly Facility Related							
		Long-Term							
1		MC ALLISTER PROPERTY, LLC							
2		FIRST BANK	X	3/17/08	4,600,000	4,600,000	3/16/11	3.7500	174,896
3		LOAN COSTS	X		3,675				14,701
4									
5									
		Working Capital							
6		FIRST MERIT BANK	X	3/17/08	600,000	440,055	REVOLV	5.0000	27,794
7									
8		INFINITY FINANCIAL	X	6/10/10	59,255	52,717	5/31/15	2.9000	11,140
9		TOTAL Facility Related			5,259,255	5,096,447			906
		B. Non-Facility Related*							239,437
10		BED TAX							
11		REAL ESTATE TAXES							6,078
12		PAYROLL TAX							1,198
13									541
14		TOTAL Non-Facility Related							7,817
15		TOTALS (line 9+line14)			5,259,255	5,096,447			237,254

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 S, 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.)

1. Real Estate Tax accrual used on 2009 report.				\$	247,500	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.)				\$	247,527	2
3. Under or (over) accrual (line 2 minus line 1).				\$	27	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	317,527	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 \$ 12,857 For 2007 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(12,857)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	234,697	7

2005	8
2006	9
2007	231,660
2008	287,500
2009	247,527

Real Estate Tax History:
Real Estate Tax Bill for Calendar Year:
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL PLUS 70,000 OWED ON 2008 TAX BILL. THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY
13	FROM R. E. TAX STATEMENT FOR 2009 \$
14	PLUS APPEAL COST FROM LINE 5 \$
15	LESS REFUND FROM LINE 6 \$
16	AMOUNT TO USE FOR RATE CALCULATION \$

- 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.

X. BUILDING AND GENERAL INFORMATION:

Facility Name & ID Number: **MCALLISTER NURSING AND REHAB**

A. Square Feet: _____ **B. General Construction Type:** _____ **Exterior:** _____ **Frame:** _____ **Number of Stories:** _____

C. Does the Operating Entity? (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. (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? 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: _____

XI. OWNERSHIP COSTS:

A. Land.

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

1	2	3	4
Use	Square Feet	Year Acquired	Cost
1 NURSING HOME		2008	726,776
2			
3 TOTALS			726,776

Facility Name & ID Number MCALLISTER NURSING AND REHAB XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	
Bed#	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation																								
111		2008	2008	2,907,102	105,713	27.5	105,713		295,115																								
	DOORS			4,517	164	27.5	164		477																								
	DOVE BASE FLOORING (LANDLORD)			2,520	92	27.5	92		142																								
	DOORS (LANDLORD)			5,131	186	27.5	186		287																								
	HANDRAILS (LANDLORD)			16,217	590	27.5	590		909																								
	2 NURSE STATIONS (LANDLORD)			3,600	131	27.5	131		202																								
	FIRE SPRINKLER SYSTEM (LANDLORD)			2,500	91	27.5	91		140																								
	PYROCHEM SYSTEM (LANDLORD)			3,156	115	27.5	115		177																								
	NURSE CALL LIGHT SYSTEM (LANDLORD)			5,200	189	27.5	189		291																								
	SPRINKLERS (LANDLORD)			38,000	1,382	27.5	1,382		2,131																								
	ROOF (LANDLORD)			4,781	174	27.5	174		268																								
	CARPETING (LANDLORD)			11,000	399	27.5	399		616																								
	PAINING (LANDLORD)			4,087	654	5	654		818																								
	CURTAINS (LANDLORD)			53,725	8,596	5	8,596		10,746																								
	BLINDS (LANDLORD)			19,732	3,157	5	3,157		3,946																								
	DRAPES (LANDLORD)			4,550	730	5	730		912																								
	DRAPES (LANDLORD)			6,677	4,007	5	4,007		401																								
	DRAPES (LANDLORD)			3,662	3,662	5	3,662		366																								
	OUTDOOR LIGHTING (LANDLORD)			7,380	246	15	246		246																								
	DRAPES (LANDLORD)			2,817	30	27.5	30		30																								

*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

STATE OF ILLINOIS
0049502
As of 12/31/2010

Facility Name & ID Number: MCALLISTER NURSING AND REHAB
XV. BALANCE SHEET - Unrestricted Operating Fund.
Report Period Beginning: 01/01/2010 Ending: 12/31/2010
(last day of reporting year)

This report must be completed even if financial statements are attached.

	1		2	
	Operating	After Consolidation*	Operating	After Consolidation*
A. Current Assets				
1 Cash on Hand and in Banks	\$ 23,917	\$		
2 Cash-Patient Deposits				
3 Accounts & Short-Term Notes Receivable- Patients (less allowance (\$5,000))	393,646			
4 Supply Inventory (priced at)				
5 Short-Term Investments				
6 Prepaid Insurance	218,601			
7 Other Prepaid Expenses	1,508			
8 Accounts Receivable (owners or related parties)	1,191,130			
9 Other(specify):				
TOTAL Current Assets				
10 (sum of lines 1 thru 9)	\$ 1,828,802	\$		
B. Long-Term Assets				
11 Long-Term Notes Receivable				
12 Long-Term Investments				
13 Land				
14 Buildings, at Historical Cost				
15 Leasehold Improvements, at Historical Cost	4,517			
16 Equipment, at Historical Cost	245,123			
17 Accumulated Depreciation (book methods)	(160,588)			
18 Deferred Charges	22,500			
19 Organization & Pre-Operating Costs				
20 Accumulated Amortization - Organization & Pre-Operating Costs				
21 Restricted Funds				
22 Other Long-Term Assets (see develop. costs)	28,086			
23 Other(specify): due from meallister properties	350,933			
TOTAL Long-Term Assets				
24 (sum of lines 11 thru 23)	\$ 490,571	\$		
TOTAL ASSETS				
25 (sum of lines 10 and 24)	\$ 2,319,373	\$		
C. Current Liabilities				
26 Accounts Payable	\$ 857,011	\$		
27 Officer's Accounts Payable				
28 Accounts Payable-Patient Deposits	12,726			
29 Short-Term Notes Payable	440,055			
30 Accrued Salaries Payable	126,650			
31 Accrued Taxes Payable				
31 (excluding real estate taxes)	36,611			
32 Accrued Real Estate Taxes(Sch.IX-B)	317,527			
33 Accrued Interest Payable				
34 Deferred Compensation				
35 Federal and State Income Taxes				
35 Other Current Liabilities(specify):				
36				
37				
TOTAL Current Liabilities				
38 (sum of lines 26 thru 37)	\$ 1,790,580	\$		
D. Long-Term Liabilities				
39 Long-Term Notes Payable				
40 Mortgage Payable	52,717			
41 Bonds Payable				
42 Deferred Compensation				
42 Other Long-Term Liabilities(specify):				
43				
44				
TOTAL Long-Term Liabilities				
45 (sum of lines 39 thru 44)	\$ 52,717	\$		
TOTAL LIABILITIES				
46 (sum of lines 38 and 45)	\$ 1,843,297	\$		
TOTAL EQUITY (page 18, line 24)				
47 TOTAL LIABILITIES AND EQUITY				
48 (sum of lines 46 and 47)	\$ 2,319,373	\$		

*(See instructions.)

		I
		Total
1	Balance at Beginning of Year, as Previously Reported	\$ 124,760
2	Restatements (describe):	
3	POST CLOSING ADJUSTMENT	(1,267)
4		
5		
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 123,493
A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	409,401
8	Acquisitions of Pooled Companies	
9	Proceeds from Sale of Stock	
10	Stock Options Exercised	
11	Contributions and Grants	
12	Expenditures for Specific Purposes	
13	Dividends Paid or Other Distributions to Owners	(56,818)
14	Donated Property, Plant, and Equipment	
15	Other (describe)	
16	Other (describe)	
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 352,583
B. Transfers (Itemize):		
18		
19		
20		
21		
22		
23	TOTAL Transfers (sum of lines 18-22)	\$
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 476,076 *

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

Revenue	Amount	Expenses	Amount
A. Inpatient Care		A. Operating Expenses	
1 Gross Revenue - All Levels of Care	\$ 5,807,128	31 General Services	873,490
2 Discounts and Allowances for all Levels	()	32 Health Care	1,764,731
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,807,128	33 General Administration	1,577,774
B. Ancillary Revenue		B. Capital Expense	
4 Day Care		34 Ownership	870,595
5 Other Care for Outpatients		C. Ancillary Expense	
6 Therapy	63,790	35 Special Cost Centers	314,154
7 Oxygen		36 Provider Participation Fee	60,773
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,790	D. Other Expenses (specify):	
C. Other Operating Revenue		37	
9 Payments for Education		38	
10 Other Government Grants		39	
11 CNA Training Reimbursements		40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,461,517
12 Gift and Coffee Shop		41 Income before Income Taxes (line 30 minus line 40)**	409,401
13 Barber and Beauty Care		42 Income Taxes	
14 Non-Patient Meals		43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) \$	409,401
15 Telephone, Television and Radio			
16 Rental of Facility Space			
17 Sale of Drugs			
18 Sale of Supplies to Non-Patients			
19 Laboratory			
20 Radiology and X-Ray			
21 Other Medical Services			
22 Laundry			
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) \$			
D. Non-Operating Revenue			
24 Contributions			
25 Interest and Other Investment Income***			
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) \$			
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)			
28			
28a			
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a) \$			
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) \$	5,870,918		

* 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.

Line	Description	1		3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued		Reporting Period Total Salaries Wages	Average Hourly Wage
1	Director of Nursing	2,150	2,234	\$ 86,741	\$ 38.83	
2	Assistant Director of Nursing					
3	Registered Nurses	3,676	3,732	104,919	28.11	
4	Licensed Practical Nurses	23,447	24,205	560,198	23.14	
5	CNAs & Orderlies	55,497	57,523	579,484	10.07	
6	CNA Trainees					
7	Licensed Therapist					
8	Rehab/Therapy Aides	2,890	3,131	93,728	29.94	
9	Activity Director	1,918	2,097	34,933	16.66	
10	Activity Assistants	6,325	6,803	64,625	9.50	
11	Social Service Workers	628	639	11,630	18.20	
12	Dietician					
13	Food Service Supervisor	2,468	2,669	48,025	17.99	
14	Head Cook	1,650	1,694	14,344	8.47	
15	Cook Helpers/Assistants	13,280	14,471	143,849	9.94	
16	Dishwashers					
17	Maintenance Workers	1,883	1,927	24,823	12.88	
18	Housekeepers	334	334	3,343	10.01	
19	Laundry					
20	Administrator	2,824	2,840	117,503	41.37	
21	Assistant Administrator	1,928	1,976	78,926	39.94	
22	Other Administrative					
23	Office Manager					
24	Clerical	9,618	10,211	149,127	14.60	
25	Vocational Instruction					
26	Academic Instruction					
27	Medical Director					
28	Qualified MR Prof. (QMRP)					
29	Resident Services Coordinator					
30	Habilitation Aides (DD Homes)					
31	Medical Records	1,397	1,524	24,058	15.79	
32	Other Health C-CARE PLAN	1,635	1,749	59,683	34.12	
33	Other(specify) MARKETING	26	26	927	35.65	
34	TOTAL (lines 1 - 33)	133,574	139,785	\$ 2,200,866 *	\$ 15.74	

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

B. CONSULTANT SERVICES

Line	Description	1		2	3
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period		
35	Dietary Consultant	M	0	\$	1-3 35
36	Medical Director	O	16,200		9-3 36
37	Medical Records Consultant	N	0		10-3 37
38	Nurse Consultant	T	4,700		10-3 38
39	Pharmacist Consultant	H	1,770		10-3 39
40	Physical Therapy Consultant	L	2,800		10a-3 40
41	Occupational Therapy Consultant	Y	0		10a-3 41
42	Respiratory Therapy Consultant		2,430		10a-3 42
43	Speech Therapy Consultant	F	0		10a-3 43
44	Activity Consultant	B	0		11-3 44
45	Social Service Consultant	E	0		12-3 45
46	Other(specify) Nursing Program	S	1,444		10-3 46
47	Dental		3,871		10-3 47
48					
49	TOTAL (lines 35 - 48)			\$ 33,615	

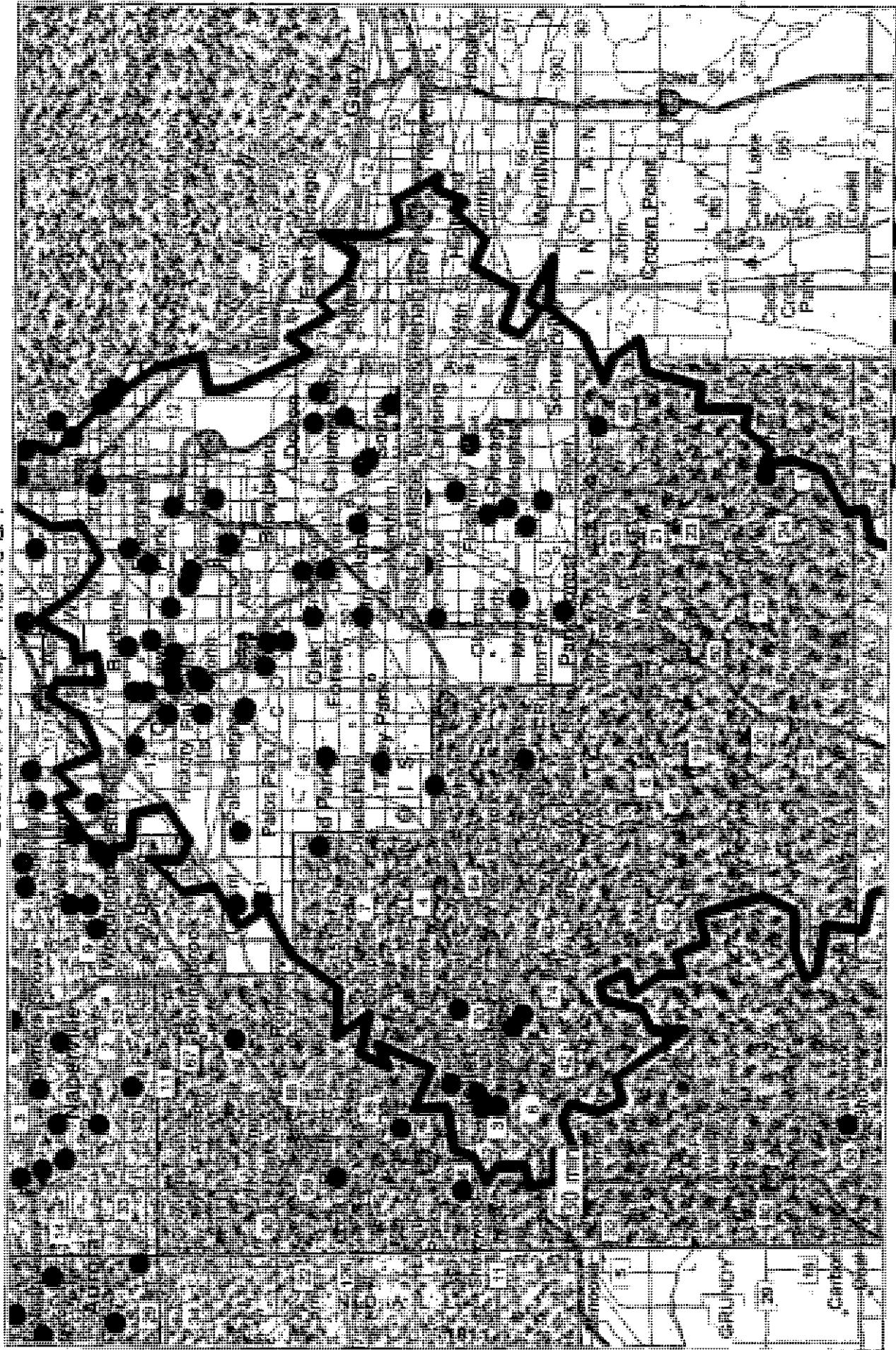
C. CONTRACT NURSES

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

30-Minute Travel Time Chart
 Accessibility of Area Facilities and Beds

FACID	FACNAME	CITY	# of Licensed Nursing Beds	Nursing Occupancy	Private Rm Charge	Double Rm Charge	Not Accessible, Restrictive Beds	
6009252	Sunny Hill Nursing Home Will County	Joliet	300	71.4%	\$ 153	\$ 153		
6008338	Salem Village Nursing & Rehab	Joliet	266	77.0%	\$ 177	\$ 157		
6002604	Hillcrest Nursing & Rehab Center	Joliet	168	89.0%	\$ 135	\$ 126		
8004550	Holy Family Villa	Lemont	99	96.1%	\$ 260	\$ 240		
6007918	Glenshire Nsg & Rehab Centre	Richton Park	294	74.0%	\$ 190	\$ 180		
6010664	St. James Manor & Villa	Crete	110	72.5%	\$ 232	\$ 210		
6003297	Frankfort Terrace	Frankfort	120	98.3%		\$ 130	120 ICF	
6018059	Smith Crossing	Orland Park	30	96.6%	\$ 297	\$ 236	30 No Medicare/Medicaid	
6014922	Alden-Orland Park Rehab & Hcc	Orland Park	200	73.0%	\$ 285	\$ 279		
6014682	Lexington Health Care Center	Orland Park	278	87.3%	\$ 375	\$ 210		
6000467	Applewood Nrsng & Rehab Center	Matteson	115	77.6%	\$ 220	\$ 163		
6005904	McAllister Nursing & Rehab	Country Club Hills	111	76.5%	\$ 150	\$ 150		
6008753	Oak Forest Hospital	Oak Forest	10	49.7%	\$ -	\$ -		
6002285	Crestwood Care Centre	Midlothian	303	78.7%	\$ 154	\$ 154		
6002273	Crestwood Terrace	Midlothian	126	96.8%	\$ 124	\$ -	97 MI	
6014534	Manorcare of Palos Heights West	Palos Heights	130	92.0%	\$ 305	\$ 258		
6010912	Manorcare of Palos Heights East	Palos Heights	174	93.5%	\$ 174	\$ 90		
6004352	Hickory Nursing Pavilion	Hickory Hills	74	65.6%	\$ 140	\$ 140	43 MI; 40 ICF	
6001697	Chicago Ridge Nursing Center	Chicago Ridge	231	94.4%	\$ 150	\$ 150	196 MI	
6007934	Ridgeland Nrsng & Rehab Center	Palos Heights	101	89.4%	\$ 227	\$ 200		
6000343	Manorcare of Oak Lawn West	Oak Lawn	192	82.7%	\$ 225	\$ 207		
6012967	Lexington Of Chicago Ridge	Chicago Ridge	203	93.3%	\$ 288	\$ 210		
6002059	Concord Nursing & Rehab Center	Oak Lawn	134	88.9%	\$ 175	\$ 150		
6007843	Providence HC & Rehab of Palos Heights	Palos Heights	193	64.8%	\$ 230	\$ 230	48 ICF	
6000236	Manorcare of Oak Lawn East	Oak Lawn	122	94.5%	\$ 381	\$ 339	81 Not Medicaid;	
6011720	Advocate South Suburban Hospital	Hazel Crest	41	31.6%	\$ 708	\$ 559	41 Not Medicaid	
6004741	Imperial Of Hazel Crest	Hazel Crest	199	90.1%	\$ 182	\$ 142	96 MI	
6008064	Riviera Care Center	Chicago Heights	200	82.9%	\$ 135	\$ 135	200 MI; 100 ICF	
6011746	Prairie Manor Nsg & Rehab Ctr	Chicago Heights	146	88.6%	\$ 185	\$ 175		
6007991	Woodside Manor	S Chicago Hts	112	98.0%	\$ 119	\$ 119	48 ICF	
8009385	Thornton Heights Terrace	Chicago Heights	222	91.4%	\$ 260	\$ 130	222 MI; 222 ICF	
6006084	South Suburban Rehab Center	Homewood	259	41.3%	\$ 225	\$ 175		
6012611	Manorcare of Homewood	Homewood	120	85.8%	\$ 236	\$ 206		
6001077	Plaza Nursing & Rehab Center	Midlothian	91	91.5%	\$ 160	\$ 160	46 MI; 43 ICF	
6005623	Lydia Healthcare	Robbins	412	96.4%	\$ 115	\$ 110	412 MI; 412 ICF	
6004139	Heather Healthcare Center	Harvey	173	71.8%	\$ 194	\$ 175	99 MI	
6003628	Glenwood Healthcare & Rehab.	Glenwood	184	76.5%	\$ 153	\$ 143		
6010078	Windmill Nursing Pavilion	South Holland	150	85.6%	\$ 150	\$ 140		
6007868	Providence of South Holland	South Holland	171	68.0%	\$ 208	\$ 222		
6011589	Manorcare of South Holland	South Holland	200	78.4%	\$ 251	\$ 219		
6002190	Countryside Nursing & Rehab Center	Dolton	197	87.5%	\$ 137	\$ 126	150 MI; 97 ICF	
6009443	Tri-State Manor Nursing Home	Lansing	84	92.8%	\$ 250	\$ 182	28 ICF	
6000822	Bethaven Nursing & Rehab Center	Chicago	221	89.7%	\$ 185	\$ 175		
6009732	Washington & Jane Smith Comm.	Chicago	103	88.2%	\$ 242	\$ 207		
6001036	Blue Island Nursing Home	Blue Island	0	0.0%	\$ -	\$ -		
8003958	Renaissance Park South	Chicago	300	80.7%	\$ 150	\$ 140		
6014781	Southport Nur & Rehab Center	Chicago	228	79.7%	\$ 160	\$ 170		
			7,899	82.5%	\$ 198	\$ 170	1955 24.8%	
New Perm Victorian Village						\$ 381	\$ 110	
Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development			Homor Glen	50				

General LTC Map - HSA 6 & 7



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30-Minute Travel Time Chart
Providing Area Facility Utilization

FACID	FACNAME	CITY	# of Licensed		Nursing		Nursing		Admissions	ALOS	Travel Time		Drive Distance
			Nursing Beds	Patient Days	Occupancy	Admissions	Adjusted	77 IAC 1100.510(d)					
6009252	Sunny Hill Nursing Home Will County	Joliet	300	78,138	71.4%	133	587.5	27.6	19.34				
6008338	Salem Village Nursing & Rehab	Joliet	266	74,712	77.0%	307	245.5	28.75	19.71				
6002604	Hilicrest Nursing & Rehab Center	Joliet	166	54,585	89.0%	115	474.7	29.9	18.18				
6004550	Holy Family Villa	Lemont	99	34,724	96.1%	132	263.1	29.9	17.34				
6007918	Glenshire Nsg & Rehab Centre	Richton Park	294	79,393	74.0%	374	212.3	9.2	5.74				
6010664	St. James Manor & Villa	Crete	110	29,128	72.5%	215	135.5	29.9	14.85				
6003297	Frankfort Terrace	Frankfort	120	43,037	98.3%	73	589.5	18.4	9.97				
6016059	Smith Crossing	Orland Park	30	10,573	96.6%	53	199.5	17.25	8.84				
6014922	Aden-Orland Park Rehab & Hoc	Orland Park	200	53,318	73.0%	1,274	41.9	18.1	9.09				
6014682	Lexington Health Care Center	Orland Park	278	88,573	87.3%	481	184.1	20.7	11.42				
6000467	Applewood Nrsng & Rehab Center	Matteson	115	32,565	77.6%	396	82.2	8.05	4.34				
6005904	McAllister Nursing & Rehab	Country Club Hills	111	31,001	76.5%	96	322.9	0	0				
6006753	Oak Forest Hospital	Oak Forest	10	1,814	49.7%	0	0	5.75	3.46				
6002265	Crestwood Care Centre	Midlothian	303	87,047	78.7%	898	97.2	11.5	5.54				
6002273	Crestwood Terrace	Midlothian	126	44,530	96.8%	85	523.9	18.4	7.73				
6014534	Manorcare of Palos Heights West	Palos Heights	130	43,674	92.0%	962	45.4	25.3	11.44				
6010912	Manorcare of Palos Heights East	Palos Heights	174	59,396	93.5%	1,282	46.3	25.3	11.18				
6004352	Hickory Nursing Pavilion	Hickory Hills	74	23,124	85.6%	39	592.9	29.9	14.31				
6001697	Chicago Ridge Nursing Center	Chicago Ridge	231	79,580	94.4%	94	846.6	27.6	12.71				
6007934	Ridgeland Nrsng & Rehab Center	Palos Heights	101	32,969	89.4%	147	224.3	20.7	9.7				
6000943	Manorcare of Oak Lawn West	Oak Lawn	192	57,980	82.7%	1,001	57.9	29.9	12.79				
6012987	Lexington Of Chicago Ridge	Chicago Ridge	203	69,153	93.3%	932	74.2	27.6	12.04				
6002059	Concord Nursing & Rehab Center	Oak Lawn	134	43,494	88.9%	133	327.0	29.9	12.78				
6007843	Providence HC & Rehab of Palos Heights	Palos Heights	193	45,669	64.8%	916	49.9	19.55	8.2				
6000236	Manorcare of Oak Lawn East	Oak Lawn	122	42,098	94.5%	1,145	36.8	29.9	12.19				
6011720	Advocate South Suburban Hospital	Hazel Crest	41	4,733	31.6%	467	10.1	8.05	3.67				
6004741	Imperial Of Hazel Crest	Hazel Crest	199	65,432	90.1%	117	559.2	5.75	3.15				
6008064	Riviera Care Center	Chicago Heights	200	60,525	82.9%	209	289.6	17.25	7.67				
6011746	Prairie Manor Nsg & Rehab Ctr	Chicago Heights	148	47,836	88.6%	292	163.8	13.8	6.49				
6007991	Woodside Manor	S Chicago Hts	112	40,068	98.0%	75	534.2	20.7	9.5				
6009385	Thornside Heights Terrace	Chicago Heights	222	74,028	91.4%	30	2,467.6	18.4	8.17				
6006084	South Suburban Rehab Center	Homewood	259	39,031	41.3%	194	201.2	17.25	5.29				
6012611	Manorcare of Homewood	Homewood	120	37,560	85.8%	567	66.2	19.55	6.13				
6001077	Plaza Nursing & Rehab Center	Midlothian	91	30,380	91.5%	120	253.2	14.95	7.53				
6005623	Lydia Healthcare	Robbins	412	144,940	96.4%	152	953.6	17.25	8.53				
6004139	Heather Healthcare Center	Harvey	173	45,312	71.8%	158	286.8	16.1	7.9				
6003628	Glenwood Healthcare & Rehab.	Glenwood	164	51,396	76.5%	147	349.6	23	10.67				
6010078	Windmill Nursing Pavilion	South Holland	150	46,853	85.6%	131	357.7	23	10.28				
6007868	Providence of South Holland	South Holland	171	42,468	68.0%	554	76.7	21.85	10.12				
6011589	Manorcare of South Holland	South Holland	200	57,214	78.4%	1,132	50.5	27.8	16.1				
6002190	Countyside Nursing & Rehab Center	Dorton	197	62,950	87.5%	184	342.1	29.9	17.94				
6008443	Tri-State Manor Nursing Home	Lansing	84	28,455	92.8%	153	186.0	26.45	15.64				
8000822	Belhaven Nursing & Rehab Center	Chicago	221	72,323	89.7%	213	339.5	25	12.58				
6009732	Washington & Jane Smith Comm.	Chicago	103	33,173	88.2%	242	137.1	25	12.6				
6001036	Blue Island Nursing Home	Blue Island	0	0	0.0%	0	0.0	19.55	10.82				
6003958	Renaissance Park South	Chicago	300	88,354	80.7%	345	256.1	25	12.98				
6014781	Southport Nur & Rehab Center	Chicago	228	66,289	79.7%	205	323.4	26.25	14.73				
			7,899	2,379,591	82.5%	16,968	140.2						
	New Perm Victorian Village	Homert Glen	50					28.75	15.4				

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

30-Minute Travel Time Chart

FACID	FACNAME	CITY	# of Licensed Nursing Beds	Travel Time	
				Adjusted 77 IAC 1100.510(d)	Drive Distance
6009252	Sunny Hill Nursing Home Will County	Joliet	300	27.6	19.34
6008338	Salem Village Nursing & Rehab	Joliet	266	28.75	19.71
6002604	Hillcrest Nursing & Rehab Center	Joliet	168	29.9	18.18
6004550	Holy Family Villa	Lemont	99	29.9	17.34
6007918	Glenshire Nsg & Rehab Centre	Richton Park	294	9.2	5.74
6010664	St. James Manor & Villa	Crete	110	29.9	14.85
6003297	Frankfort Terrace	Frankfort	120	18.4	9.97
6016059	Smith Crossing	Orland Park	30	17.25	8.84
6014922	Alden-Orland Park Rehab & Hcc	Orland Park	200	16.1	9.09
6014682	Lexington Health Care Center	Orland Park	278	20.7	11.42
6000467	Applewood Nrsg & Rehab Center	Matteson	115	8.05	4.34
6005904	McAllister Nursing & Rehab	Country Club Hills	111	0	0
6006753	Oak Forest Hospital	Oak Forest	10	5.75	3.46
6002265	Crestwood Care Centre	Midlothian	303	11.5	5.54
6002273	Crestwood Terrace	Midlothian	126	18.4	7.73
6014534	Manorcare of Palos Heights West	Palos Heights	130	25.3	11.44
6010912	Manorcare of Palos Heights East	Palos Heights	174	25.3	11.18
6004352	Hickory Nursing Pavilion	Hickory Hills	74	29.9	14.31
6001697	Chicago Ridge Nursing Center	Chicago Ridge	231	27.6	12.71
6007934	Ridgeland Nrsg & Rehab Center	Palos Heights	101	20.7	9.7
6000343	Manorcare of Oak Lawn West	Oak Lawn	192	29.9	12.79
6012967	Lexington Of Chicago Ridge	Chicago Ridge	203	27.6	12.04
6002059	Concord Nursing & Rehab Center	Oak Lawn	134	29.9	12.78
6007843	Providence HC & Rehab of Palos Heights	Palos Heights	193	19.55	8.2
6000236	Manorcare of Oak Lawn East	Oak Lawn	122	29.9	12.19
6011720	Advocate South Suburban Hospital	Hazel Crest	41	8.05	3.67
6004741	Imperial Of Hazel Crest	Hazel Crest	199	5.75	3.15
6008064	Riviera Care Center	Chicago Heights	200	17.25	7.67
6011746	Prairie Manor Nsg & Rehab Ctr	Chicago Heights	148	13.8	6.49
6007991	Woodside Manor	S Chicago Hts	112	20.7	9.5
6009385	Thomton Heights Terrace	Chicago Heights	222	18.4	8.17
6006084	South Suburban Rehab Center	Homewood	259	17.25	5.29
6012611	Manorcare of Homewood	Homewood	120	19.55	6.13
6001077	Plaza Nursing & Rehab Center	Midlothian	91	14.95	7.53
6005623	Lydia Healthcare	Robbins	412	17.25	8.53
6004139	Heather Healthcare Center	Harvey	173	16.1	7.9
6003628	Glenwood Healthcare & Rehab.	Glenwood	184	23	10.67
6010078	Windmill Nursing Pavilion	South Holland	150	23	10.26
6007868	Providence of South Holland	South Holland	171	21.85	10.12
6011589	Manorcare of South Holland	South Holland	200	27.6	16.1
6002190	Countryside Nursing & Rehab Center	Dolton	197	29.9	17.94
6009443	Tri-State Manor Nursing Home	Lansing	84	26.45	15.64
6000822	Belhaven Nursing & Rehab Center	Chicago	221	25	12.58
6009732	Washington & Jane Smith Comm.	Chicago	103	25	12.6
6001036	Blue Island Nursing Home	Blue Island	0	19.55	10.82
6003958	Renaissance Park South	Chicago	300	25	12.98
6014781	Southport Nur & Rehab Center	Chicago	228	26.25	14.73
			7,899		
	New Perm Victorian Village	Homer Glen	50	28.75	15.4

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Develop

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SUNKY HILL NURSING HOME OF WILL COUNTY JOLIET

SUNKY HILL NURSING HOME OF WILL COUNTY
 431 DORIS AVENUE
 JOLIET, IL 60433
 Facility ID 6006252
 Reference Numbers 009 Planning Services Area 197
 Health Service Area 009 Planning Services Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	28	137	0	3	46	0	214
Skilled Under 22	0	0	0	0	0	0	0
ICF/ID	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	28	137	0	3	46	0	214

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/ID	Skilled	Shelter	Totals
African Amer.	0	0	0	0	0	0
Asian	0	0	0	0	0	0
Black	31	0	0	0	0	31
Hispanic/Pac. Isl.	2	0	0	0	0	2
White	181	0	0	0	0	181
Race Unknown	0	0	0	0	0	0
Total	214	0	0	0	0	214

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	3.00
Director of Nursing	1.00
Registered Nurses	11.6
LPN's	1.1
Certified Aides	1.1
Other Health Staff	1.1
Non-Health Staff	73.00
Totals	21.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Charity Expense	Charity Expense as % of Total Net Revenue
3,091,465	6,457,075	5,470	52,367	2,371,748	0	12,778,120	0.0%

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SUNKY HILL NURSING HOME OF WILL COUNTY JOLIET

SUNKY HILL NURSING HOME OF WILL COUNTY
 431 DORIS AVENUE
 JOLIET, IL 60433
 Facility ID 6006252
 Reference Numbers 009 Planning Services Area 197
 Health Service Area 009 Planning Services Area 197

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	No.
Neoplasms	2
Endocrine/Metabolic	4
Blood Disorders	0
Nervous System Non Alcoholic	0
Alzheimer Disease	6
Mental Illness	9
Developmental Disability	2
Circulatory System	55
Respiratory System	8
Digestive System	3
Genitourinary System Disorders	5
Skin Disorders	2
Musculo-skeletal Disorders	11
Injuries and Poisonings	8
Other Medical Conditions	89
Non-Medical Conditions	0
TOTALS	214

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Admissions	Discharges
Nursing Care	209	133
Skilled Under 22	133	128
ICF/ID	128	214
Skilled Care	0	0
TOTALS	470	475

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Charity Expense	Charity Expense as % of Total Net Revenue
Nursing Care	9405	3,996	54,959	49.8%	0	537	1,957	71.4%
Skilled Under 22	0	0	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0	0	0.0%	0	0	0	0.0%
Skilled Care	0	0	0	0.0%	0	0	0	0.0%
TOTALS	9405	3,996	54,959	49.8%	0	537	1,957	71.4%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	1
45 to 59	2	6	0	0	0	0	2	6	8
60 to 74	3	0	0	0	0	0	3	0	3
65 to 74	14	15	0	0	0	0	14	15	29
75 to 84	10	47	0	0	0	0	10	47	57
85+	13	100	0	0	0	0	13	100	113
TOTALS	42	172	0	0	0	0	42	172	214

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SALEM VILLAGE NURSING & REHAB JOLIET

SALEM VILLAGE NURSING & REHAB
 1314 ROWELL AVENUE
 JOLIET, IL 60433
 Reference Numbers Facility ID 8003338
 Health Services Area 009 Planning Services Area 197
 Administrator
 KELLY COVARRELLAS, RN
 Contact Person and Telephone
 KELLY COVARRELLAS, RN
 915-727-5451
 Registered Against Information
 Lawrence Schwartz
 9170 N. McCormick Blvd Suite 219
 Skokie, IL 60087
 FACILITY OWNERSHIP
 LIMITED LIABILITY CO
 CONTINUING CARE COMMUNITY
 LIFE CARE FACILITY

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	44	123	0	5	31	0	203
Skilled Under Z2	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	44	123	0	5	31	0	205

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Totals
Asian	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	43	0	0	0	43
Hispanic	0	0	0	0	0
White	159	0	0	2	161
Race Unknown	0	0	0	0	0
Total	203	0	0	2	205

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
49.7%	36.9%	0.0%	2.6%	10.8%	0.0%	100.0%
5,119,000	6,029,475	0	417,232	1,769,039	0	18,334,733

Charity Expenses does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SALEM VILLAGE NURSING & REHAB JOLIET

SALEM VILLAGE NURSING & REHAB
 1314 ROWELL AVENUE
 JOLIET, IL 60433
 Reference Numbers Facility ID 8003338
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 Administrator
 KELLY COVARRELLAS, RN
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 Registered Against Information
 Lawrence Schwartz
 9170 N. McCormick Blvd Suite 219
 Skokie, IL 60087
 FACILITY OWNERSHIP
 LIMITED LIABILITY CO
 CONTINUING CARE COMMUNITY
 LIFE CARE FACILITY

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	No.
Alzheimer's/Dementia	11
Endocrine/Metabolic	5
Blood Disorders	4
Neurological System Non Alzheimer	17
Alzheimer Disease	7
Mental Illness	2
Overweight/Obesity	87
Circulatory System	17
Respiratory System	2
Digestive System	18
Genitourinary System Disorders	13
SKN Disorders	7
Musculoskeletal Disorders	3
Injury and Poisonings	13
Other Medical Conditions	0
Non-Medical Conditions	205
TOTALS	90

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Totals
Asian	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	43	0	0	0	43
Hispanic	0	0	0	0	0
White	159	0	0	2	161
Race Unknown	0	0	0	0	0
Total	203	0	0	2	205

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
49.7%	36.9%	0.0%	2.6%	10.8%	0.0%	100.0%
5,119,000	6,029,475	0	417,232	1,769,039	0	18,334,733

Charity Expenses does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SALEM VILLAGE NURSING & REHAB JOLIET

SALEM VILLAGE NURSING & REHAB
 1314 ROWELL AVENUE
 JOLIET, IL 60433
 Reference Numbers Facility ID 8003338
 Health Services Area 009 Planning Services Area 197
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 KELLY COVARRELLAS, RN
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 9170 N. McCormick Blvd Suite 219
 Skokie, IL 60087
 FACILITY OWNERSHIP
 LIMITED LIABILITY CO
 CONTINUING CARE COMMUNITY
 LIFE CARE FACILITY

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER Z2		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
19 to 44	1	0	0	0	0	0	0	0	1	0	1
45 to 59	6	4	0	0	0	0	0	0	6	4	10
60 to 64	7	7	0	0	0	0	0	0	7	7	14
65 to 74	17	23	0	0	0	0	0	0	17	23	40
75 to 84	24	41	0	0	0	0	1	0	25	41	66
85+	11	62	0	0	0	0	1	1	11	63	74
TOTALS	68	137	0	0	0	0	1	1	67	138	205

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Totals
Asian	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	43	0	0	0	43
Hispanic	0	0	0	0	0
White	159	0	0	2	161
Race Unknown	0	0	0	0	0
Total	203	0	0	2	205

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
49.7%	36.9%	0.0%	2.6%	10.8%	0.0%	100.0%
5,119,000	6,029,475	0	417,232	1,769,039	0	18,334,733

Charity Expenses does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HILLCREST NURSING & REHAB CENTER JOLIET

777 DRAPER
 JOLIET, IL 60432
 Reference Numbers Facility ID 6002904
 Health Service Area 009 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	2	138	9	0	0	149
Skilled Under 22	0	0	0	0	0	0
Intermediate DO	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	2	138	9	0	0	149

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled 22	ICF/DD	Skilled	TOTALS
Asian	0	0	0	0	0
Amer. Indian	2	0	0	0	2
Black	41	0	0	0	41
Hawaiian/Pac. Isl.	4	0	0	0	4
White	102	0	0	0	102
Race Unknown	0	0	0	0	0
Total	149	0	0	0	149

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
91.7%	7.0%	0.5%	0.0%	0.0%	0.0%
6,273,470	534,988	31,410	0	0	0
TOTALS	6,839,969				

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HILLCREST NURSING & REHAB CENTER JOLIET

777 DRAPER
 JOLIET, IL 60432
 Reference Numbers Facility ID 6002904
 Health Service Area 008 Planning Service Area 187

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Aggression/Social	0
Chronic Alcoholism	0
Developmentally Disabled	17
Drug Addiction	11
Medical Recipient	8
Medicaid Recipient	4
Mental Illness	04
Non-ambulatory	0
Non-Mobile	14
Public Aid Recipient	5
Under 65 Years Old	4
Unable to Self-Medicate	3
Verbalizer Dependent	3
Infectious Disease w/ Isolation	4
Other Restrictions	0
No Restrictions	3
Note: Reported restrictions denied by '1'	149
TOTALS	149

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	168	150	149	19	84	168
Skilled Under 22	0	0	0	0	0	0
Intermediate DO	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTAL BEDS	168	150	149	19	84	168

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Admissions	Discharges
Nursing Care	144	115
Skilled Under 22	0	0
Intermediate DO	0	0
Skilled Care	0	0
TOTALS	144	115

Total Residents Diagnosed as Mentally Ill 149

HILLCREST NURSING & REHAB CENTER

777 DRAPER
 JOLIET, IL 60432
 Reference Numbers Facility ID 6002904
 Health Service Area 008 Planning Service Area 187

ADMISSION RESTRICTIONS

RESTRICTION	Count
Aggression/Social	0
Chronic Alcoholism	0
Developmentally Disabled	17
Drug Addiction	11
Medical Recipient	8
Medicaid Recipient	4
Mental Illness	04
Non-ambulatory	0
Non-Mobile	14
Public Aid Recipient	5
Under 65 Years Old	4
Unable to Self-Medicate	3
Verbalizer Dependent	3
Infectious Disease w/ Isolation	4
Other Restrictions	0
No Restrictions	3
Note: Reported restrictions denied by '1'	149
TOTALS	149

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	168	150	149	19	84	168
Skilled Under 22	0	0	0	0	0	0
Intermediate DO	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTAL BEDS	168	150	149	19	84	168

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS						
Nursing Care	1026	6.0%	52541	85.7%	218	0	0	0	0	0	54585	89.0%
Skilled Under 22	0	0.0%	0	0	0	0	0	0	0	0	0	0.0%
Intermediate DO	0	0.0%	0	0	0	0	0	0	0	0	0	0.0%
Skilled Care	0	0.0%	0	0	0	0	0	0	0	0	0	0.0%
TOTALS	1026	6.0%	52541	85.7%	218	0	0	0	0	0	54585	89.0%

Facility Utilization - 2010

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER 22		INTERMEDIATE DO		SHELTERED		TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	
Under 13	0	0	0	0	0	0	0	0	0
19 to 44	32	16	0	0	0	0	0	0	48
45 to 59	48	20	0	0	0	0	0	0	68
60 to 84	11	3	0	0	0	0	0	0	14
85 to 94	4	3	0	0	0	0	0	0	7
75 to 94	5	5	0	0	0	0	0	0	10
85+	2	0	0	0	0	0	0	0	2
TOTALS	102	47	0	0	0	0	0	0	149

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 GLENESHIRE NURSING & REHAB CENTRE RICHTON PARK

GLENESHIRE NURSING & REHAB CENTRE
 22860 SOUTH CICERO AVENUE
 RICHTON PARK, IL 60471
 Facility ID 6007918
 Planning Service Area 007

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Aggression/Anti-Social	1
Alcoholism	0
Encephalopathy	11
Encephalopathy/Alcohol	30
Blood Disorders	3
*Nervous System Non Alzheimer	12
Alzheimer Disease	20
Mental Illness	12
Developmental Disability	28
Circulatory System	10
Respiratory System	60
Digestive System	5
Genitourinary System Disorders	7
Skin Disorders	6
Musculoskeletal Disorders	10
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	216

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care	TOTALS
African	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	153	0	0	0	0	0	153
Hispanic/Latino	0	0	0	0	0	0	0
White	63	0	0	0	0	0	63
Race Unknown	0	0	0	0	0	0	0
TOTALS	216	0	0	0	0	0	216

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care Expense*	Cherty Care Expense as % of Total Net Revenue
2,092,150	11,556,021	171,432	525,578	234,062	0	0.0%

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 GLENESHIRE NURSING & REHAB CENTRE RICHTON PARK

GLENESHIRE NURSING & REHAB CENTRE
 22860 SOUTH CICERO AVENUE
 RICHTON PARK, IL 60471
 Facility ID 6007918
 Planning Service Area 007

ADMISSION RESTRICTIONS

RESTRICTION	Count
Aggression/Anti-Social	1
Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Amputatory	0
Non-Mobile	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self Medicate	0
Ventilator Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0
Notes: Reported restrictions checked 'Y'	0
TOTALS	216

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	204	213	374
Skilled Under ZZ	0	0	371
Intermediate DD	0	0	216
Skilled Care	0	0	4
TOTAL BEDS	204	213	965

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care	Unpaid	Set Up
Nursing Care	7205	15.5%	6848	83.9%	333	1191	0	74.0%
Skilled Under ZZ	0	0.0%	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0.0%
Skilled Care	0	0.0%	0	0.0%	0	0	0	0.0%
TOTALS	7205	15.5%	6848	83.9%	333	1191	0	74.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	NURSING CARE		INTERMED. DD		SHELTERED		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0
18 to 44	10	6	0	0	0	0	10	6
45 to 59	53	26	0	0	0	0	52	26
60 to 74	22	17	0	0	0	0	22	17
75 to 84	19	13	0	0	0	0	18	13
85+	15	16	0	0	0	0	15	18
TOTALS	126	90	0	0	0	0	128	90

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 GLENESHIRE NURSING & REHAB CENTRE RICHTON PARK

GLENESHIRE NURSING & REHAB CENTRE
 22860 SOUTH CICERO AVENUE
 RICHTON PARK, IL 60471
 Facility ID 6007918
 Planning Service Area 007

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care	TOTALS
Nursing Care	14	193	2	3	4	0	216
Skilled Under ZZ	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	14	193	2	3	4	0	216

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care	TOTALS
African	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	153	0	0	0	0	0	153
Hispanic/Latino	0	0	0	0	0	0	0
White	63	0	0	0	0	0	63
Race Unknown	0	0	0	0	0	0	0
TOTALS	216	0	0	0	0	0	216

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Cherty Care Expense*	Cherty Care Expense as % of Total Net Revenue
2,092,150	11,556,021	171,432	525,578	234,062	0	0.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	NURSING CARE		INTERMED. DD		SHELTERED		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0
18 to 44	10	6	0	0	0	0	10	6
45 to 59	53	26	0	0	0	0	52	26
60 to 74	22	17	0	0	0	0	22	17
75 to 84	19	13	0	0	0	0	18	13
85+	15	16	0	0	0	0	15	18
TOTALS	126	90	0	0	0	0	128	90

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 ST. JAMES MANOR & VILLA
 ST. JAMES MANOR & VILLA
 1231 EAST RICHMOND ROAD
 CRETE, IL 60417
 Facility ID 6010684
 Reference Numbers Health Service Area 008 Planning Service Area 187
 Administrator Tina Stroncu
 The Subbu
 Contact Person and Telephone Tina Stroncu 708-367-4491
 Registered Agent Information Date Completed 3/1/2011

ADMISSION RESTRICTIONS
 Aggressive/Anti-Social 1
 Chronic Alcoholism 1
 Down Syndrome/Disabled 0
 Drug Addiction 0
 Medicaid Recipient 0
 Medicare Recipient 0
 Mental Illness 1
 Non-Abolition 0
 Non-Abolition 0
 Public Aid Recipient 0
 Under 65 Years Old 0
 Unable to Self-Medicate 0
 Ventilator Dependent 1
 Infectious Disease w/ Isolation 0
 Other Restrictions 0
 No Restrictions 0
 Note: Reported restrictions omitted by !!

RESIDENTS BY PRIMARY DIAGNOSIS
 Dementia 75
 Chronic Alcoholism 215
 Endocrine/Metabolic 14
 Blood Disorders 2
 Nervous System Non-Achilles 5
 Alzheimer Diseases 9
 Mental Illness 0
 Developmental Disability 0
 Circulatory System 13
 Respiratory System 13
 Digestive System 4
 Genitourinary System Disorders 4
 Skin Disorders 1
 Musculo-skeletal Disorders 33
 Injuries and Poisonings 5
 Other Medical Conditions 0
 Non-Medical Conditions 0
 TOTALS 97
 Total Residents Diagnosed as Mentally Ill 0

ADMISSIONS AND DISCHARGES - 2010
 Residents on 1/1/2010 75
 Total Admissions 2010 215
 Total Discharges 2010 193
 Residents on 12/31/2010 97
 Identified Offenders 0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK BEDS	PEAK BEDS IN USE	MEDICARE/MEDICAID CERTIFIED BEDS
Nursing Care	110	110	110
Skilled Under 22	0	0	0
Intermediate DD	0	0	0
Skilled Care	0	0	0
TOTAL BEDS	110	110	110

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	13	0	0	0	13
Hispanic/Hispanic Isd.	0	0	0	0	0
White	84	0	0	0	84
Race Unknown	0	0	0	0	0
Total	97	0	0	0	97

ETHNICITY

ETHNICITY	Nursing	Skilled	ICF/DD	Shelter	Totals
Hispanic	2	0	0	0	2
Non-Hispanic	94	0	0	0	94
Ethnicity Unknown	0	0	0	0	0
Total	97	0	0	0	97

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	14.00
LPNs	13.00
Certified Aides	52.00
Other Health Staff	9.00
Non-Health Staff	35.00
Totals	121.00

NET REVENUE BY PAVOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
50.9%	14.2%	0.0%	0.8%	34.6%	0.0%
4,822,169	1,379,096	0	57,482	3,360,039	0

*Charity Expense does not include expenses which may be considered a community benefit.

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Charity	Private Pay	Peak Beds
Nursing Care	10291	25.0%	12364	61.5%	1324	216	4653
Skilled Under 22	0	0.0%	0	0.0%	0	0	0
Intermediate DD	0	0.0%	0	0.0%	0	0	0
Skilled Care	0	0.0%	0	0.0%	0	0	0
TOTALS	10291	25.0%	12364	61.5%	1324	216	4653

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - OCTOBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER 22		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0
60 to 74	1	2	0	0	0	0	0	0	1	2	3
75 to 84	10	4	0	0	0	0	0	0	10	4	14
85+	16	37	0	0	0	0	0	0	16	37	53
TOTALS	33	64	0	0	0	0	0	0	33	64	97

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Charity	TOTALS
Nursing Care	42	33	0	1	21	97
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	42	33	0	1	21	97

NET REVENUE BY PAVOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
50.9%	14.2%	0.0%	0.8%	34.6%	0.0%
4,822,169	1,379,096	0	57,482	3,360,039	0

NET REVENUE BY PAVOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
50.9%	14.2%	0.0%	0.8%	34.6%	0.0%
4,822,169	1,379,096	0	57,482	3,360,039	0

NET REVENUE BY PAVOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
50.9%	14.2%	0.0%	0.8%	34.6%	0.0%
4,822,169	1,379,096	0	57,482	3,360,039	0

NET REVENUE BY PAVOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity
50.9%	14.2%	0.0%	0.8%	34.6%	0.0%
4,822,169	1,379,096	0	57,482	3,360,039	0

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 FRANKFORT TERRACE

FRANKFORT TERRACE
40 NORTH SMITH STREET
FRANKFORT, IL 60423
Reference Numbers Facility ID 6003297
Health Services Area 008 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	114	0	0	1	0	115
Skilled Under ZZ	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	0	114	0	0	1	0	115

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	50	0	0	0	50
Hispanic/Latino	0	0	0	0	0
White	65	0	0	0	65
Race Unknown	0	0	0	0	0
Total	115	0	0	0	115

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
0.0%	98.8%	0.0%	0.0%	1.2%	0.0%
0	4,288,390	0	0	50,775	0
*Charity Expense does not include expenses which may be considered a community benefit.					

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 FRANKFORT TERRACE

FRANKFORT TERRACE
40 NORTH SMITH STREET
FRANKFORT, IL 60423
Reference Numbers Facility ID 6003297
Health Services Area 008 Planning Service Area 197

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	No.
Neurosis	1
Endocrine/Metabolic	15
Blood Disorders	8
Nervous System Non Alzheimer	16
Alzheimer Disease	3
Mental Illness	24
Developmental Disability	0
Circulatory System	20
Respiratory System	14
Digestive System	2
Genitourinary System Disorders	2
Skin Disorders	0
Neuro-vascular Disorders	5
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	113

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	BEDES	BEDES	MEDICARE	MEDICAID
	SET-UP	USED	IN USE	CERTIFIED	CERTIFIED
Nursing Care	120	120	115	5	121
Skilled Under ZZ	0	0	0	0	0
Intermediate DD	0	0	0	0	0
Sheltered Care	0	0	0	0	0
TOTALS	120	120	115	5	121

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicaid	Medicare	Other Public	Private Insurance	Charity Care	Peak Beds
	Pat. days	Occ. Pat.	Pat. days	Pat. days	Pat. days	Set-Up
Nursing Care	0	0.0%	4237	98.0%	0	4307
Skilled Under ZZ	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0	0	0.0%
TOTALS	0	0.0%	4237	98.0%	0	4307

RESIDENTS BY AGE GROUP, SET AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER ZZ		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	7	4	0	0	0	0	0	0	7	4	11
45 to 56	27	15	0	0	0	0	0	0	27	15	42
57 to 64	10	6	0	0	0	0	0	0	10	6	16
65 to 74	15	10	0	0	0	0	0	0	15	10	25
75 to 84	5	9	0	0	0	0	0	0	5	9	14
85+	2	5	0	0	0	0	0	0	2	5	7
TOTALS	66	49	0	0	0	0	0	0	66	49	115

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SMITH CROSSING ORLAND PARK

SMITH CROSSING
 10501 EMILIE LANE
 ORLAND PARK, IL 60467
 Reference Numbers Facility ID 6010059
 Health Service Area 009 Planning Service Area 197

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicare	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	4	7	0	0	13	0	24
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	4	7	0	0	13	0	24

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	0	0	0	0	0
Hispanic	0	0	0	0	0
White	29	0	0	0	29
Race Unknown	0	0	0	0	0
Total	29	0	0	0	29

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
25.0%	17.0%	0.0%	2.8%	54.9%	0.0%
750,097	501,015	0	75,690	1,622,778	27,363
TOTALS	1,251,740	0	75,690	1,622,778	27,363

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SMITH CROSSING ORLAND PARK

SMITH CROSSING
 10501 EMILIE LANE
 ORLAND PARK, IL 60467
 Reference Numbers Facility ID 6010059
 Health Service Area 009 Planning Service Area 197

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	DIAGNOSIS	Count
Aggravated Social	Neoplasms	0
Chronic Alcoholism	Endocrine/Metabolic	3
Developmentally Disabled	Blood Disorders	0
Drug Addiction	"Nervous System Non Alcoholic	0
Medicaid Recipient	Alzheimer Disease	3
Medicare Recipient	Mental Illness	3
Mental Illness	Developmental Disability	0
Non-Apparatus	Circulatory System	10
Non-Midline	Respiratory System	1
Public Aid Recipient	Digestive System	2
Under 65 Year Old	Genitourinary System Disorders	1
Unable to Self-Medicare	Skin Disorders	0
Ventilator Dependent	Musculo-Skeletal Disorders	4
Infectious Disease w/ Isolation	Injuries and Poisonings	2
Other Restrictions	Other Medical Conditions	0
No Restrictions	Non-Medical Conditions	0
TOTALS	TOTALS	28

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	30	30	26
Skilled Under 22	0	0	53
ICF/DD	0	0	50
Skilled Care	0	0	28
TOTAL BEDS	30	30	157

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds
Nursing Care	1393	2162	0	0	7008	0	96.8%
Skilled Under 22	0	0	0	0	0	0	0.0%
ICF/DD	0	0	0	0	0	0	0.0%
Skilled Care	1393	2162	0	0	7008	0	96.8%
TOTALS	1393	2162	0	0	7008	0	96.8%

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds
Nursing Care	1393	2162	0	0	7008	0	96.8%
Skilled Under 22	0	0	0	0	0	0	0.0%
ICF/DD	0	0	0	0	0	0	0.0%
Skilled Care	1393	2162	0	0	7008	0	96.8%
TOTALS	1393	2162	0	0	7008	0	96.8%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 16	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0
60 to 74	0	0	0	0	0	0	0
75 to 84	1	4	0	0	0	0	5
85+	5	19	0	0	0	0	24
TOTALS	6	23	0	0	0	0	29

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 ALDEN-ORLAND PARK REHAB & HCC ORLAND PARK

ALDEN-ORLAND PARK REHAB & HCC
 18450 SOUTH 97TH AVENUE
 ORLAND PARK, IL 60467
 Reference Numbers Facility ID 8014522
 Health Services Area 007 Planning Services Area 705

RESIDENTS BY PAYOR SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	63	27	3	7	28	128
Skilled Under ZZ	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	63	27	3	7	28	128

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	IC/DD	Skilled	Shelter	Totals
Asian	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0
Black	6	0	0	0	0	6
Hispanic/Pac. Isl.	0	0	0	0	0	0
White	118	0	0	3	118	128
Race Unknown	4	0	0	0	4	4
Total	128	0	0	0	128	128

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
14,958,177	312,537	1,027,486	2,037,251	0	20,428,572

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 ALDEN-ORLAND PARK REHAB & HCC ORLAND PARK

ALDEN-ORLAND PARK REHAB & HCC
 18450 SOUTH 97TH AVENUE
 ORLAND PARK, IL 60467
 Reference Numbers Facility ID 8014922
 Health Services Area 007 Planning Services Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	1	2	3	4	5
Neurosis	0	0	0	0	0	0
Neurosis	0	0	0	0	0	0
Endocrine/Metabolic	0	0	0	0	0	0
Blood Disorders	0	0	0	0	0	0
Reproductive System Men	0	0	0	0	0	0
Alzheimer Disease	0	0	0	0	0	0
Mental Illness	0	0	0	0	0	0
Developmental Disability	0	0	0	0	0	0
Circulatory System	0	0	0	0	0	0
Respiratory System	0	0	0	0	0	0
Digestive System	0	0	0	0	0	0
Genitourinary System Disorders	0	0	0	0	0	0
Skin Disorders	0	0	0	0	0	0
Musculoskeletal Disorders	0	0	0	0	0	0
Injuries and Poisonings	0	0	0	0	0	0
Other Medical Conditions	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
Nursing Care	147	1274	1295	128	0	2844
Skilled Under ZZ	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	147	1274	1295	128	0	2844

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
27915	10832	1418	2071	2588	34414

ALDEN-ORLAND PARK REHAB & HCC

18450 SOUTH 97TH AVENUE
 ORLAND PARK, IL 60467

ADMISSION RESTRICTIONS

RESTRICTION	0	1	2	3	4	5
Aggressive/Unsocial	0	0	0	0	0	0
Chronic Alcoholism	0	0	0	0	0	0
Developmentally Disabled	0	0	0	0	0	0
Drug Addiction	0	0	0	0	0	0
Medically Recalcitrant	0	0	0	0	0	0
Medicare Recipients	0	0	0	0	0	0
Mental Illness	0	0	0	0	0	0
Non-Ambulatory	0	0	0	0	0	0
Non-Applicable	0	0	0	0	0	0
Public Aid Recipients	0	0	0	0	0	0
Under 65 Years Old	0	0	0	0	0	0
Unable to Self-Medicate	0	0	0	0	0	0
Vascular Disease w/ Isolation	0	0	0	0	0	0
Other Restrictions	0	0	0	0	0	0
No Restrictions	0	0	0	0	0	0
Not Reported restrictions allowed by J1	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
Nursing Care	200	184	162	184	126	756
Skilled Under ZZ	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	200	184	162	184	126	756

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0
45 to 59	1	2	0	0	1	2	3
60 to 64	0	0	0	0	0	0	0
65 to 74	7	11	0	0	7	11	18
75 to 84	13	20	0	0	13	28	41
85+	14	47	0	0	14	47	61
TOTALS	35	91	0	0	35	91	126

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LEXINGTON HEALTH CARE CENTER ORLAND PARK

LEXINGTON HEALTH CARE CENTER
 14601 S. JOHN HUMPHREY DRIVE
 ORLAND PARK, IL 60462
 Reference Numbers Facility ID 6014682
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	68	149	0	3	13	0	233
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	68	149	0	3	13	0	231

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Asian	0	0	0	0	0	0	0
Am. Indian	0	0	0	0	0	0	0
Black	35	0	0	0	0	0	35
Hispanic	0	0	0	0	0	0	0
White	196	0	0	0	0	0	196
Race Unknown	0	0	0	0	0	0	0
Total	231	0	0	0	0	0	231

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
41.3%	50.1%	0.6%	1.9%	6.7%	0.0%
7,331,393	8,694,443	0	342,439	1,186,210	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LEXINGTON HEALTH CARE CENTER ORLAND PARK

LEXINGTON HEALTH CARE CENTER
 14601 S. JOHN HUMPHREY DRIVE
 ORLAND PARK, IL 60462
 Reference Numbers Facility ID 6014682
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Nephritis	1
Endocrine/Metabolic	7
Blood Disorders	1
Nervous System Non Alzheimer	6
Alzheimer Disease	0
Mental Illness	3
Developmental Disability	3
Circulatory System	34
Respiratory System	8
Digestive System	3
Genitourinary System Disorders	7
Skin Disorders	1
Musculoskeletal Disorders	41
Infectious and Parasitosis	7
Other Medical Conditions	111
Non-Medical Conditions	0
TOTALS	231

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
Nursing Care	245	451	0	0	0	0	696
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	245	451	0	0	0	0	696

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
Nursing Care	15,2%	67,3%	0%	0%	0%	0%	82,5%
Skilled Under 22	0%	0%	0%	0%	0%	0%	0%
Intermediate DD	0%	0%	0%	0%	0%	0%	0%
Sheltered Care	0%	0%	0%	0%	0%	0%	0%
TOTALS	15,2%	67,3%	0%	0%	0%	0%	82,5%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER 22		INTERMED. DD		SHELTERED		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	0	1
45 to 59	3	2	0	0	0	0	0	0	3	2
60 to 64	4	3	0	0	0	0	0	0	4	3
65 to 74	13	15	0	0	0	0	0	0	13	15
75 to 84	14	54	0	0	0	0	0	0	14	54
85+	15	107	0	0	0	0	0	0	15	107
TOTALS	49	182	0	0	0	0	0	0	49	182

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 APPELWOOD NRSNG & REHAB CENTER MATTESON

APPELWOOD NRSNG & REHAB CENTER
21000 KOSTNER AVENUE
MATTESON, IL 60443
Reference Numbers Facility ID 6000467
Health Service Area 007 Planning Service Area 765

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private	Charity	TOTALS
Nursing Care	19	73	0	0	6	0	98
Skilled Under ZZ	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	19	73	0	0	6	0	98

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Number	Subtotal	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	50	0	0	0	50
Hispanic	0	0	0	0	0
White	48	0	0	0	48
Race Unknown	0	0	0	0	0
Total	98	0	0	0	98

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Expenses as % of Total Net Revenue
44.2%	42.1%	4.8%	3.0%	6.1%	0.0%	0.0%
2,501,045	2,307,111	263,000	166,813	340,830	0	5,684,299

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 APPELWOOD NRSNG & REHAB CENTER MATTESON

APPELWOOD NRSNG & REHAB CENTER
21000 KOSTNER AVENUE
MATTESON, IL 60443
Reference Numbers Facility ID 6000467
Health Service Area 007 Planning Service Area 765

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Number
Aggravated Alcoholism	0
Chronic Alcoholism	0
Encephalopathy/Alcohol	0
Blood Disorders	7
*Nervous System Non-Alzheimer	1
Alzheimer Disease	1
Mental Illness	1
Developmental Disability	54
Circulatory System	9
Respiratory System	4
Digestive System	1
Genitourinary System Disorders	1
Skin Disorders	17
Neurological Disorders	1
Injuries and Poisonings	1
Other Restrictions	8
Non-Medical Conditions	0
TOTALS	98

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS	PEAK	BEDS USED	BEDS IN USE	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	115	114	109	116	115	115	Residents on 1/1/2010: 308 Total Admissions 2010: 309 Total Discharges 2010: 309 Residents on 12/31/2010: 98
Skilled Under ZZ	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	115	114	109	116	115	115	308

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Insurance	Private	Charity	TOTAL	Licensed Beds	Peak Beds	
Nursing Care	784	18.8%	20177	48.1%	2169	417	1928	0	32565	77.6%
Skilled Under ZZ	0	0.0%	0	0.0%	0	0	0	0	0	0.0%
ICF/DD	0	0.0%	0	0.0%	0	0	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0	0	0.0%
TOTALS	784	18.8%	20177	48.1%	2169	417	1928	0	32565	77.6%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL	GRAND TOTAL
Under 10	0	0	0	0	0	0	0	0
10 to 44	0	1	0	0	0	0	1	1
45 to 59	2	3	0	0	0	0	5	5
60 to 64	1	1	0	0	0	0	2	2
65 to 74	4	16	0	0	0	0	20	20
75 to 84	9	27	0	0	0	0	36	36
85+	6	28	0	0	0	0	34	34
TOTALS	22	76	0	0	0	0	98	98

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 MCALISTER NURSING & REHAB TRINLEY PARK

MCALISTER NURSING & REHAB
18300 SOUTH LAVERGNE AVENUE
TRINLEY PARK, IL 60477
Reference Numbers Facility ID 6005904
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	14	73	0	0	11	0	98
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	14	73	0	0	11	0	98

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Asian	Amer. Indian	Black	Hispanic/Latino	White	Race Unknown	Total
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	0	0	34	0	0	0	34
Hispanic/Latino	0	0	0	0	0	0	0
White	0	0	64	0	0	0	64
Race Unknown	0	0	0	0	0	0	0
Total	0	0	98	0	0	0	98

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
31.4%	51.5%	0.0%	0.0%	17.0%	0.0%	100.0%
1,331,840	3,003,868	0	0	991,113	0	5,326,821

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 MCALISTER NURSING & REHAB TRINLEY PARK

MCALISTER NURSING & REHAB
18300 SOUTH LAVERGNE AVENUE
TRINLEY PARK, IL 60477
Reference Numbers Facility ID 6005904
Health Service Area 007 Planning Service Area 706

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Neoplasms	4
Endocrine/Metabolic	33
Blood Disorders	7
Nervous System Non Alzheimer	8
Alzheimer Disease	7
Mental Illness	6
Developmental Disability	5
Circulatory System	11
Respiratory System	1
Digestive System	0
Genitourinary System Disorders	2
Skin Disorders	1
Musculo-skeletal Disorders	1
Injuries and Poisonings	0
Other Medical Conditions	7
Non-Medical Conditions	1
TOTALS	98

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Admissions	Discharges
Nursing Care	80	80
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	80	80

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Unlicensed Beds
Nursing Care	4137	21801	53.6%	0	2485	2578	31001
Skilled Under 22	0	0	0.0%	0	0	0	0
Intermediate DD	0	0	0.0%	0	0	0	0
Skilled Care	0	0	0.0%	0	0	0	0
TOTALS	4137	21801	53.6%	0	2485	2578	31001

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 59	3	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
60 to 64	3	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 to 74	8	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75 to 84	10	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
85+	10	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	39	59	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 OAK FOREST HOSPITAL

OAK FOREST HOSPITAL
 1590 SOUTH CICERO AVENUE
 OAK FOREST, IL 60452
 Reference Numbers Facility ID 6009753
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	2	3	0	0	0	0	5
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	2	3	0	0	0	0	5

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled 22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	2	0	0	0	2
Hispanic/Pac. Isl.	0	0	0	0	0
White	2	0	0	0	2
Race Unknown	1	0	0	0	1
Total	5	0	0	0	5

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Charity Expense	Total Net Revenue
0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
0	0	0	0	0	0	0	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 OAK FOREST HOSPITAL

OAK FOREST HOSPITAL
 1590 SOUTH CICERO AVENUE
 OAK FOREST, IL 60452
 Reference Numbers Facility ID 6009753
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	1	2	3	4	5
Aggressive/Alcohol	0	0	0	0	0	0
Chronic Alcoholism	0	0	0	0	0	0
Developmentally Disabled	0	0	0	0	0	0
Drug Addiction	0	0	0	0	0	0
Medicaid Recipient	0	0	0	0	0	0
Non-Alcohol	0	0	0	0	0	0
Non-Subsidiary	0	0	0	0	0	0
Non-Mobile	0	0	0	0	0	0
Public Aid Recipient	0	0	0	0	0	0
Under 65 Years Old	0	0	0	0	0	0
Unable to Self-Medicate	0	0	0	0	0	0
Ventilator Dependent	0	0	0	0	0	0
Infectious Disease w/ Isolation	0	0	0	0	0	0
Other Restrictions	1	0	0	0	0	0
No Restrictions	0	0	0	0	0	0
Total Residents Diagnosed as Mentally Ill	0	0	0	0	0	0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	LICENSED BEDS	PEAK BEDS	PEAK BEDS USED	BEDS IN USE	AVAILABLE BEDS	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	10	5	5	5	5	0	10	Residents on 1/17/2010: 5 Total Admissions 2010: 0 Residents on 12/31/2010: 5
Skilled Under 22	0	0	0	0	0	0	0	
Intermediate DD	0	0	0	0	0	0	0	
Sheltered Care	0	0	0	0	0	0	0	Identified Offenders: 1
TOTAL BEDS	10	5	5	5	5	0	10	

FACILITY UTILIZATION - 2010

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds Loaded
Nursing Care	770	1044	28.6%	0	0	0	1814
Skilled Under 22	0	0	0.0%	0	0	0	0
Intermediate DD	0	0	0.0%	0	0	0	0
Sheltered Care	0	0	0.0%	0	0	0	0
TOTALS	770	1044	28.6%	0	0	0	1814

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Male	Female	Male	Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	0	1	0	0	0	0	0	0	1
45 to 59	3	1	0	0	0	0	3	1	4
60 to 64	0	0	0	0	0	0	0	0	0
65 to 74	0	0	0	0	0	0	0	0	0
75 to 84	0	0	0	0	0	0	0	0	0
85+	0	0	0	0	0	0	0	0	0
TOTALS	3	2	0	0	0	0	3	2	5

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 CRESTWOOD TERRACE OPERATORS, LLC CRESTWOOD

CRESTWOOD TERRACE OPERATORS, LLC
 13301 SOUTH CENTRAL AVENUE
 CRESTWOOD, IL 60445
 Facility ID 8002273
 Health Service Area 007 Planning Services Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	122	0	0	0	0	122
Skilled Under ZZ	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Shelter	0	0	0	0	0	0	0
TOTALS	0	122	0	0	0	0	122

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	67	0	0	0	67
Hispanic/Latino	0	0	0	0	0
White	54	0	0	0	54
Race Unknown	0	0	0	0	0
Total	122	0	0	0	122

ETHNICITY

ETHNICITY	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Hispanic	3	0	0	0	3
Non-Hispanic	119	0	0	0	119
Ethnicity Unknown	0	0	0	0	0
Total	122	0	0	0	122

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Other Public	Private Insurance	Private Pay	Charity Care	Charity Expense as % of Total Net Revenue
0.0%	98.6%	0.0%	1.4%	0.0%	0.0%
0	4,951,323	0	68,742	0	0
TOTALS	100.0%	4,718,065	0	0	0.0%

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 CRESTWOOD TERRACE OPERATORS, LLC CRESTWOOD

CRESTWOOD TERRACE OPERATORS, LLC
 13301 SOUTH CENTRAL AVENUE
 CRESTWOOD, IL 60445
 Facility ID 8002273
 Health Service Area 007 Planning Services Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	DIAGNOSIS	Count
Aggravated/And Social	Neoplasms	4
Chronic Alcoholism	Endocrine/Metabolic	0
Developmentally Disabled	Blood Disorders	0
Drug Addiction	Nervous System Non Alzheimer	5
Medicaid Recipient	Alzheimer Disease	80
Medicare Recipient	Mental Illness	0
Non-Admission	Developmental Disability	3
Non-Medical	Circulatory System	3
Public Aid Recipient	Respiratory System	5
Under 65 Years Old	Digestive System	4
Unable to Self-Medicate	Genitourinary System Disorders	0
Ventilator Dependent	Skin Disorders	3
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	5
Other Restrictions	Injuries and Poisonings	0
No Restrictions	Other Medical Conditions	5
TOTALS	Non-Medical Conditions	0
TOTALS	TOTALS	122

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	126	126	126
Skilled Under ZZ	0	0	0
Intermediate DD	0	0	0
Sheltered Care	0	0	0
TOTALS	126	126	126

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	126	126	126
Skilled Under ZZ	0	0	0
Intermediate DD	0	0	0
Sheltered Care	0	0	0
TOTALS	126	126	126

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Other Public	Private Insurance	Private Pay	Charity Care	Unreimb. Beds	Peak Beds
Nursing Care	0	0.0%	0	0	0	0	126
Skilled Under ZZ	0	0.0%	0	0	0	0	0
Intermediate DD	0	0.0%	0	0	0	0	0
Sheltered Care	0	0.0%	0	0	0	0	0
TOTALS	0	0.0%	0	0	0	0	126

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	10	10	0	0	0	0	10	10	20
45 to 59	40	24	0	0	0	0	40	24	64
60 to 74	10	10	0	0	0	0	10	10	20
75 to 84	8	4	0	0	0	0	6	4	10
85+	1	6	0	0	0	0	1	6	7
TOTALS	67	55	0	0	0	0	67	55	122

ATTACHMENT-12C

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 MANOR CARE OF PALOS HEIGHTS WEST PALOS HEIGHTS

MANOR CARE OF PALOS HEIGHTS WEST
 11800 SOUTHWEST HIGHWAY
 PALOS HEIGHTS, IL 60463
 Facility ID 6014534
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
Nursing Care	69	31	0	6	14	0	122
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	69	31	0	6	14	0	122

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Amr. Indian	0	0	0	0	0
Black	12	0	0	0	12
Hispanic	0	0	0	0	0
White	109	0	0	0	109
Race Unknown	1	0	0	0	1
TOTAL	122	0	0	0	122

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
73.7%	12,355,801	8.0%	1,476,868	0.4%	70,950	1,492,199
				8.2%	1,373,040	10,765,763

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 MANOR CARE OF PALOS HEIGHTS WEST PALOS HEIGHTS

MANOR CARE OF PALOS HEIGHTS WEST
 11800 SOUTHWEST HIGHWAY
 PALOS HEIGHTS, IL 60463
 Facility ID 6014534
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Neoplasms	6														
Endocrine/Metabolic	0														
Blood Disorders	2														
*Nervous System Non-Acheint	0														
Alzheimer Disease	0														
Mental Illness	0														
Developmental Disability	35														
Respiratory System	13														
Digestive System	2														
Genitourinary System Disorders	12														
Skin Disorders	5														
Musculo-Skeletal Disorders	29														
Injuries and Poisonings	18														
Other Medical Conditions	2														
Other Medical Conditions	0														
TOTALS	122														

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	BEES	SET-UP	IN USE	BEES	AVAILABLE	MEDICARE	MEDICAID	CERTIFIED	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	130	130	100	122	8	130	52	52	Residents on 1/1/2010: 111
Skilled Under 22	0	0	0	0	0	0	0	0	Total Admissions 2010: 962
Intermediate DD	0	0	0	0	0	0	0	0	Total Discharges 2010: 551
Skilled Care	0	0	0	0	0	0	0	0	Residents on 12/31/2010: 122
TOTAL BEDS	130	130	100	122	8	130	52	52	Identified Offenders: 0

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTAL	Licensee	Peak Beds
Nursing Care	22986	50.5%	12312	64.8%	0	4353	0	43674	92.0%
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0	0.0%
Skilled Care	0	0.0%	0	0.0%	0	0	0	0	0.0%
TOTALS	23986	50.5%	12312	64.8%	0	4353	0	43674	92.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0
45 to 59	2	4	0	0	0	0	2	4	6
60 to 64	3	3	0	0	0	0	3	3	6
65 to 74	4	12	0	0	0	0	4	12	16
75 to 84	14	21	0	0	0	0	14	21	35
85+	16	43	0	0	0	0	16	43	59
TOTALS	39	87	0	0	0	0	39	87	122

ATTACHMENT - 12C

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MANORCARE OF PALOS HEIGHTS EAST PALOS HEIGHTS

MANORCARE OF PALOS HEIGHTS EAST
 7850 WEST COLLEGE DRIVE
 PALOS HEIGHTS, IL 60463
 Reference Numbers Facility ID 6010312
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	MEDICARE				MEDICAID				OTHER				TOTALS				
	Nursing Care	Skilled Under ZZ	Intermediate DD	Shelter	Nursing Care	Skilled Under ZZ	Intermediate DD	Shelter	Private Pay	Charity Care	Nursing Care	Skilled Under ZZ	Intermediate DD	Shelter	Private Pay	Charity Care	TOTALS
Nursing Care	103	0	0	0	32	4	7	18	0	0	164	0	0	0	0	0	164
Skilled Under ZZ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shelter	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	103	0	0	0	32	4	7	18	0	0	164	0	0	0	0	0	164

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	Intermediate	Shelter	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	4	0	0	0	4
Hispanic	0	0	0	0	0
White	158	0	0	0	158
Race Unknown	2	0	0	0	2
Total	164	0	0	0	164

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Payor Source	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Charity Expense as % of Total Net Revenue
Medicare	17,902,019	7.9%	111,627	4.8%	2,218,540	0	0.0%
Medicaid	1,815,201	0.5%	1,105,310	9.0%	23,153,700	0	0.0%
TOTALS	19,717,220	100.0%	1,105,310	23,153,700	0	0	0.0%

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MANORCARE OF PALOS HEIGHTS EAST PALOS HEIGHTS

MANORCARE OF PALOS HEIGHTS EAST
 7850 WEST COLLEGE DRIVE
 PALOS HEIGHTS, IL 60463
 Reference Numbers Facility ID 6010312
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	Diagnosis	Count
Aggressive/Alcohol-Social	Neoplasms	10
Chronic Alcoholism	Epilepsy/Seizures	4
Developmentally Disabled	Blood Disorders	2
Drug Addiction	*Nervous System Non Abuser	1
Medicaid Recipient	Alzheimer's Disease	3
Medicare Recipient	Mental Illness	0
Non-Ambulatory	Developmental Disability	0
Non-Mobile	Circulatory System	30
Public Aid Recipient	Respiratory System	12
Under 65 Years Old	Digestive System	8
Unable to Self-Medicate	Genitourinary System Disorders	3
Ventilator Dependent	Skin Disorders	3
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	24
Other Restrictions	Injuries and Poisonings	37
No Restrictions	Other Medical Conditions	27
TOTALS	Non-Medical Conditions	0
	TOTALS	164

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Admissions	Discharges
Nursing Care	159	1262
Skilled Under ZZ	0	1277
Intermediate DD	0	164
Sheltered Care	0	0
TOTALS	159	2703

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Pay	Charity Care	Medicaid Certified	Medicare Certified	Medicaid Available	Medicare Available	Medicaid Certified	Medicare Certified
Nursing Care	35,469	54.8%	1,268	38.4%	1142	2785	7374	0	9008	93.5%	93.3%
Skilled Under ZZ	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0	0	0.0%	0.0%
TOTALS	35,469	54.8%	1,268	38.4%	1142	2785	7374	0	9008	93.5%	93.3%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER ZZ		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	3	0	0	0	0	0	0	0	3	3
60 to 64	0	1	0	0	0	0	0	0	0	1	1
65 to 74	9	11	0	0	0	0	0	0	9	11	20
75 to 84	13	44	0	0	0	0	0	0	13	44	57
85+	12	71	0	0	0	0	0	0	12	71	83
TOTALS	34	130	0	0	0	0	0	0	34	130	164

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HICKORY NURSING PAVILION HICKORY HILLS

HICKORY NURSING PAVILION
 8246 SOUTH ROBERTS ROAD
 HICKORY HILLS, IL 60457
 Facility ID 6004332
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	59	0	0	1	0	60
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	0	59	0	0	1	0	60

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	IC/DD	Shelter	Totals
African	1	0	0	0	1
Amer. Indian	0	0	0	0	0
Black	17	0	0	0	17
Hispanic	0	0	0	0	0
Non-Hispanic	40	0	0	0	40
Race Unknown	2	0	0	0	2
Total	60	0	0	0	60

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
17.0%	80.5%	0.0%	0.0%	2.5%	0.0%
537,992	2,549,374	0	0	78,955	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HICKORY NURSING PAVILION HICKORY HILLS

HICKORY NURSING PAVILION
 8246 SOUTH ROBERTS ROAD
 HICKORY HILLS, IL 60457
 Facility ID 6004332
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Aggravated/Anxiety/Social	0
Chronic Alcoholism	0
Developmentally Disabled	4
Drug Addiction	0
Endocrine/Metabolic	8
Neurosis	10
Nervous System Non-Structural	31
Alzheimer Disease	2
Mental Illness	5
Developmental Disability	0
Circulatory System	0
Respiratory System	1
Digestive System	0
Genitourinary System Disorders	1
Skin Disorders	0
Musculo-skeletal Disorders	0
Injuries and Poisonings	1
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	60

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	74	68	74
Skilled Under 22	0	0	0
Intermediate DD	0	0	0
Skilled Care	0	0	0
TOTALS	74	68	74

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Unpaid Beds	Peak Beds
Nursing Care	188	30.9%	2112	78.2%	0	0	544	0
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0
Skilled Care	0	0.0%	0	0.0%	0	0	0	0
TOTALS	188	30.9%	2112	78.2%	0	544	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	3	4	0	0	0	0	7
45 to 59	16	7	0	0	0	0	23
60 to 64	5	3	0	0	0	0	8
65 to 74	4	4	0	0	0	0	8
75 to 84	2	8	0	0	0	0	10
85+	1	3	0	0	0	0	4
TOTALS	31	29	0	0	0	0	60

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Unpaid Beds	Peak Beds
Nursing Care	188	30.9%	2112	78.2%	0	0	544	0
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0
Skilled Care	0	0.0%	0	0.0%	0	0	0	0
TOTALS	188	30.9%	2112	78.2%	0	544	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	3	4	0	0	0	0	7
45 to 59	16	7	0	0	0	0	23
60 to 64	5	3	0	0	0	0	8
65 to 74	4	4	0	0	0	0	8
75 to 84	2	8	0	0	0	0	10
85+	1	3	0	0	0	0	4
TOTALS	31	29	0	0	0	0	60

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 CHICAGO RIDGE NURSING CENTER CHICAGO RIDGE

CHICAGO RIDGE NURSING CENTER
10802 SOUTHWEST HIGHWAY
CHICAGO RIDGE, IL 60415
Reference Numbers Facility ID 6001697
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicare	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	13	185	2	0	5	0	215
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	13	185	2	0	5	0	215

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	SKU/Under 22	ICF/DD	Shelter	Totals
Asian	1	0	0	0	1
Amer. Indian	1	0	0	0	1
Black	70	0	0	0	70
Hispanic/Latino	0	0	0	0	0
White	143	0	0	0	143
Race Unknown	0	0	0	0	0
Total	215	0	0	0	215

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expense as % of Total Net Revenue
16.3%	78.4%	1.4%	0.3%	2.4%	0.7%	0.7%
1,675,434	8,187,235	144,769	50,859	246,480	0	10,284,016

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 CHICAGO RIDGE NURSING CENTER CHICAGO RIDGE

CHICAGO RIDGE NURSING CENTER
10802 SOUTHWEST HIGHWAY
CHICAGO RIDGE, IL 60415
Reference Numbers Facility ID 6001697
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	1	DIAGNOSIS	217
Aggressive/Social	1	Neoplasms	74
Chronic Alcoholism	0	Endocrine/Metabolic	8
Developmentally Disabled	0	Blood Disorders	0
Drug Addiction	0	Nervous System Non-Alzheimer	0
Medical Recipient	0	Alzheimer Disease	78
Medicaid Recipient	0	Mental Illness	0
Mental Illness	0	Developmental Disability	16
Non-Ambulatory	0	Circulatory System	12
Non-Mobile	0	Respiratory System	10
Public Aid Recipient	0	Digestive System	4
Under 65 Years Old	0	Genitourinary System Disorders	0
Unable to Self-Care	0	Skin Disorders	0
Ventilator Dependent	1	Musculoskeletal Disorders	7
Infectious Disease w/ Isolation	0	Injuries and Poisonings	5
Other Restrictions	0	Other Medical Conditions	215
No Restrictions	0	Non-Medical Conditions	182
Note: Reported restrictions identified by J1			
TOTALS			
Total Residents Diagnosed as Mentally Ill			

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	231	217
Skilled Under 22	0	94
Intermediate DD	0	56
Skilled Care	0	215
TOTAL BEDS	231	27

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL
Nursing Care	394	7243	85.0%	1064	268	1851	7960
Skilled Under 22	0	0	0.0%	0	0	0	0
Intermediate DD	0	0	0.0%	0	0	0	0
Skilled Care	0	0	0.0%	0	0	0	0
TOTALS	394	7243	85.0%	1064	268	1851	7960

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	21	10	0	0	0	0	31
45 to 59	60	27	0	0	0	0	87
60 to 84	21	13	0	0	0	0	34
85 to 94	18	21	0	0	0	0	39
75 to 84	3	9	0	0	0	0	12
65+	4	8	0	0	0	0	12
TOTALS	177	88	0	0	0	0	265

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE - OAK LAWN WEST

MAJOR CARE - OAK LAWN WEST
 6300 WEST 95TH STREET
 OAK LAWN, IL 60453
 Facility ID 6000343
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	52	57	7	10	16	0	142
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	52	57	7	10	16	0	142

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Private	Charity	TOTALS
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	45	0	0	0	0	0	45
Hawaiian/Pac. Isl	0	0	0	0	0	0	0
White	97	0	0	0	0	0	97
Race Unknown	0	0	0	0	0	0	0
Total	142	0	0	0	0	0	142

ETHNICITY

ETHNICITY	Nursing	Skilled	ICF/DD	Skilled	Private	Charity	TOTALS
Hispanic	8	0	0	0	0	0	8
Non-Hispanic	134	0	0	0	0	0	134
Ethnicity Unknown	0	0	0	0	0	0	0
Total	142	0	0	0	0	0	142

NET REVENUE BY PAYOR SOURCE (Fiscal Year Oct)

Medicare	Other Public	Private Insurance	Private Pay	Charity Care
65.7%	14.0%	1.4%	8.2%	10.7%
13,198,711	2,807,474	288,192	1,640,190	2,151,000
				20,085,567

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE - OAK LAWN WEST

MAJOR CARE - OAK LAWN WEST
 6300 WEST 95TH STREET
 OAK LAWN, IL 60453
 Facility ID 6000343
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	1	DIAGNOSIS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggravating-Social	1	Nervitis	8
Chronic Alcoholism	0	Endocrine/Metabolic	2
Developmentally Disabled	0	Blood Disorders	0
Drug Addiction	0	*Nervous System Non Alzheimer	17
Medically Referred	0	Alzheimer Disease	3
Necrosis Recipient	0	Mental Illness	1
Wentil Illness	0	Developmental Disability	1
Non-ambulatory	0	Circulatory System	21
Non-able	0	Respiratory System	23
Public Aid Recipient	0	Digestive System	0
Under 65 Years Old	0	Genitourinary System Disorders	11
Unable to Self-Medicate	0	Skin Disorders	4
Ventilator Dependent	1	Multicystic/Osteoporosis	11
Infectious Disease w/ Isolation	0	Injuries and Poisonings	0
Other Restrictions	1	Other Medical Conditions	34
No Restrictions	0	Non-Medical Conditions	0
Total	142	TOTALS	142

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Learned	Peak Beds
Nursing Care	192	177	180	142	76	Residents on 1/1/2010	159
Skilled Under 22	0	0	0	0	0	Total Admissions 2010	1001
Intermediate DD	0	0	0	0	0	Residents on 12/31/2010	142
Skilled Care	192	177	180	142	76	Identified Offenders	1
TOTAL BEDS	192	177	180	142	76	Total Residents Diagnosed as Mentally Ill	17

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Learned	Peak Beds
Nursing Care	20359	21236	74.6%	2099	7317	57520	82.7%
Skilled Under 22	0	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0	0.0%	0	0	0	0.0%
Skilled Care	20359	21236	74.6%	2099	7317	57520	82.7%
TOTALS	23358	21768	74.6%	2099	7317	57260	82.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Skilled Care	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Grand Total
Under 15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 to 44	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
45 to 50	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
51 to 64	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4
65 to 74	10	7	0	0	0	0	0	0	0	0	0	0	0	0	17
75 to 84	13	20	0	0	0	0	0	0	0	0	0	0	0	0	33
85+	10	59	0	0	0	0	0	0	0	0	0	0	0	0	69
TOTALS	40	102	0	0	0	0	0	0	0	0	0	0	0	0	142

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE - OAK LAWN WEST

MAJOR CARE - OAK LAWN WEST
 6300 WEST 95TH STREET
 OAK LAWN, IL 60453
 Facility ID 6000343
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	52	57	7	10	16	0	142
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	52	57	7	10	16	0	142

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Private	Charity	TOTALS
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	45	0	0	0	0	0	45
Hawaiian/Pac. Isl	0	0	0	0	0	0	0
White	97	0	0	0	0	0	97
Race Unknown	0	0	0	0	0	0	0
Total	142	0	0	0	0	0	142

ETHNICITY

ETHNICITY	Nursing	Skilled	ICF/DD	Skilled	Private	Charity	TOTALS
Hispanic	8	0	0	0	0	0	8
Non-Hispanic	134	0	0	0	0	0	134
Ethnicity Unknown	0	0	0	0	0	0	0
Total	142	0	0	0	0	0	142

NET REVENUE BY PAYOR SOURCE (Fiscal Year Oct)

Medicare	Other Public	Private Insurance	Private Pay	Charity Care
65.7%	14.0%	1.4%	8.2%	10.7%
13,198,711	2,807,474	288,192	1,640,190	2,151,000
				20,085,567

*Charity Expense does not include expenses which may be considered a community benefit.

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Learned	Peak Beds
Nursing Care	192	177	180	142	76	Residents on 1/1/2010	159
Skilled Under 22	0	0	0	0	0	Total Admissions 2010	1001
Intermediate DD	0	0	0	0	0	Residents on 12/31/2010	142
Skilled Care	192	177	180	142	76	Identified Offenders	1
TOTAL BEDS	192	177	180	142	76	Total Residents Diagnosed as Mentally Ill	17

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LEXINGTON OF CHICAGO RIDGE CHICAGO RIDGE

LEXINGTON OF CHICAGO RIDGE
 10000 SOUTHWEST HIGHWAY
 CHICAGO RIDGE, IL 60415
 Reference Numbers Facility ID 6012967
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	37	103	0	28	7	0	175
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	37	103	0	28	7	0	175

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	38	0	0	0	38
Hawaiian/Pac. Isl	0	0	0	0	0
White	137	0	0	0	137
Race Unknown	0	0	0	0	0
Total	175	0	0	0	175

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
33.3%	35.8%	0.0%	25.5%	5.4%	0.0%
\$,491,863	\$,800,897	0	4,242,647	864,730	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LEXINGTON OF CHICAGO RIDGE CHICAGO RIDGE

LEXINGTON OF CHICAGO RIDGE
 10000 SOUTHWEST HIGHWAY
 CHICAGO RIDGE, IL 60415
 Reference Numbers Facility ID 6012967
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	1	2	3	4	5	6	7	TOTALS
Alzheimer's/Dementia	1	0	0	0	0	0	0	1
Chronic Alcoholism	1	0	0	0	0	0	0	1
Developmentally Disabled	1	0	0	0	0	0	0	1
Blood Disorders	1	0	0	0	0	0	0	1
Nervous System Non Alzheimer	3	0	0	0	0	0	0	3
Alzheimer Disease	2	0	0	0	0	0	0	2
Mental Illness	7	0	0	0	0	0	0	7
Developmental Disability	0	0	0	0	0	0	0	0
Circulatory System	32	0	0	0	0	0	0	32
Respiratory System	8	0	0	0	0	0	0	8
Digestive System	3	0	0	0	0	0	0	3
Genitourinary System Disorders	3	0	0	0	0	0	0	3
Skin Disorders	4	0	0	0	0	0	0	4
Infectious Diseases w/ Isolation	20	0	0	0	0	0	0	20
Infectious Diseases w/ Isolation	12	0	0	0	0	0	0	12
Other Restrictions	67	0	0	0	0	0	0	67
No Restrictions	0	0	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0	0	0
TOTALS	175	0	0	0	0	0	0	175

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	No.	Reported restrictions removed by 1/1	Total Residents Diagnosed as Mentally Ill
Agitated/Anxious-Social	1	0	7
Chronic Alcoholism	1	0	0
Developmentally Disabled	1	0	0
Drug Addiction	1	0	0
Medical Resident	0	0	0
Medicare Recipient	0	0	0
Mental Illness	1	0	0
Non-Ambulatory	0	0	0
Non-Mobile	0	0	0
Public Aid Recipient	0	0	0
Under 65 Years Old	0	0	0
Unable to Self-Medications	0	0	0
Verbalizer Dependent	1	0	0
Infectious Diseases w/ Isolation	0	0	0
Other Restrictions	0	0	0
No Restrictions	0	0	0
Total	7	0	7

DISCHARGES - 2010

DISCHARGES - 2010	Residents on 1/1/2010	Total Discharges 2010	Residents on 12/31/2010
192	192	192	192
949	949	949	949
175	175	175	175
0	0	0	0

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTAL	Licensed Beds	Peak Beds
Nursing Care	11569	48044	60.5%	0	8833	3887	69153	93.3%	93.3%
Skilled Under 22	0	0	0.0%	0	0	0	0	0.0%	0.0%
Intermediate DD	0	0	0.0%	0	0	0	0	0.0%	0.0%
Sheltered Care	0	0	0.0%	0	0	0	0	0.0%	0.0%
TOTALS	11569	48044	60.5%	0	8833	3887	69153	93.3%	93.3%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER 22		INTERMED. DD		SHELTERED		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0
45 to 59	3	0	0	0	0	0	3	0	3	0
60 to 64	0	2	0	0	0	0	0	2	2	3
65 to 74	13	17	0	0	0	0	13	17	30	30
75 to 84	17	41	0	0	0	0	17	41	58	58
85+	13	69	0	0	0	0	13	69	82	82
TOTALS	46	129	0	0	0	0	46	129	175	175

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 PROVIDENCE HC & REHAB OF PALOS HEIGHTS PALOS HEIGHTS

PROVIDENCE HC & REHAB OF PALOS HEIGHTS
 13259 SOUTH CENTRAL AVENUE
 PALOS HEIGHTS, IL 60463
 Reference Numbers Facility ID 6007843
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	65	32	0	4	22	0	123
Sickled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	65	32	0	4	22	0	123

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Sickled Under 22	ICF/DD	Sheltered	Total
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	7	0	0	0	7
Hispanic	0	0	0	0	0
White	116	0	0	0	116
Race Unknown	0	0	0	0	0
Total	123	0	0	0	123

ETHNICITY

ETHNICITY	Nursing	Sickled Under 22	ICF/DD	Sheltered	Total
Hispanic	0	0	0	0	0
Non-Hispanic	123	0	0	0	123
Charity Unknown	0	0	0	0	0
Total	123	0	0	0	123

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
71.4%	12.3%	0.0%	6.4%	9.9%	0.0%
10,746,528	1,854,323	0	849,117	1,485,803	0
*Charity Expense does not include expenses which may be considered a community benefit.					

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 PROVIDENCE HC & REHAB OF PALOS HEIGHTS PALOS HEIGHTS

PROVIDENCE HC & REHAB OF PALOS HEIGHTS
 13259 SOUTH CENTRAL AVENUE
 PALOS HEIGHTS, IL 60463
 Reference Numbers Facility ID 6007843
 Health Service Area 007 Planning Service Area 705

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	1	DIAGNOSIS
Aggravated/Social	1	Neglects
Chronic Alcoholism	1	Excessive/Alcoholic
Developmentally Disabled	1	Blood Disorders
Drug Addiction	0	Neurological Non-Alzheimer
Medicaid Recipient	0	Alzheimer Disease
Medicaid Recipient	0	Mental Illness
Mental Illness	0	Developmental Disability
Non-Ambulatory	0	Circulatory System
Non-Mobile	0	Respiratory System
Public Aid Recipient	7	Digestive System
Under 65 Years Old	0	Cardiovascular System Disorders
Unable to Self-Medicare	0	Skin Disorders
Verbal Dependent	1	Multisystemic Disorders
Infectious Disease w/ Isolation	2	Injuries and Poisonings
Other Restrictions	0	Other Medical Conditions
No Restrictions	98	Non-Medical Conditions
TOTALS	123	TOTALS

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTAL BEDES	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTAL BEDES	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

PROVIDENCE HC & REHAB OF PALOS HEIGHTS
 13259 SOUTH CENTRAL AVENUE
 PALOS HEIGHTS, IL 60463
 Reference Numbers Facility ID 6007843
 Health Service Area 007 Planning Service Area 705

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	1	DIAGNOSIS
Aggravated/Social	1	Neglects
Chronic Alcoholism	1	Excessive/Alcoholic
Developmentally Disabled	1	Blood Disorders
Drug Addiction	0	Neurological Non-Alzheimer
Medicaid Recipient	0	Alzheimer Disease
Medicaid Recipient	0	Mental Illness
Mental Illness	0	Developmental Disability
Non-Ambulatory	0	Circulatory System
Non-Mobile	0	Respiratory System
Public Aid Recipient	7	Digestive System
Under 65 Years Old	0	Cardiovascular System Disorders
Unable to Self-Medicare	0	Skin Disorders
Verbal Dependent	1	Multisystemic Disorders
Infectious Disease w/ Isolation	2	Injuries and Poisonings
Other Restrictions	0	Other Medical Conditions
No Restrictions	98	Non-Medical Conditions
TOTALS	123	TOTALS

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTAL BEDES	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159	144	159	120	159	120	145	90	90	2506

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDES	SETUP	USED	PEAK	BEDES	SETUP	IN USE	BEDES	AVAILABLE	MEDICARE CERTIFIED	MEDICARE CERTIFIED
Nursing Care	120	159	144	159	120	159	120	145	90	90	125
Sickled Under 22	0	0	0	0	0	0	0	0	0	0	918
Intermediate DD	0	0	0	0	0	0	0	0	0	0	918
Sheltered Care	0	0	0	0	0	0	0	0	0	0	123
TOTALS	120	159									

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE OF OAK LAWN EAST OAK LAWN

MAJOR CARE OF OAK LAWN EAST
 9401 SOUTH KOSTNER AVENUE
 OAK LAWN, IL 60453
 Reference Numbers Facility ID 8000236
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	63	24	0	19	11	0	117
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	63	24	0	19	11	0	117

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	ICF/PDD	Skilled	Shelter	Totals
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	59	0	0	0	0	0	59
Hawaiian/Pac Isl	0	0	0	0	0	0	0
White	56	0	0	0	0	0	56
Race Unknown	2	0	0	0	0	0	2
Total	117	0	0	0	0	0	117

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
73.6%	7.0%	0.2%	13.1%	6.1%	0.0%
11,504,553	1,126,729	24,797	2,115,889	947,820	0
TOTALS 16,105,000					

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE OF OAK LAWN EAST OAK LAWN

MAJOR CARE OF OAK LAWN EAST
 9401 SOUTH KOSTNER AVENUE
 OAK LAWN, IL 60453
 Reference Numbers Facility ID 8000236
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	1	2	3	4	5	6	7
Agitated/Anxi-Social	0	0	0	0	0	0	0	0
Chronic Alcoholism	0	0	0	0	0	0	0	0
Developmentally Disabled	0	0	0	0	0	0	0	0
Drug Addiction	0	0	0	0	0	0	0	0
Medicaid Recipient	0	0	0	0	0	0	0	0
Medical Recipient	0	0	0	0	0	0	0	0
Mental Illness	0	0	0	0	0	0	0	0
Non-Ambulatory	0	0	0	0	0	0	0	0
Public Aid Recipient	0	0	0	0	0	0	0	0
Under 65 Years Old	0	0	0	0	0	0	0	0
Unable to Self-Medications	0	0	0	0	0	0	0	0
Verbalizer Dependent	0	0	0	0	0	0	0	0
Infectious Disease w/ Isolation	0	0	0	0	0	0	0	0
Other Reservations	0	0	0	0	0	0	0	0
No Reservations	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	PEAK	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	122	122	122	117	5	122	41	109
Skilled Under 22	0	0	0	0	0	0	0	1145
Intermediate DD	0	0	0	0	0	0	0	1137
Skilled Care	0	0	0	0	0	0	0	117
TOTALS	122	122	122	117	5	122	41	2

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Licensed Beds	Peak Beds
Nursing Care	23364	52.5%	9617	57.0%	0	4653	42098	94.5%
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0.0%
Skilled Care	0	0.0%	0	0.0%	0	0	0	0.0%
TOTALS	23364	52.5%	9617	57.0%	0	4653	42098	94.5%

*Charity Expense does not include expenses which may be considered a community benefit.

ATTACHMENT - 12C

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

Page 1219 of 2216

8/12/2011

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SOUTH SUBURBAN HOSPITAL HAZEL CREST

SOUTH SUBURBAN HOSPITAL
17600 SOUTH KEDZIE AVENUE
HAZEL CREST, IL 60429
Reference Numbers Facility ID 6011720
Health Services Area 007 Planning Services Area 705
Administration Facility ID 6011720
Health Services Area 007 Planning Services Area 705

ADMISSION RESTRICTIONS

Aggravated/Abuse-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Addiction	0
Medicaid recipient	1
Medicare recipient	0
Mental Illness	0
Non-Applicable	0
Non-Mobile	0
Public Aid Recipient	1
Under 65 Years Old	0
Unable to Self-Maintain	0
Verbalizer Dependent	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0
TOTALS	14

RESIDENTS BY PRIMARY DIAGNOSIS

Neoplasms	0
Endocrine/Metabolic	0
Blood Disorders	0
Nervous System Non Alzheimer	0
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	1
Respiratory System	0
Digestive System	0
Genitourinary System Disorders	0
Skin Disorders	0
Musculo-skeletal Disorders	5
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	14

LICENSED BEDS, BEDS IN USE, MEDICAID/MEDICARE CERTIFIED BEDS

Licensed Beds	41	21	19	21	14	27	31
Peak	21	19	21	14	27	31	31
Used	0	0	0	0	0	0	0
Set Up	0	0	0	0	0	0	0
TOTALS	41	21	19	21	14	27	31

ADMISSIONS AND DISCHARGES - 2010

Residents on 1/1/2010	11
Total Admissions 2010	487
Total Discharges 2010	464
Residents on 12/31/2010	14
Identified Offenders	0

ADMISSIONS AND DISCHARGES - 2010

Residents on 1/1/2010	11
Total Admissions 2010	487
Total Discharges 2010	464
Residents on 12/31/2010	14
Identified Offenders	0

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SOUTH SUBURBAN HOSPITAL HAZEL CREST

SOUTH SUBURBAN HOSPITAL
17600 SOUTH KEDZIE AVENUE
HAZEL CREST, IL 60429
Reference Numbers Facility ID 6011720
Health Services Area 007 Planning Services Area 705
Administration Facility ID 6011720
Health Services Area 007 Planning Services Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other: Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	10	0	0	0	4	0	14
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0
TOTALS	10	0	0	0	4	0	14

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Private Pay	Charity Care	TOTALS
Asian	0	0	0	0	0	0	0
Amer Indian	0	0	0	0	0	0	0
Black	0	0	0	0	0	0	0
Hispanic/Latino	0	0	0	0	0	0	0
White	0	0	0	0	0	0	0
Race Unknown	0	0	0	0	0	0	0
Total	14	0	0	0	0	0	14

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	0.00
Registered Nurses	9.90
LPN's	0.10
Certified Assistants	10.20
Other Health Staff	1.00
Non-Health Staff	2.00
Total	23.90

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	706	539
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
0	0	0	0	0	0	0

*Charity Expense does not include expenses which may be considered a community benefit.

FACILITY UTILIZATION - 2010

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Learned	Peak Beds	
Nursing Care	374	33.0%	0	0	0	0	4733	31.6%	61.7%
Skilled Under 22	0	0.0%	0	0	0	0	0	0.0%	0.0%
Intermediate DD	0	0.0%	0	0	0	0	0	0.0%	0.0%
Skilled Care	0	0.0%	0	0	0	0	0	0.0%	0.0%
TOTALS	374	33.0%	0	0	0	0	4733	31.6%	61.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0	0	0	0	0
60 to 64	2	0	0	0	0	0	0	0	2	0	0	0	2
65 to 74	1	0	0	0	0	0	0	0	1	0	0	0	1
75 to 84	2	4	0	0	0	0	0	0	2	4	0	0	6
85+	1	2	0	0	0	0	0	0	1	2	0	0	3
TOTALS	6	6	0	0	0	0	0	0	6	6	0	0	12

10/21/2010 Permit abandoned to discontinue 41 bed General Nursing (Long-Term Care) Unit, 41 beds returned to inventory.
3/2/2010 Permit issued to discontinue 41 bed Skilled Nursing category of service.

09-060
09-066

SOUTH SUBURBAN HOSPITAL
17600 SOUTH KEDZIE AVENUE
HAZEL CREST, IL 60429
Reference Numbers Facility ID 6011720
Health Services Area 007 Planning Services Area 705
Administration Facility ID 6011720
Health Services Area 007 Planning Services Area 705

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SOUTH SUBURBAN HOSPITAL HAZEL CREST

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development

Page 1852 of 2216

8/11/2011

ATTACHMENT-12C

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 IMPERIAL OF HAZEL CREST HAZEL CREST

IMPERIAL OF HAZEL CREST
 3300 WEST 15TH STREET
 HAZEL CREST, IL 60429
 Reference Numbers Facility ID 6004741
 Health Services Area 007 Planning Service Area 716

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other			Private			Charity			TOTALS		AVERAGE DAILY PAYMENT RATES		
	Medicare	Medicaid	Public	Insurance	Pay	Care	Pay	Care	Pay	Care	Pay	Care	SINGLE	DOUBLE
Nursing Care	4	167	0	0	0	0	4	0	0	0	175	0	132	142
Skilled Under 22	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	4	167	0	0	0	0	4	0	0	0	175	0	132	142

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	IC/DD	Shelter	Total
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	117	0	0	0	117
Hispanic/Pac. Isl.	0	0	0	0	0
White	58	0	0	0	58
Race Unknown	0	0	0	0	0
Total	175	0	0	0	175

ETHNICITY

ETHNICITY	Nursing	Skilled	IC/DD	Shelter	Total
Hispanic	8	0	0	0	8
Non-Hispanic	167	0	0	0	167
Ethnicity Unknown	0	0	0	0	0
Total	175	0	0	0	175

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Charity Care
7.2%	67.3%	1.7%	0.0%	3.7%	100.0%	0.0%
559,067	0,770,638	133,611	1,804	290,034	7,753,992	0

*Charity Expenses does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 IMPERIAL OF HAZEL CREST HAZEL CREST

IMPERIAL OF HAZEL CREST
 3300 WEST 15TH STREET
 HAZEL CREST, IL 60429
 Reference Numbers Facility ID 6004741
 Health Services Area 007 Planning Service Area 716

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	DIAGNOSIS	Count
Aggressive/Alcoholism	Nephritis	1
Chronic Alcoholism	Endocrine/Metabolic	4
Developmentally Disabled	Blood Disorders	0
Drug Addiction	Nervous System Non-Alzheimer	10
Medicaid Recipient	Alzheimer Disease	20
Medicare Recipient	Mental Illness	84
Non-Resident	Developmental Disability	7
Non-Ambulatory	Circulatory System	4
Non-Viable	Respiratory System	8
Public Aid Recipient	Digestive System	0
Under 65 Years Old	Cardiovascular System Disorders	9
Unable to Self-Medicate	Skin Disorders	1
Ventilator Dependent	Musculo-Skeletal Disorders	14
Infectious Disease w/ Isolation	Injuries and Poisonings	6
Other Restrictions	Other Medical Conditions	8
No Restrictions	Non-Medical Conditions	0
Total Residents Diagnosed as Mentally Ill	TOTALS	175

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	199	187	199
Skilled Under 22	0	0	0
Intermediate DD	0	0	0
Sheltered Care	0	0	0
TOTAL BEDS	199	187	199

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicaid	Medicare	Other Public	Private Insurance	Private Pay	Charity Care	Charity	Licensed Beds	Peak Beds
Nursing Care	1829	2.6%	60909	83.7%	0	38	2696	0	86432
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0	0.0%
TOTALS	1829	2.6%	60909	83.7%	0	38	2696	0	86432

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Total	Grand Total
Under 18	0	0	0	0	0	0
18 to 44	7	4	0	0	7	4
45 to 59	39	35	0	0	39	35
60 to 84	14	13	0	0	14	13
65 to 74	18	18	0	0	18	18
75 to 84	10	10	0	0	10	10
85+	1	6	0	0	1	6
TOTALS	88	88	0	0	88	88

ATTACHMENT-12C

Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development
 8/11/2011
 Page 1032 of 2216

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 RIVERA CARE CENTER CHICAGO HEIGHTS

RIVERA CARE CENTER
490 WEST 16TH PLACE
CHICAGO HEIGHTS, IL 60411
Reference Numbers Facility ID 6008064
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	185	0	0	1	186
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTALS	0	185	0	0	1	186

RESIDENTS BY RACE/ETHNICITY (GROUPING)

RACE	Nursing	Skilled	Int' Med	Shelter	TOTALS
African Amer. Indian	2	0	0	0	2
Black	107	0	0	0	107
Hispanic/Hispanic	0	0	0	0	0
White	57	0	0	0	57
Race Unknown	0	0	0	0	0
TOTAL	166	0	0	0	166

NET REVENUE BY PAYOR SOURCE (Fiscal Year 09)

Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expense as % of Total Net Revenue
0.0%	99.1%	0.0%	0.0%	0.0%	100.0%
0	6,323,188	0	56,128	0	6,381,288

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 RIVERA CARE CENTER CHICAGO HEIGHTS

RIVERA CARE CENTER
490 WEST 16TH PLACE
CHICAGO HEIGHTS, IL 60411
Reference Numbers Facility ID 6008064
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	37	18	44	44	21	0	0	0	2	0	153	209	198	168	59
Neoplasms	0	37	18	44	44	21	0	0	0	2	0	153	209	198	168	59
Endocrine/Metabolic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blood Disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neurotic System Non-Alzheimer	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Alzheimer Disease	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Illness	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Developmental Disability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Circulatory System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Respiratory System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Digestive System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Genitourinary System Disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skin Disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Musculo-Skeletal Disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injuries and Poisonings	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Medical Conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0	153	209	198	168	59	0	0	0	0	0	0	0	0	0	0

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	SETUP	USED	IN USE	BEDS	AVAILABLE	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	200	165	170	185	186	34	45	190	Residents on 1/1/2010: 153 Total Admissions 2010: 209 Total Discharges 2010: 198 Residents on 12/31/2010: 168
Skilled Under 22	0	0	0	0	0	0	0	0	
Intermediate DD	0	0	0	0	0	0	0	0	
Sheltered Care	0	0	0	0	0	0	0	0	Identified Offenders: 59
TOTAL BEDS	200	165	170	185	186	34	45	190	

FACILITY UTILIZATION - 2010

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Learned Care	Peak Beds
Nursing Care	0	0.0%	0	0	0	0	60525	83.0%
Skilled Under 22	0	0.0%	0	0	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0	0	0	0	0.0%
TOTALS	0	0.0%	0	0	0	0	60525	83.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER 22		INTERMED. DD		SHELTERED		TOTAL	GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female		
Under 18	0	0	0	0	0	0	0	0	0	0
18 to 44	43	14	0	0	0	0	0	0	43	14
45 to 59	68	17	0	0	0	0	0	0	68	17
60 to 64	8	5	0	0	0	0	0	0	10	5
65 to 74	7	1	0	0	0	0	0	0	7	1
75 to 84	1	0	0	0	0	0	0	0	1	0
85+	0	0	0	0	0	0	0	0	0	0
TOTALS	129	37	0	0	0	0	0	0	129	37

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WOODSIDE MANOR SOUTH CHICAGO HEIGHTS

WOODSIDE MANOR
 120 WEST 26TH STREET
 SOUTH CHICAGO HEIGHTS, IL 60611
 Reference Numbers Facility ID 6007991
 Health Services Area 007 Planning Services Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	15	94	0	0	3	0	112
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	15	94	0	0	3	0	112

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICFDD	Shelter	Totals
Asian	1	0	0	0	1
Amer./Indian	0	0	0	0	0
Black	71	0	0	0	71
Hispanic/Lat. Am.	0	0	0	0	0
White	34	0	0	0	34
Race Unknown	6	0	0	0	6
Total	112	0	0	0	112

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
23.5%	76.6%	0.0%	0.0%	0.0%	0.0%
1,307,739	4,198,305	0	0	50,813	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WOODSIDE MANOR SOUTH CHICAGO HEIGHTS

WOODSIDE MANOR
 120 WEST 26TH STREET
 SOUTH CHICAGO HEIGHTS, IL 60611
 Reference Numbers Facility ID 6007991
 Health Services Area 007 Planning Services Area 705

ADMISSION RESTRICTIONS

Restriction	Count
Aggravated/Am. Society	1
Chronic Alcoholism	0
Developmentally Disabled	1
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	28
Non-Amputatory	0
Public Aid Recipient	51
Under 65 Years Old	1
Unable to Self-Medicate	0
Vascular Dementia	0
Infectious Disease w/ Isolation	0
Other Restrictions	0
No Restrictions	0
None Reported/Restrictions Admitted by J1	112
TOTALS	28

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	Set-Up	Used	Set-Up	In Use	Medicare Certified	Medicaid Certified
Nursing Care	112	112	112	112	20	112
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTAL BEDS	112	112	112	112	20	112

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Learned Peak Beds
Nursing Care	3072	41.1%	36707	89.8%	0	357	40265
Skilled Under 22	0	0.0%	0	0.0%	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0.0%
Sheltered Care	0	0.0%	0	0.0%	0	0	0.0%
TOTALS	3072	41.1%	36707	89.8%	0	357	40265

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	5	5	0	0	0	5	5	10	10
45 to 59	23	18	0	0	0	23	18	41	41
60 to 64	12	10	0	0	0	12	10	22	22
65 to 74	13	11	0	0	0	13	11	24	24
75 to 84	7	6	0	0	0	7	6	13	13
85+	0	2	0	0	0	0	2	2	2
TOTALS	60	52	0	0	0	60	52	112	112

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 THORNTON HEIGHTS TERRACE CHICAGO HEIGHTS

THORNTON HEIGHTS TERRACE
160 WEST 10TH STREET
CHICAGO HEIGHTS, IL 60611
Reference Numbers Facility ID 6009385
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	209	0	0	0	0	209
Skilled Under ZZ	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	0	209	0	0	0	0	209

RESIDENTS BY RACE/ETHNICITY/OCCUPANCY

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Asian	2	0	0	0	2
Amer. Indian	0	0	0	0	0
Black	81	0	0	0	81
Hispanic/Pac. Isl.	0	0	0	0	0
White	126	0	0	0	126
Race Unknown	0	0	0	0	0
Totals	209	0	0	0	209

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
0.0%	97.5%	0.0%	2.5%	0.0%	0.0%
0	6,897,661	0	222,240	0	0

*Charity Expense data not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 THORNTON HEIGHTS TERRACE CHICAGO HEIGHTS

THORNTON HEIGHTS TERRACE
160 WEST 10TH STREET
CHICAGO HEIGHTS, IL 60611
Reference Numbers Facility ID 6009385
Health Service Area 007 Planning Service Area 705

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	DIAGNOSIS
Aggressive/Abil-Social	0
Chronic Alcoholism	0
Developmentally Disabled	0
Drug Dependence	0
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	209
Non-Ambulatory	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicate	0
Verbalizer/Dependent	0
Infectious Diseases w/ Isolation	0
Other Restrictions	0
No Restrictions	0
TOTALS	209

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	SET UP	USED	PEAK	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	222	220	220	213
Skilled Under ZZ	0	0	0	30
Intermediate DD	0	0	0	34
Sheltered Care	0	0	0	209
TOTAL BEDS	222	220	220	5

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Unlicensed Beds
Nursing Care	0	0.0%	99.9%	0	0	0	74023
Skilled Under ZZ	0	0.0%	0	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0	0	0	0.0%
TOTALS	0	0.0%	99.9%	0	0	0	91.4%

Total Residents Diagnosed as Mentally Ill

ADMISSIONS AND DISCHARGES - 2010

Retirements on 11/20/10

Total Admissions 2010

Retirements on 12/31/2010

Identified Offenders

ADMISSIONS AND DISCHARGES - 2010

Retirements on 11/20/10

Total Admissions 2010

Retirements on 12/31/2010

Identified Offenders

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER ZZ		INTERMED. DD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	20	18	0	0	0	0	0	0	20	18	38
45 to 59	66	59	0	0	0	0	0	0	66	59	125
60 to 64	13	18	0	0	0	0	0	0	13	18	31
65 to 74	3	7	0	0	0	0	0	0	3	7	10
75 to 84	3	2	0	0	0	0	0	0	3	2	5
85+	0	0	0	0	0	0	0	0	0	0	0
TOTALS	105	104	0	0	0	0	0	0	105	104	209

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SOUTH SUBURBAN REHAB CENTER HOMEWOOD

SOUTH SUBURBAN REHAB CENTER
1900 HALSTED STREET
HOMEWOOD, IL 60430
Reference Numbers Facility ID 6016487
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	MEDICAID			PRIVATE PAY			CHARTY CARE			TOTALS		
	Medicare	Medicaid	Other	Public	Private	Insurance	Pay	Charity	Care	Pay	Charity	Totals
Nursing Care	21	107	0	0	0	0	3	0	0	0	0	131
Skilled Under ZZ	0	0	0	0	0	0	0	0	0	0	0	0
KCFDD	0	0	0	0	0	0	0	0	0	0	0	0
Skilled Care	21	107	0	0	0	0	3	0	0	0	0	131

RESIDENTS BY RACIA/ETHNICITY GROUPING

RACE	Nursing	Skilled Under ZZ	KCFDD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	96	0	0	0	96
Hispanic/Latino	0	0	0	0	0
White	33	0	0	0	33
Race Unknown	0	0	0	0	0
Total	131	0	0	0	131

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Expense as % of Total Net Revenue
39.3%	56.2%	0.0%	0.1%	4.4%	0.0%
2,766,593	3,940,359	0	5,473	308,819	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 SOUTH SUBURBAN REHAB CENTER HOMEWOOD

SOUTH SUBURBAN REHAB CENTER
1900 HALSTED STREET
HOMEWOOD, IL 60430
Reference Numbers Facility ID 6016487
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	1
Aggression/and-Boor	0
Chronic Alcoholism	0
Developmentally Disabled	0
Endocrine/Metabolic	0
Blood Disorders	0
Nervous System/Non-Alzheimer	37
Alzheimer Disease	0
Mental Illness	0
Developmental Disability	0
Circulatory System	39
Respiratory System	12
Digestive System	0
Genitourinary System Disorders	16
Skin Disorders	10
Musculo-skeletal Disorders	17
Injuries and Poisonings	0
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	131

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	BEDS	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	259	158	131	108
Skilled Under ZZ	0	0	0	194
Intermediate DD	0	0	0	171
Skilled Care	259	158	131	131
TOTALS	259	158	131	2

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Licensed Beds
Nursing Care	55.9	6.7%	31.0%	0.0%	0.0%	0.0%	69.0%
Skilled Under ZZ	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Intermediate DD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Skilled Care	55.9	6.7%	31.0%	0.0%	0.0%	0.0%	69.0%

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Licensed Beds
Nursing Care	55.9	6.7%	31.0%	0.0%	0.0%	0.0%	69.0%
Skilled Under ZZ	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Intermediate DD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Skilled Care	55.9	6.7%	31.0%	0.0%	0.0%	0.0%	69.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		INTERMED. DD		SKILLED UNDER ZZ		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0	0	0
18 to 44	3	0	0	0	0	0	0	0	3	0	3
45 to 59	2	7	0	0	0	0	0	0	2	7	9
60 to 64	2	4	0	0	0	0	0	0	2	4	6
65 to 74	15	71	0	0	0	0	0	0	15	21	36
75 to 84	23	18	0	0	0	0	0	0	23	18	41
85+	9	27	0	0	0	0	0	0	9	27	36
TOTALS	54	77	0	0	0	0	0	0	54	77	131

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MAJOR CARE OF HOMEWOOD HOMEWOOD

MAJOR CARE OF HOMEWOOD
 840 MAPLE AVENUE
 HOMEWOOD, IL 60430
 Reference Numbers Facility ID 6012611
 Health Service Area 007 Planning Service Area 705
 Administrator
 Legal Status
 Contact Person and Telephone
 Local Sponsor and Management Team
 708-760-0244 Data Completed
 Registered Agent Information 7/22/2011

LEVEL OF CARE	Medicare	Medicaid	Private Insurance	Other Payers	Private Charity	Private Pay	Private Charity	Private Charity
Nursing Care	40	49	5	11	0	105	0	0
Skilled Under ZZ	0	0	0	0	0	0	0	0
ICFIDD	0	0	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0	0	0
TOTALS	40	49	5	11	0	105	0	0

RACE	Asian	Am. Indian	Black	Hispanic	Non-Hispanic	White	Other	Totals
Asian	0	0	0	0	0	0	0	0
Am. Indian	0	0	0	0	0	0	0	0
Black	62	0	0	0	0	0	0	62
Hispanic	0	0	0	0	0	0	0	0
Non-Hispanic	43	0	0	0	0	0	0	43
White	105	0	0	0	0	0	0	105
TOTALS	105	0	0	0	0	0	0	105

ETHNICITY	Medicare	Medicaid	Private Insurance	Other Payers	Private Charity	Private Pay	Private Charity
Medicare	69.4%	10.9%	1.4%	3.0%	5.1%	11,451,201	0.0%
Medicaid	7,947,291	2,276,450	169,802	434,152	833,605	0	0
TOTALS	11,451,201	0	0	0	0	0	0

LEVEL OF CARE	Medicare	Medicaid	Private Insurance	Other Payers	Private Charity	Private Pay	Private Charity
Nursing Care	149-2	34.1%	1899	0	0	0	0
Skilled Under ZZ	0	0.0%	0	0	0	0	0
Intermediate DD	0	0.0%	0	0	0	0	0
Skilled Care	149-2	34.1%	1899	0	0	0	0
TOTALS	149-2	34.1%	1899	0	0	0	0

AGE GROUPS	Male	Female	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0	0	0
18 to 24	0	0	0	0	0	0	0	0	0
25 to 34	1	2	0	0	0	0	1	2	3
35 to 44	3	0	0	0	0	0	0	0	3
45 to 54	5	12	0	0	0	0	5	12	17
55 to 64	10	28	0	0	0	0	10	28	38
65 to 74	7	37	0	0	0	0	7	37	44
75 to 84	23	82	0	0	0	0	23	82	105
85+	0	0	0	0	0	0	0	0	0
TOTALS	69	161	0	0	0	0	69	161	230

LEVEL OF CARE	Medicare	Medicaid	Private Insurance	Other Payers	Private Charity	Private Pay	Private Charity
Nursing Care	149-2	34.1%	1899	0	0	0	0
Skilled Under ZZ	0	0.0%	0	0	0	0	0
Intermediate DD	0	0.0%	0	0	0	0	0
Skilled Care	149-2	34.1%	1899	0	0	0	0
TOTALS	149-2	34.1%	1899	0	0	0	0

LEVEL OF CARE	Medicare	Medicaid	Private Insurance	Other Payers	Private Charity	Private Pay	Private Charity
Nursing Care	149-2	34.1%	1899	0	0	0	0
Skilled Under ZZ	0	0.0%	0	0	0	0	0
Intermediate DD	0	0.0%	0	0	0	0	0
Skilled Care	149-2	34.1%	1899	0	0	0	0
TOTALS	149-2	34.1%	1899	0	0	0	0

ATTACHMENT-12C
 Source: Long-Term Care Facility Questionnaire for 2010, Illinois Department of Public Health, Health Systems Development
 Page 1211 of 2216
 8/11/2011

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 PLAZA NURSING & REHAB CENTER MIDLOTHIAN

PLAZA NURSING & REHAB CENTER
 3249 WEST 147 STREET
 MIDLOTHIAN, IL 60445
 Reference Numbers Facility ID 6001077
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private Pay	Charity	TOTALS
Nursing Care	3	77	1	0	1	0	82
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Skilled Care	3	77	1	0	1	0	82

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Skilled	Shelter	Totals
Asian	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0
Black	40	0	0	0	0	40
Hispanic/Lat. Pl.	0	0	0	0	0	0
White	42	0	0	0	0	42
Race Unknown	0	0	0	0	0	0
Total	82	0	0	0	0	82

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	3.00
Director of Nursing	1.00
Registered Nurses	4.00
LPNs	10.00
Certified Aides	15.00
Other Health Staff	4.00
Non-Health Staff	15.00
Totals	50.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Payor Source	Medical	Other Public	Private Insurance	Private Pay	Charity	Charity Care Expense as % of Total Net Revenue
Medical	16.7%	76.5%	0.0%	1.3%	3.6%	0.0%
Other Public	783,283	3,211,914	0	149,215	53,472	0
TOTALS	4,197,890					

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 PLAZA NURSING & REHAB CENTER MIDLOTHIAN

PLAZA NURSING & REHAB CENTER
 3249 WEST 147 STREET
 MIDLOTHIAN, IL 60445
 Reference Numbers Facility ID 6001077
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	1	2	3	4	5	6	7	8	9	TOTALS
Aggressive/Alcoholism	0	0	0	0	0	0	0	0	0	0	0
Chronic Alcoholism	0	0	0	0	0	0	0	0	0	0	0
Developmentally Disabled	0	0	0	0	0	0	0	0	0	0	0
Drug Addiction	0	0	0	0	0	0	0	0	0	0	0
Medicaid Recipient	0	0	0	0	0	0	0	0	0	0	0
Medicare Recipient	0	0	0	0	0	0	0	0	0	0	0
Mental Illness	0	0	0	0	0	0	0	0	0	0	0
Non-Applicable	0	0	0	0	0	0	0	0	0	0	0
Developmental Disability	0	0	0	0	0	0	0	0	0	0	0
Cerebral Palsy	0	0	0	0	0	0	0	0	0	0	0
Respiratory System	0	0	0	0	0	0	0	0	0	0	0
Digestive System	0	0	0	0	0	0	0	0	0	0	0
Genitourinary System Disorders	0	0	0	0	0	0	0	0	0	0	0
Skin Disorders	0	0	0	0	0	0	0	0	0	0	0
Respiratory/Heart Disorders	0	0	0	0	0	0	0	0	0	0	0
Injuries and Poisonings	0	0	0	0	0	0	0	0	0	0	0
Other Medical Conditions	0	0	0	0	0	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0	0	0	0	0	0
TOTALS	82	0	0	0	0	0	0	0	0	0	82

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	ADMISSIONS	DISCHARGES
Nursing Care	89	89
Skilled Under 22	0	0
Intermediates DD	0	0
Skilled Care	89	89
TOTALS	89	89

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	ADMISSIONS	DISCHARGES
Nursing Care	89	89
Skilled Under 22	0	0
Intermediates DD	0	0
Skilled Care	89	89
TOTALS	89	89

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicaid	Medicare	Other Public	Private Insurance	Private Pay	Charity	Charity Care
Nursing Care	1535	11.0%	24810	74.7%	2398	895	244
Skilled Under 22	0	0.0%	0	0.0%	0	0	0
Intermediates DD	0	0.0%	0	0.0%	0	0	0
Skilled Care	1535	11.0%	24810	74.7%	2398	895	244
TOTALS	1535	11.0%	24810	74.7%	2398	895	244

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediates DD	Skilled Care	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	10	0	0	0	10	17	27
45 to 59	15	0	0	0	15	13	28
60 to 74	13	0	0	0	13	9	22
75 to 84	0	0	0	0	0	2	2
85+	0	0	0	0	0	3	3
TOTALS	38	0	0	0	38	44	82

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediates DD	Skilled Care	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	10	0	0	0	10	17	27
45 to 59	15	0	0	0	15	13	28
60 to 74	13	0	0	0	13	9	22
75 to 84	0	0	0	0	0	2	2
85+	0	0	0	0	0	3	3
TOTALS	38	0	0	0	38	44	82

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LYDIA HEALTHCARE ROBBINS

13001 SOUTH LYDIA
ROBBINS, IL, 60472
Reference Numbers Facility ID 8005623
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	0	351	0	0	1	0	352
Skilled Under 22	0	0	0	0	0	0	0
ICF/OD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	0	351	0	0	1	0	352

RESIDENTS BY RACE/ETHNICITY GROUP

RACE	Nursing	Skilled Under 22	ICF/OD	Shelter	Totals
African American	2	0	0	0	2
Black	302	0	0	0	302
Hispanic/Latino	0	0	0	0	0
White	86	0	0	0	86
Race Unknown	0	0	0	0	0
Total	390	0	0	0	390

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expense % of Total Net Revenue
0.0%	97.3%	2.6%	0.0%	0.1%	0.0%	100.0%
0	15,493,565	415,489	0	18,800	0	15,928,854

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 LYDIA HEALTHCARE ROBBINS

13001 SOUTH LYDIA
ROBBINS, IL, 60472
Reference Numbers Facility ID 8005623
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	0	1	2	3	4	5	6	7	8	9	TOTALS
Alzheimer's Disease	0	0	0	0	0	0	0	0	0	0	0
Arthritis	0	0	0	0	0	0	0	0	0	0	0
Cardiovascular Disease	0	0	0	0	0	0	0	0	0	0	0
Diabetes	0	0	0	0	0	0	0	0	0	0	0
Dementia	0	0	0	0	0	0	0	0	0	0	0
Depression	0	0	0	0	0	0	0	0	0	0	0
Fractures	0	0	0	0	0	0	0	0	0	0	0
Headaches	0	0	0	0	0	0	0	0	0	0	0
Injuries and Poisonings	0	0	0	0	0	0	0	0	0	0	0
Other Medical Conditions	0	0	0	0	0	0	0	0	0	0	0
Non-Medical Conditions	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0	0	0

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES	Net
Nursing Care	412	412	412	0
Skilled Under 22	0	0	0	0
Intermediate OD	0	0	0	0
Sheltered Care	0	0	0	0
TOTAL BEDS	412	412	412	0

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds
Nursing Care	0	0.0%	141,559	94.1%	3215	0	144,840
Skilled Under 22	0	0.0%	0	0.0%	0	0	0
Intermediate OD	0	0.0%	0	0.0%	0	0	0
Sheltered Care	0	0.0%	0	0.0%	0	0	0
TOTALS	0	0.0%	141,559	94.1%	3215	0	144,840

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds
Nursing Care	0	0.0%	141,559	94.1%	3215	0	144,840
Skilled Under 22	0	0.0%	0	0.0%	0	0	0
Intermediate OD	0	0.0%	0	0.0%	0	0	0
Sheltered Care	0	0.0%	0	0.0%	0	0	0
TOTALS	0	0.0%	141,559	94.1%	3215	0	144,840

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	112	40	0	0	112	40	152
45 to 59	139	55	0	0	139	55	194
60 to 64	21	8	0	0	21	8	29
65 to 74	9	8	0	0	9	8	17
75 to 84	0	0	0	0	0	0	0
85+	0	0	0	0	0	0	0
TOTALS	281	108	0	0	281	108	389

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HEATHER HEALTH CARE CENTER HARVEY

HEATHER HEALTH CARE CENTER
16600 SOUTH HONORE STREET
HARVEY, IL 60426
Reference Numbers Facility ID 6004139
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	9	115	1	0	0	0	125
Skilled Under ZZ	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	9	115	1	0	0	0	125

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	Intermediate	Sheltered	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	79	0	0	0	79
Hispanic/Latino	0	0	0	0	0
White	46	0	0	0	46
Other Unknown	0	0	0	0	0
TOTALS	125	0	0	0	125

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care Expense*
20.0%	77.1%	1.2%	0.7%	0.0%	0.0%
1,285,904	4,953,037	60,089	44,747	50,629	0
					6,435,004

*Charity Expense does not include expenses which may be considered a community benefit.

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurse	2.00
LPNs	12.71
Certified Aides	19.67
Other Health Staff	8.33
Non-Health Staff	15.74
Totals	57.41

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 HEATHER HEALTH CARE CENTER HARVEY

HEATHER HEALTH CARE CENTER
16600 SOUTH HONORE STREET
HARVEY, IL 60426
Reference Numbers Facility ID 6004139
Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSES

DIAGNOSIS	Count
Nephritis	0
Endocrine/metabolic	2
Blood Disorders	0
*Nervous System Non Alzheimer	4
Alzheimer Disease	6
Mental Illness	71
Developmental Disability	1
Cerebral Palsy	4
Respiratory System	11
Digestive System	10
Genitourinary System Disorders	2
Skin Disorders	1
Multisystemic Disorders	5
Injuries and Poisonings	5
Other Medical Conditions	0
Non-Medical Conditions	0
TOTALS	125

Note: Reported restrictions derived by JF
Total Residents 0 reported as Mentally Ill

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK	BEDES	BEDES IN USE	MEDICARE CERTIFIED	MEDICAID CERTIFIED	ADMISSIONS AND DISCHARGES - 2010
Nursing Care	173	133	125	173	173	Residents on 1/1/2010: 121 Total Admissions 2010: 154 Discharges 2010: 154 Residents on 12/31/2010: 125
Skilled Under ZZ	0	0	0	0	0	
Intermediate DD	0	0	0	0	0	
Sheltered Care	0	0	0	0	0	Identified Offenders: 10
TOTAL BEDS	173	133	125	173	173	

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Peak Beds
2493	42033	677	95	338	0	45312
3.4%	69.9%	0.0%	0.0%	0.0%	0.0%	71.8%
0	0	0	0	0	0	0.0%
0	0	0	0	0	0	0.0%
0	0	0	0	0	0	0.0%
0	0	0	0	0	0	0.0%
TOTALS	2199	42033	677	338	0	45312

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP'S	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	17	8	0	0	17	8	25
45 to 59	20	24	0	0	28	24	52
60 to 64	5	4	0	0	5	4	9
65 to 74	10	12	0	0	10	12	22
75 to 84	5	4	0	0	5	4	9
85+	4	4	0	0	4	4	8
TOTALS	69	56	0	0	69	56	125

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 GLENWOOD HEALTHCARE & REHAB. INC. GLENWOOD

GLENWOOD HEALTHCARE & REHAB. INC.
 1930 SOUTH COTTAGE GROVE
 GLENWOOD, IL 60435
 Reference Numbers Facility ID 6003528
 Health Services Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	5	89	27	0	5	0	136
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Skilled Care	5	89	27	0	5	0	136

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Medicare	Medicaid	ICF/DD	Skilled	Private	Charity	TOTALS
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	70	0	0	0	0	0	70
Hispanic/Latino	0	0	0	0	0	0	0
White	62	0	0	0	0	0	62
Race Unknown	4	0	0	0	0	0	4
Total	136	0	0	0	0	0	136

ETHNICITY

ETHNICITY	Nursing	SK/Under 22	ICF/DD	Skilled	Private	Charity	TOTALS
Hispanic	0	0	0	0	0	0	0
Non-Hispanic	132	0	0	0	0	0	132
Ethnicity Unknown	4	0	0	0	0	0	4
Total	136	0	0	0	0	0	136

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expense as % of Total Net Revenue
14.0%	76.2%	9.4%	0.0%	2.8%	0.0%	100.0%
1,202,494	9,512,722	551,059	0	223,588	0	8,549,863

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 GLENWOOD HEALTHCARE & REHAB. INC. GLENWOOD

GLENWOOD HEALTHCARE & REHAB. INC.
 1930 SOUTH COTTAGE GROVE
 GLENWOOD, IL 60435
 Reference Numbers Facility ID 6003528
 Health Services Area 007 Planning Service Area 705

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	1	DIAGNOSIS
Aggressive/Anti-Social	0	Nervousness
Chronic Alcoholism	0	Etiology/Metabolic
Developmentally Disabled	0	Blood Disorders
Drug Addiction	0	Nervous System Non Alzheimer
Medicaid Recipient	0	Alzheimer Disease
Mental Illness	0	Mental Illness
Non-Ambulatory	0	Developmental Disability
Non-Mobile	0	Circulatory System
Public Aid Recipient	0	Respiratory System
Unable 65 Years Old	0	Digestive System
Variable to Self-Medicare	0	Circulatory System Disorders
Ventilator Dependent	1	Skin Disorders
Infectious Disease w/ Isolation	0	Musculoskeletal Disorders
Other Restrictions	0	Injuries and Poisonings
No Restrictions	0	Other Medical Conditions
	0	Non-Medical Conditions
	138	TOTALS

Note: Reported restrictions decreased by 11

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Medicare	Medicaid	ICF/DD	Skilled	Private	Charity	TOTALS
Nursing Care	134	174	174	136	48	184	148
Skilled Under 22	0	0	0	0	0	0	147
Intermediate DD	0	0	0	0	0	0	135
Skilled Care	0	0	0	0	0	0	10
TOTAL BEDS	134	174	174	136	48	184	164

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	ICF/DD	Skilled	Private	Charity	TOTALS
Nursing Care	2760	44392	96.1%	2740	0	0	51396
Skilled Under 22	0	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0	0.0%	0	0	0	0.0%
Skilled Care	0	0	0.0%	0	0	0	0.0%
TOTALS	2760	44392	96.1%	2740	0	0	51396

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL	GRAND TOTAL
Under 18	0	0	0	0	0	0	0	0
18 to 44	5	3	0	0	0	0	8	8
45 to 59	30	15	0	0	0	0	45	45
60 to 64	4	9	0	0	0	0	13	13
65 to 74	13	10	0	0	0	0	23	23
75 to 84	13	11	0	0	0	0	24	24
85+	8	15	0	0	0	0	23	23
TOTALS	73	63	0	0	0	0	136	136

ATTACHMENT-12C

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WINDMILL NURSING PAVILION SOUTH HOLLAND

WINDMILL NURSING PAVILION		ADMISSION RESTRICTIONS		RESIDENTS BY PRIMARY DIAGNOSIS	
10000 SOUTH WABASH		Aggravated/Social	1	DIAGNOSIS	
SOUTH HOLLAND, IL 60473		Chronic Alcoholism	0	Neoplasms	5
Reference Numbers Facility ID 6016078		Developmentally Disabled	0	Endocrine/Metabolic	5
Health Service Area 007 Planning Service Area 703		Drug Addiction	1	Bleeds Disorders	7
Administrators		Medicaid Recipient	0	Nervous System Non Alcoholic	4
Arenas Hillington		Medicare Recipient	0	Alzheimer Disease	4
Contact Person and Telephone		Mental Illness	1	Mental Illness	2
ANNAHARE HARRINGTON		Non-Abundant	0	Developmental Disability	2
708-336-0800		Non-Male	0	Circulatory System	60
Replaced Agent Information	Date	Public Aid Recipient	0	Respiratory System	13
321/2011	Completed	Under 65 Years Old	0	Dependent System	16
151 N. Wacker Drive		Unable to Self-Medicate	0	Genitourinary System Disorders	16
Chicago, IL 60006		Ventilator Dependent	1	Skin Disorders	0
FACILITY OWNERSHIP		Infectious Diseases w/ Isolation	0	Musculo-skeletal Disorders	0
FOR-PROF CORPORATION		Other Residents	0	Injuries and Poisonings	6
CONTINUING CARE COMMUNITY	No	No Residents	0	Other Medical Conditions	16
LIFE CARE FACILITY	No	Note: Reported residents denoted by //	0	Non-Medical Conditions	134
		Total Residents Diagnosed as Mentally Ill	2	TOTALS	134

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS		ADMISSIONS AND DISCHARGES - 2010	
LEVEL OF CARE	PEAK	LICENSED BEDS	ADMISSIONS
Nursing Care	150	150	126
Skilled Under 22	0	134	131
Intermediate OD	0	0	123
Skilled Care	0	0	134
TOTAL	150	134	1

FACILITY UTILIZATION - 2010											
BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE											
LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Cherry Care	Unlicensed Beds	Peak Beds	Set Up	Dec. Pct.
Nursing Care	3761	4073	0	1000	1669	0	46653	85.6%	85.6%	0.0%	0.0%
Skilled Under 22	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Intermediate OD	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Skilled Care	3761	4073	0	1000	1669	0	46653	85.6%	85.6%	0.0%	0.0%
TOTALS	3761	4073	0	1000	1669	0	46653	85.6%	85.6%	0.0%	0.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010											
AGE GROUPS	NURSING CARE		SKILLED 22		INTERMED. OD		SHELTERED		TOTAL		GRAND TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Under 19	0	0	0	0	0	0	0	0	0	0	0
19 to 44	0	0	0	0	0	0	0	0	0	0	0
45 to 64	4	3	0	0	0	0	4	3	7	7	11
65 to 74	3	0	0	0	0	0	0	0	3	8	16
75 to 84	6	10	0	0	0	0	0	0	6	10	16
85+	18	23	0	0	0	0	18	23	45	46	54
TOTALS	39	95	0	0	0	0	39	95	85	85	134

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WINDMILL NURSING PAVILION SOUTH HOLLAND

WINDMILL NURSING PAVILION		RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE	
10000 SOUTH WABASH		Medicare	115
SOUTH HOLLAND, IL 60473		Medicaid	0
Reference Numbers Facility ID 6016078		Public Insurance	0
Health Service Area 007 Planning Service Area 703		Other	0
Administrators		Private Pay	7
Arenas Hillington		Charity Care	0
Contact Person and Telephone		TOTALS	134
ANNAHARE HARRINGTON			
708-336-0800			
Replaced Agent Information			
321/2011			
151 N. Wacker Drive			
Chicago, IL 60006			
FACILITY OWNERSHIP			
FOR-PROF CORPORATION			
CONTINUING CARE COMMUNITY			
LIFE CARE FACILITY			

RESIDENTS BY RACE/ETHNICITY GROUPING		STAFFING	
RACE	EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT	
Asian	Administrators	1.00	
Black	Physicians	0.00	
Hispanic	Director of Nursing	1.00	
White	Registered Nurses	4.00	
Race Unknown	LPN's	24.00	
TOTAL	Certified Aides	3.00	
	Other Health Staff	6.00	
	Non-Health Staff	26.00	
	TOTALS	107.00	

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)					
Medicare	23.0%	1,695,904	Other Public	2.1%	150,560
Medicaid	70.6%	5,071,471	Private Insurance	0.0%	0
Private Pay	3.6%	260,235	Charity	0.0%	0
TOTALS		7,179,170			

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010	
LEVEL OF CARE	LEVEL OF CARE
Nursing Care	115
Skilled Under 22	0
Intermediate OD	0
Skilled Care	0
TOTALS	115

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 PROVIDENCE OF SOUTH HOLLAND SOUTH HOLLAND

PROVIDENCE OF SOUTH HOLLAND
 16300 WINDSAU AVE
 SOUTH HOLLAND, IL 60473
 Reference Numbers Facility ID 6007698
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicaid	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	53	30	0	3	28	114
Skilled Under 22	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTALS	53	30	0	3	28	114

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	28	0	0	0	28
Hispanic	86	0	0	0	86
White	0	0	0	0	0
Race Unknown	0	0	0	0	0
Total	114	0	0	0	114

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.00
Physicians	0.00
Directors of Nursing	1.00
Registered Nurses	7.00
LPN's	12.00
Certified Aides	37.00
Other Health Staff	1.00
Non-Health Staff	57.00
TOTALS	115.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
68.9%	11.5%	0.0%	1.5%	16.7%	0.3%
9,024,596	1,630,414	0	265,558	2,374,173	0
*Charity Expense does not include expenses which may be considered a community benefit.					

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 PROVIDENCE OF SOUTH HOLLAND SOUTH HOLLAND

PROVIDENCE OF SOUTH HOLLAND
 16300 WINDSAU AVE
 SOUTH HOLLAND, IL 60473
 Reference Numbers Facility ID 6007698
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	DIAGNOSIS
Aggravated/Alcohol	Neoplasms
Chronic Alcoholism	Endocrine/Metabolic
Developmentally Disabled	Blood Disorders
Drug Addiction	'Nervous System Non-Alzheimer
Medicaid Recipient	Alzheimer Disease
Medicare Recipient	Mental Illness
Non-Ambulatory	Developmental Disability
Non-Mobile	Circulatory System
Public Aid Recipient	Respiratory System
Under 65 Years Old	Digestive System
Unable to Self-Medicate	Genitourinary System Disorders
Ventilator Dependent	Skin Disorders
Infectious Disease w/ Isolation	Musculo-skeletal Disorders
Other Restrictions	Injuries and Poisonings
No Restrictions	Other Medical Conditions
	Non-Medical Conditions
TOTALS	114

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	171	148	171
Skilled Under 22	0	0	0
Intermediate DD	0	0	0
Sheltered Care	0	0	0
TOTAL BEDS	171	148	171

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Licensed Beds	Peak Beds
Nursing Care	19658	31483	0	782	8555	0	42468	89.0%
Skilled Under 22	0	0	0	0	0	0	0	0.0%
Intermediate DD	0	0	0	0	0	0	0	0.0%
Sheltered Care	0	0	0	0	0	0	0	0.0%
TOTALS	19658	31483	0	782	8555	0	42468	89.0%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Male	Female	Total	Grand Total
Under 18	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0
45 to 59	2	0	0	0	0	0	2	3
60 to 64	1	0	0	0	0	0	1	2
65 to 74	3	0	0	0	0	0	3	8
75 to 84	11	23	0	0	0	0	34	38
85+	53	52	0	0	0	0	105	95
TOTALS	84	84	0	0	0	0	168	114

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MANOR CARE OF SOUTH HOLLAND SOUTH HOLLAND

MANOR CARE OF SOUTH HOLLAND
 2145 EAST 170TH STREET
 SOUTH HOLLAND, IL 60873
 Reference Numbers Facility ID 6011589
 Health Service Area D07 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Public	Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	60	44	0	15	17	0	137
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	60	44	0	15	17	0	137

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	78	0	0	0	78
Hispanic	0	0	0	0	0
White	59	0	0	0	59
Race Unknown	0	0	0	0	0
Total	137	0	0	0	137

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Expenses % of Total Revenue
59.4%	8.8%	1.7%	13.7%	7.1%	0.0%	0.0%
15,462,878	1,955,777	371,136	2,834,649	1,572,411	0	72,268,951

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 MANOR CARE OF SOUTH HOLLAND SOUTH HOLLAND

MANOR CARE OF SOUTH HOLLAND
 2145 EAST 170TH STREET
 SOUTH HOLLAND, IL 60873
 Reference Numbers Facility ID 6011589
 Health Service Area D07 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	1
Neoplasms	2
Endocrine/Metabolic	2
Blood Disorders	2
Nervous System Non-Achilles	5
Alzheimer Disease	7
Mental Illness	0
Developmental Disability	23
Circulatory System	14
Respiratory System	8
Digestive System	14
Genitourinary System Disorders	2
Skin Disorders	10
Musculoskeletal Disorders	9
Injuries and Poisonings	27
Other Medical Conditions	4
Non-Medical Conditions	137
TOTALS	42

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	200	174	1132
Skilled Under 22	0	0	1159
Intermediate DD	0	0	137
Sheltered Care	0	0	0
TOTAL BEDS	200	174	137

ADMISSIONS AND DISCHARGES - 2010 (Continued)

LEVEL OF CARE	PEAK	ADMISSIONS	DISCHARGES
Nursing Care	200	174	1132
Skilled Under 22	0	0	1159
Intermediate DD	0	0	137
Sheltered Care	0	0	0
TOTAL BEDS	200	174	137

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Charity Care	Private Pay	Charity Care	Peak Beds
Nursing Care	28065	17468	50.4%	5771	0	57214	78.4%	78.4%
Skilled Under 22	0	0	0.0%	0	0	0	0.0%	0.0%
Intermediate DD	0	0	0.0%	0	0	0	0.0%	0.0%
Sheltered Care	0	0	0.0%	0	0	0	0.0%	0.0%
TOTALS	28065	17468	50.4%	5771	0	57214	78.4%	78.4%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	2	1	0	0	2	1	3
45 to 59	3	0	0	0	3	0	3
60 to 64	2	3	0	0	2	3	5
65 to 74	18	15	0	0	18	15	33
75 to 84	14	22	0	0	14	22	36
85+	12	40	0	0	12	40	52
TOTALS	51	86	0	0	51	86	137

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 COUNTRYSIDE NURSING AND REHAB CENTER DOLTON

COUNTRYSIDE NURSING AND REHAB CENTER
 103 EAST 154TH STREET
 DOLTON, IL 60419
 Reference Numbers Facility ID 6002190
 Health Service Area 007 Planning Service Area 705
 Administrator
 CALLIE GRAHAM
 Contact Person and Telephone
 CALLIE GRAHAM
 708-841-9550
 Registered Agent Information
 Date Completed 2/25/2010

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Aggressive/Anti-Social	0
Chronic Alcoholism	2
Developmentally Disabled	16
Drug Addiction	0
Medicaid Recipient	0
Medicare Recipient	6
Mental Illness	101
Non-ambulatory	3
Non-Mobile	24
Public Aid Recipient	4
Under 65 Years Old	1
Unable to Self-Medicare	6
Verbalized Dependent	1
Infectious Diseases w/ Isolation	2
Other Restrictions	0
No Restrictions	0
Year Reported restrictions removed by //	0
TOTALS	174

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
Nursing Care	16	187	2	0	4	0	174
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	16	187	2	0	4	0	174

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled/22	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	120	0	0	0	120
Hispanic/Pac. Isl.	0	0	0	0	0
White	54	0	0	0	54
Race Unknown	0	0	0	0	0
Total	174	0	0	0	174

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicaid	Other Public	Private Insurance	Private Pay	Charity	Expense as % of Total Net Revenue
1,250,758	7,289,833	2,831	97,552	0	0.0%
83.4%	0.0%	0.0%	1.1%	0.0%	
7,289,833	2,831	0	97,552	0	

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	TOTALS
Nursing Care	16	187	2	0	4	0	174
Skilled Under 22	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	16	187	2	0	4	0	174

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	Full-time Equivalent
Administrators	2.00
Physicians	0.00
Director of Nursing	2.00
Registered Nurses	3.00
LPN's	23.13
Certified Nurses	4.16
Other Health Staff	3.11
Non-Health Staff	1.11
Totals	41.30

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 COUNTRYSIDE NURSING AND REHAB CENTER DOLTON

COUNTRYSIDE NURSING AND REHAB CENTER
 103 EAST 154TH STREET
 DOLTON, IL 60419
 Reference Numbers Facility ID 6002190
 Health Service Area 007 Planning Service Area 705
 Administrator
 CALLIE GRAHAM
 Contact Person and Telephone
 CALLIE GRAHAM
 708-841-9550
 Registered Agent Information
 Date Completed 2/25/2010

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 COUNTRYSIDE NURSING AND REHAB CENTER DOLTON

COUNTRYSIDE NURSING AND REHAB CENTER
 103 EAST 154TH STREET
 DOLTON, IL 60419
 Reference Numbers Facility ID 6002190
 Health Service Area 007 Planning Service Area 705
 Administrator
 CALLIE GRAHAM
 Contact Person and Telephone
 CALLIE GRAHAM
 708-841-9550
 Registered Agent Information
 Date Completed 2/25/2010

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
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Residents on 12/31/2010	174
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ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
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Residents on 12/31/2010	174
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ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ADMISSIONS AND DISCHARGES - 2010

ADMISSIONS AND DISCHARGES - 2010	Count
Residents on 1/1/2010	177
Total Admissions 2010	184
Total Discharges 2010	187
Residents on 12/31/2010	174
Identified Offenders	20

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 TRI-STATE NURSING & REHAB. CENTER LANING

2500 EAST 175TH STREET
 LANING, IL 60439
 Reference Numbers Facility ID 600943
 Health Service Area 007 Planning Service Area 705

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other	Private Pay	Charity Care	TOTALS
Nursing Care	8	45	0	13	0	67
Skilled Under 22	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTALS	8	45	0	13	0	67

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Amer Indian	0	0	0	0	0
Black	24	0	0	0	24
Hispanic/Lat. Hl.	0	0	0	0	0
White	43	0	0	0	43
Race Unknown	0	0	0	0	0
Total	67	0	0	0	67

ETHNICITY

ETHNICITY	Nursing	Skilled	ICF/DD	Shelter	TOTALS
Hispanic	3	0	0	0	3
Non-Hispanic	64	0	0	0	64
Ethnicity Unknown	0	0	0	0	0
Total	67	0	0	0	67

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Payers	Private Insurance	Private Pay	Charity Care
35.4%	50.6%	0.0%	1.5%	12.5%	0.0%
1,680,127	2,404,346	0	72,510	594,534	0

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	1.70
Physicians	0.60
Directors of Nursing	1.50
Registered Nurses	2.00
LPNs	12.00
Certified Aides	26.00
Other Health Staff	12.00
Non-Health Staff	12.00
TOTALS	65.00

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 TRI-STATE NURSING & REHAB. CENTER LANING

2500 EAST 175TH STREET
 LANING, IL 60439
 Reference Numbers Facility ID 600943
 Health Service Area 007 Planning Service Area 705

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	1	DIAGNOSIS
Aggressive/Alcohol	1	Neuroleptics
Chronic Alcoholism	1	Encephalomyelitis
Developmentally Disabled	0	Blood Disorders
Drug Addiction	1	*Hepatic System/Non-Alcoholic
Medical Resident	0	Alzheimer Disease
Medicare Recipient	0	Mental Illness
Mental Illness	1	Developmental Disability
Non-Ambulatory	0	Circulatory System
Non-Mobile	0	Respiratory System
Public Aid Recipient	0	Digestive System
Under 65 Years Old	0	Genitourinary System Disorders
Unable to Self-Medicate	0	Stimulants
Venifer Dependent	1	Musculo-skeletal Disorders
Infectious Disease w/ Isolation	0	Injuries and Fractures
Other Restrictions	1	Other Medical Conditions
No Restrictions	0	Non-Medical Conditions
TOTALS	67	TOTALS

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	84	73	84	67	17	58	64
Nursing Care	84	73	84	67	17	58	64
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTAL BEDS	84	73	84	67	17	58	64

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	84	73	84	67	17	58	64
Nursing Care	84	73	84	67	17	58	64
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	84	73	84	67	17	58	64

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Payers	Private Insurance	Private Pay	Charity Care
Nursing Care	4870	20.8%	19771	84.5%	0	29455
Skilled Under 22	0	0.0%	0	0.0%	0	0
Intermediate DD	0	0.0%	0	0.0%	0	0
Sheltered Care	0	0.0%	0	0.0%	0	0
TOTALS	4870	20.8%	19771	84.5%	0	29455

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUP	Nursing Care	Skilled Under 22	Intermediate DD	Sheltered	Total
Under 10	0	0	0	0	0
10 to 44	0	0	0	0	0
45 to 59	6	4	0	0	10
60 to 64	1	0	0	0	1
65 to 74	4	8	0	0	12
75 to 84	6	12	0	0	18
85+	5	21	0	0	26
TOTALS	22	45	0	0	67

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 BELHAVEN NURSING & REHABILITATION CENTRE CHICAGO

BELHAVEN NURSING & REHABILITATION CENTRE
 11401 SOUTH OAKLEY AVENUE
 CHICAGO, IL 60643
 Reference Numbers Facility ID 800822
 Health Service Area 006 Planning Service Area 603

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	MEDICARE			MEDICAID			PRIVATE PAY			CHARTY CARE			AVERAGE DAILY PAYMENT RATES	
	Medicare	Medicaid	Private	Medicare	Medicaid	Private	Medicare	Medicaid	Private	Medicare	Medicaid	Private	Single	Double
Nursing Care	20	159	5	2	5	0	191						195	175
Skilled Under 22	0	0	0	0	0	0	0						0	0
Intermediate DD	0	0	0	0	0	0	0						0	0
Sheltered Care	0	0	0	0	0	0	0						0	0
TOTALS	20	159	5	2	5	0	191							

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing	Skilled	ICF/DD	Shelter	Totals
Ashken	1	0	0	0	1
Asian	0	0	0	0	0
Black	180	0	0	0	180
Hispanic	0	0	0	0	0
White	10	0	0	0	10
Race Unknown	0	0	0	0	0
TOTAL	191	0	0	0	191

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
27.7%	64.5%	0.0%	3.5%	4.3%	0.0%
3,270,269	8,313,355	0	443,190	550,219	0

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 BELHAVEN NURSING & REHABILITATION CENTRE CHICAGO

BELHAVEN NURSING & REHABILITATION CENTRE
 11401 SOUTH OAKLEY AVENUE
 CHICAGO, IL 60643
 Reference Numbers Facility ID 800822
 Health Service Area 006 Planning Service Area 603

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	1	2	3	4	5	6	7	TOTALS
Agitated/Ano-Social	1							1
Chronic Alcoholism	0							0
Developmentally Disabled	0							0
Drug Addiction	0							0
Medical Resident	0							0
Medicare Recipient	0							0
Mental Illness	0							0
Non-ambulatory	0							0
Non-Mobile	0							0
Public Aid Recipient	0							0
Under 65 Years Old	0							0
Unable to Self-Medicate	0							0
Vaulting Disorder	1							1
Infectious Disease w/ Isolation	0							0
Other Residences	0							0
No Restrictions	0							0
Year Reported restrictions eliminated by '1'	0							0
TOTALS	191							191

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	2010	2011	2012	2013
Nursing Care	221	211	221	213
Skilled Under 22	0	0	0	0
Intermediate DD	0	0	0	0
Sheltered Care	0	0	0	0
TOTAL BEDS	221	211	221	213

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	Licensed Beds	Peak Beds
Nursing Care	7525	55549	58	6200	2891	0	72323	69.7%
Skilled Under 22	0	0	0	0	0	0	0	0.0%
Intermediate DD	0	0	0	0	0	0	0	0.0%
Sheltered Care	0	0	0	0	0	0	0	0.0%
TOTALS	7525	55549	58	6200	2891	0	72323	69.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		INTERMED. DD		SHELTERED		TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 10	0	0	0	0	0	0	0	0
18 to 44	3	0	0	0	0	0	3	0
45 to 59	19	7	0	0	0	0	19	7
60 to 64	4	13	0	0	0	0	4	13
65 to 74	14	24	0	0	0	0	14	24
75 to 84	19	28	0	0	0	0	19	28
85+	16	42	0	0	0	0	16	42
TOTALS	77	114	0	0	0	0	77	114

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WASHINGTON & JANE SMITH COMM. CHICAGO

WASHINGTON & JANE SMITH COMM.
 2320 WEST 113TH PLACE
 CHICAGO, IL 60643
 Facility ID 6009732
 Health Service Area 008 Planning Service Area 603

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Other			Private			Charity		
	Nursing	Medicaid	Public	Insurance	Pay	Care	Pay	Care	TOTALS
Nursing Care	20	13	0	0	58	0	0	0	81
Skilled Under 22	0	0	0	0	0	0	0	0	0
ICF/DD	0	0	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0	0	0
TOTALS	20	13	0	0	58	0	0	0	91

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Nursing			ICF/DD			Shelter			Totals
	Nursing	ICF/DD	Shelter	Nursing	ICF/DD	Shelter	Nursing	ICF/DD	Shelter	
Asian	0	0	0	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0	0	0	0
Black	5	0	0	0	0	0	0	0	0	5
Hispanic/Latino	0	0	0	0	0	0	0	0	0	0
White	86	0	0	0	0	0	0	0	0	86
Race Unknown	0	0	0	0	0	0	0	0	0	0
Total	91	0	0	0	0	0	0	0	0	91

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay
30.6%	7.9%	0.0%	2.5%	56.8%
2,578,824	646,395	0	208,503	4,871,605

*Charity Expense does not include expenses which may be considered a community benefit.

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2010 WASHINGTON & JANE SMITH COMM. CHICAGO

WASHINGTON & JANE SMITH COMM.
 2320 WEST 113TH PLACE
 CHICAGO, IL 60643
 Facility ID 6009732
 Health Service Area 008 Planning Service Area 603

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	Count
Neoplasms	1
Endocrine/Metabolic	2
Blood Disorders	0
Nervous System (Non Alzheimer)	0
Alzheimer Disease	1
Mental Illness	0
Developmental Disability	0
Cerebral Palsy	13
Respiratory System	5
Digestive System	3
Genitourinary System Disorders	4
Skin Disorders	4
Musculoskeletal Disorders	10
Injury and Poisoning	2
Other Medical Conditions	46
Non-Medical Conditions	0
TOTALS	91

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	PEAK		MEDICARE		MEDICAID	
	BEDS	USED	BEDS	IN USE	BEDS	CERTIFIED
Nursing Care	103	99	100	91	12	64
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0
TOTAL BEDS	103	99	100	91	12	64

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicaid			Other Public			Private Insurance			Charity		
	Pat. days	Occ. Pat.	Per. days	Pat. days	Occ. Pat.	Per. days	Pat. days	Occ. Pat.	Per. days	Pat. days	Occ. Pat.	Per. days
Nursing Care	7338	134.0%	8523	16.3%	0	0	29	30223	0	0	0	0
Skilled Under 22	0	0.0%	0	0.0%	0	0	0	0	0	0	0	0
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0	0	0	0	0
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0	0	0	0	0
TOTALS	7338	134.0%	8523	16.3%	0	0	29	30223	0	0	0	0

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SRL UNDER 22		INTERMED. DD		SHELTERED		TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	
Under 18	0	0	0	0	0	0	0	0	0
18 to 44	0	0	0	0	0	0	0	0	0
45 to 59	0	0	0	0	0	0	0	0	0
60 to 84	0	0	0	0	0	0	0	0	0
65 to 74	0	1	0	0	0	0	0	0	1
75 to 84	7	24	0	0	0	0	0	0	31
85+	7	53	0	0	0	0	0	0	59
TOTALS	14	77	0	0	0	0	0	0	91

ILLINOIS LONG-TERM CARE PROFILE - CALENDAR YEAR 2010 RENAISSANCE PARK SOUTH CHICAGO

RENAISSANCE PARK SOUTH
10933 SOUTH HALSTED STREET
CHICAGO, IL 60628
Reference Numbers Facility ID 6009328
Health Service Area 006 Planning Service Area 603
Administrators
Famit Staff
Contract Person and Telephone
Famit Staff
733-928-2000
Registered Agent Information
Peggy McCabe
7237 N Lincoln Ave.
Lansdown, IL 60112
FACILITY OWNERSHIP
LIMITED LIABILITY CO
CONTINUING CARE COMMUNITY
LIFE CARE FACILITY

ADMISSION RESTRICTIONS

ADMISSION RESTRICTIONS	1	DIAGNOSIS	RESIDENTS BY PRIMARY DIAGNOSIS
Aggressive/Anti-Social	0	Narcotics	0
Chronic Alcoholism	1	Encephalopathic	65
Developmentally Disabled	0	Blood Disorders	0
Drug Addiction	0	Nervous System: Non Alzheimer	0
Methadone Recipient	0	Alzheimer Disease	57
Moderate Recipient	0	Mental Illness	10
Non-Abusive	0	Developmental Disability	2
Non-Male	0	Circulatory System	60
Public Aid Recipient	0	Respiratory System	5
Under 65 Years Old	0	Digestive System	20
Unable to Self-Medicare	0	Centinervous System Disorders	2
Ventilator Dependent	1	Skin Disorders	0
Infectious Diseases w/ Isolation	0	Musculoskeletal Disorders	0
Other Restrictions	0	Injuries and Poisonings	0
No Restrictions	0	Other Medical Conditions	0
None: Reported restriction removed by '1'	0	Non-Medical Conditions	0
		TOTALS	241
		Total Residents Diagnosed as Mentally Ill	67

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

PEAK	PEAK	PEAK	PEAK	ADMISSIONS AND DISCHARGES - 2010
LICENSED BEDS	BEDS IN USE	MEDICARE/MEDICAID CERTIFIED BEDS	ADMISSIONS	DISCHARGES
300	263	250	222	222
0	0	0	345	345
0	0	0	336	336
0	0	0	241	241
0	0	0	0	0
300	263	250	241	241

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private	Charity	Peak Beds
Nursing Care	13565	66667	3523	1368	3344	80.7%
Skilled Under 22	0	0	0	0	0	0.0%
Intermediate DD	0	0	0	0	0	0.0%
Skilled Under 22	13565	66667	3523	1368	3344	80.7%
Intermediate DD	0	0	0	0	0	0.0%
Skilled Under 22	13565	66667	3523	1368	3344	80.7%
Intermediate DD	0	0	0	0	0	0.0%
TOTALS	13565	66667	3523	1368	3344	80.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SHELTERED DD		TOTAL	
	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0
18 to 24	6	2	0	0	6	2
25 to 34	11	13	0	0	11	13
35 to 44	10	6	0	0	10	6
45 to 54	25	26	0	0	25	26
55 to 64	27	46	0	0	27	46
65 to 74	13	35	0	0	13	35
75 to 84	59	148	0	0	59	148
85+	0	0	0	0	0	0
TOTALS	148	241	0	0	148	241

ILLINOIS LONG-TERM CARE PROFILE - CALENDAR YEAR 2010 RENAISSANCE PARK SOUTH CHICAGO

RENAISSANCE PARK SOUTH
10933 SOUTH HALSTED STREET
CHICAGO, IL 60628
Reference Numbers Facility ID 6009328
Health Service Area 006 Planning Service Area 603

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	31	181	11	3	15	0	241
Skilled Under 22	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Skilled Under 22	31	181	11	3	15	0	241

RESIDENTS BY RACE/ETHNICITY GROUPING

RACE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Asian	0	0	0	0	0	0	0
Amer. Indian	0	0	0	0	0	0	0
Black	235	0	0	0	0	0	235
Hispanic/Latino	0	0	0	0	0	0	0
White Unknown	6	0	0	0	0	0	6
Total	241	0	0	0	0	0	241

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
40.7%	52.5%	2.6%	1.4%	2.7%	0.0%
8,801,643	8,801,612	460,928	228,468	451,860	0
*Charity Expense does not include expenses which may be considered a community benefit.					

CHICAGO

AVERAGE DAILY PAYMENT RATES

LEVEL OF CARE	SINGLE	DOUBLE
Nursing Care	150	140
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Under 22	150	140

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	2.00
Registered Nurses	15.00
LPNs	38.00
Certified Aides	107.00
Other Health Staff	19.00
Non-Health Staff	47.00
TOTALS	253.00

STAFFING

EMPLOYMENT CATEGORY	FULL-TIME EQUIVALENT
Administrators	2.00
Physicians	0.00
Director of Nursing	2.00
Registered Nurses	15.00
LPNs	38.00
Certified Aides	107.00
Other Health Staff	19.00
Non-Health Staff	47.00
TOTALS	253.00

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
40.7%	52.5%	2.6%	1.4%	2.7%	0.0%
8,801,643	8,801,612	460,928	228,468	451,860	0
*Charity Expense does not include expenses which may be considered a community benefit.					

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 SOUTHPOINT NURSING AND REHAB CENTER CHICAGO

SOUTHPOINT NURSING AND REHAB CENTER CHICAGO, IL 60643

Reference Numbers Facility ID 6014781
Health Service Area 008 Planning Service Area 603

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care	TOTALS
Nursing Care	14	152	0	0	0	0	172
Skilled Under Z2	0	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0	0
Sheltered Care	0	0	0	0	0	0	0
TOTALS	14	152	0	0	0	0	172

RESIDENTS BY RACIAL/ETHNICITY GROUPING

RACE	Nursing	Skilled Under Z2	ICF/DD	Shelter	Totals
Asian	0	0	0	0	0
Amer. Indian	0	0	0	0	0
Black	170	0	0	0	170
Hispanic	0	0	0	0	0
White	2	0	0	0	2
Race Unknown	0	0	0	0	0
Total	172	0	0	0	172

ETHNICITY

ETHNICITY	Nursing	Skilled Under Z2	ICF/DD	Shelter	Totals
Hispanic	0	0	0	0	0
Non-Hispanic	172	0	0	0	172
Ethnicity Unknown	0	0	0	0	0
Total	172	0	0	0	172

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
27.0%	87.4%	0.0%	0.1%	4.7%	0.0%
3,183,308	7,676,943	0	12,240	539,080	0
*Charity Expense does not include expenses which may be considered a community benefit.					

EMPLOYMENT CATEGORY

EMPLOYMENT CATEGORY	Full-time Equivalent
Administrators	1.0
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	10.00
LPN's	36.00
Certified Aides	65.00
Other Health Staff	5.00
Non-Health Staff	68.00
Total	174.00

STAFFING

STAFFING	Charity Expense as % of Total Net Revenue
TOTALS	100.0%
Charity Expense	0.0%
11,301,500	

ILLINOIS LONG-TERM CARE PROFILE CALENDAR YEAR 2010 SOUTHPOINT NURSING AND REHAB CENTER CHICAGO

SOUTHPOINT NURSING AND REHAB CENTER CHICAGO, IL 60643

Reference Numbers Facility ID 6014781
Health Service Area 008 Planning Service Area 603

RESIDENTS BY PRIMARY DIAGNOSIS

ADMISSION RESTRICTIONS	DIAGNOSIS	Count
Aggressive/Alcoholism	Neoplasms	4
Chronic Alcoholism	Endocrine/Metabolic	14
Developmentally Disabled	Blood Disorders	0
Drug Addiction	Nervous System Non-Alzheimer	11
Medicaid Recipient	Alzheimer Disease	10
Mental Illness	Mental Illness	4
Non-Ambulatory	Developmental Disability	0
Non-Mobile	Circulatory System	57
Public Aid Recipient	Respiratory System	20
Under 65 Years Old	Digestive System	1
Unable to Self-Medicare	Conjunctive System Disorders	0
Visitor Dependent	Skin Disorders	13
Infectious Disease w/ Isolation	Musculo-skeletal Disorders	16
Other Restrictions	Injuries and Poisonings	0
No Restrictions	Other Medical Conditions	13
TOTALS	Non-Medical Conditions	172

ADMISSIONS AND DISCHARGES - 2010

LEVEL OF CARE	Licensed Beds	Peak	Medicare Certified	Medicaid Certified	Charity Certified	Peak Beds
Nursing Care	228	159	228	228	228	169
Skilled Under Z2	0	0	0	0	0	205
Intermediate DD	0	0	0	0	0	232
Sheltered Care	0	0	0	0	0	172
TOTAL BEDS	228	159	228	228	228	19

FACILITY UTILIZATION - 2010

LEVEL OF CARE	Medicare	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Total	Peak Beds
Nursing Care	6620	8.0%	58003	67.3%	0	0	66200	79.7%
Skilled Under Z2	0	0.0%	0	0.0%	0	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0	0.0%
Sheltered Care	0	0.0%	0	0.0%	0	0	0	0.0%
TOTALS	6620	8.0%	58003	67.3%	0	0	66200	79.7%

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2010

AGE GROUPS	NURSING CARE		SKILLED UNDER Z2		INTERMED. DD		SHELTERED		GRAND TOTAL	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 18	0	0	0	0	0	0	0	0	0	0
19 to 44	12	2	0	0	0	0	0	0	12	2
45 to 59	36	14	9	0	0	0	0	0	50	14
60 to 64	7	9	0	0	0	0	0	0	7	9
65 to 74	18	13	0	0	0	0	0	0	18	13
75 to 84	11	35	0	0	0	0	0	0	11	35
85+	4	19	0	0	0	0	0	0	4	19
TOTALS	90	92	0	0	0	0	0	0	90	92

ATTACHMENT-12C

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive.

The Applicant is proposing to establish 102,373 gross square feet of newly constructed space for the replacement of 111 nursing beds and the addition of 89 additional nursing care beds for a total of 200 beds. This equates to a total of 514 gross square feet per bed that appears to be well within the standards of 435-713 building square feet per bed as found under and appended as ATTACHMENT-13A which is a copy of the 77 IAC 1110 Appendix B that cites the range of square footage per bed for projects establishing the nursing category of care.

2. If the gross square footage exceeds the GSF standards in Appendix B, justify the discrepancy by documenting one of the following:

- a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

Since the square footage per bed is well within the guidelines as established by the Board, it does appear that this criterion is applicable.

- b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

The existing building has physical constraints that do not allow it to be modernized effectively or efficiently. Therefore, the entire existing building will be demolished and replaced. Thus, this item is not germane.

- c. The project involves the conversion of existing bed space that results in excess square footage.

This project does not involve the conversion of existing bed space; therefore, this item is not applicable.

ATTACHMENT-13

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER II: HEALTH FACILITIES AND SERVICES REVIEW BOARD
SUBCHAPTER a: ILLINOIS HEALTH CARE FACILITIES PLAN
PART 1110 PROCESSING, CLASSIFICATION POLICIES AND REVIEW CRITERIA
SECTION 1110.APPENDIX B STATE GUIDELINES - SQUARE FOOTAGE AND UTILIZATION

HFSRB NOTE: The standards for Post-Anesthesia Recovery Phase I and Post-Anesthesia Recovery Phase II shall be used as the standards for recovery stations associated with Surgical Operating Suite (Class C) and Surgical Procedure Suite (Class B).

OTHER FACILITIES

The following standards apply to new construction, the development of freestanding facilities, modernization, and the development of facilities in existing structures, including the use of leased space. For new construction, the standards are based upon the inclusion of all building components and are expressed in building gross square feet (bgsf). For modernization projects, the standards are based upon interior build-out only and are expressed in departmental gross square feet (dgsf). Spaces to be included in the applicant's determination of square footage shall include all functional areas minimally required for the applicable service areas by the appropriate rules required for IDPH licensure and/or federal certification and any additional spaces required by the applicant's operational program.

Service Areas	Square Feet/Unit	Annual Utilization/Unit
General Long-Term Care	435-713 bgsf/Bed 350-570 dgsf/Bed	See 77 Ill. Adm. Code 1100
ICF/DD Facilities	505-580 bgsf/Bed 404-464 dgsf/Bed	See 77 Ill. Adm. Code 1100
Ambulatory Surgical Treatment Center (ASTC) <ul style="list-style-type: none"> • Operating Room • Procedure Room • Recovery 	2075-2750 bgsf/Treatment Room 1660-2200 dgsf/Treatment Room	Maximum of 4 recovery stations per operating room 1500 hrs of Surgery/OR or Procedure Room
In-Center Hemodialysis	450-650 bgsf/Room 360-520 dgsf/Room	See 77 Ill. Adm. Code 1100
Freestanding Emergency Center	840-1170 bgsf/Treatment Station 672-936 dgsf/Treatment Station	2000 visits/Treatment Room/year

(Source: Amended at 34 Ill. Reg. 6121, effective April 13, 2010)

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE
(Continued ii)

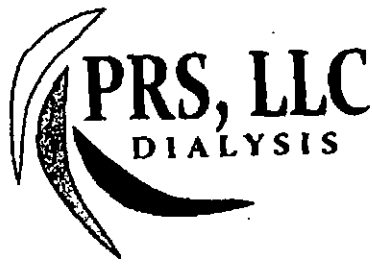
PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFPB has not established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110. Appendix B.

It appears that this criterion is not germane since this project is a Long-Term Nursing Care Category of Service for which the Health Facilities and Services Review Board has established occupancy targets in 77 IAC 1100. However, this Applicant is proposing to exceed the occupancy standard of 90% for the second full year of operations with patient days for calendar year 2015 of 65,700 days or 90%. The rationale for this projection is based upon its existing utilization and experience. Upon opening, the Applicant expects to transfer all existing patients what total 35,546 patient days, nearly 50% (48.7%). To reach and maintain 90%, the Applicant is expecting a 14-16 month fill-up. This is a extremely modest projection that based upon existing population, population growth, physician referrals, as well as demand that the existing facility could not accommodate due to its physical plant deficiencies. It should also be noted that the existing facility provides home dialysis to its residents who require this service. The proposed facility will also provide this service and appended as ATTACHMENT-14A is a "dialysis unit" feasibility study summary stating the need for such a unit and the residents that it could attract. This is only provided to illustrate all avenues that are currently and will be used to fill the replacement McAllister Nursing and Rehab.

ATTACHMENT-14



188 Industrial Drive
Suite #100
Elmhurst, IL
60126
Phone: (630) 359-3249
Fax: (630) 359-3251

McAllister Nursing & Rehab
Dialysis Unit Feasibility
7/12/2011

McAllister Nursing & Rehab is located in Tinley Park, Illinois and this analysis was initiated to determine if the need for dialysis services in the SNF would generate sufficient referral flow to justify the development costs as well as a projection to reach 75% utilization.

The surrounding area has 11 community dialysis centers with 216 stations within 10 miles of McAllister Nursing & Rehab. This represents a capacity of 1037 dialysis patients. Dialysis patients experience a higher frequency of hospitalizations and CMS data reveals this to be 1.8 times per patient per year on average. Estimated total post acute dialysis population would be 1,867 per year.

The percentage of dialysis patients with SNF placements following a hospital stay is 40% (747). Approximately 15% (112) of these are long term residents of SNFs that are returning to the same SNF. The patients in balance (635) are community residents in need of a rehabilitation stay that averages 45 days.

There are very few dialyses SNF in the immediate market area. The competitive landscape is favorable for this project with a total of 635 rehabilitation patients within 10 miles. A conservative estimate of 50% to 75% of this market represents 318 to 476 patients who can be captured with an average of 39 to 59 patient censuses at 45 days per stay. The proposed unit would have a capacity of 39 to 59 patients but the market can support a larger unit.

There are over 100 Nephrologists in more than 15 Nephrology Groups in this market. A majority are on staff at these well recognized organizations: Nephrology Associates of Northern Illinois, Ltd; University Medical Diagnostic Associates Inc.; The University of Illinois; Cook County; Advocates Health and Hospital Corporation; Southwest Nephrology Associates SC; Associates in Nephrology; Loyola University Medical Center and University of Chicago. The target is for 4 staff Nephrologists to maintain a census of 39 to 59 patients which is achievable given the patient volume in the market and the physicians' desire to follow their own patients and receive assignments.

The market analysis supports the need for a 10 chair unit with a capacity of 39 to 59 patients in two shifts per day. A third shift per day would be required as the census increases to over 40. We anticipate that space would be available in the facility to allow a 10 chair unit to be built. Given the minimal competition, the unit will be able to fill in 4 to 6 months. These units experience a 12% vacancy factor so a 39 to 59 patient capacity will yield an average census of 34 to 47.

PRS, LLC provides the highest quality renal care. The presence of a dialysis registered nurse along with experienced dialysis technicians for every treatment assures that the patient is receiving care that exceeds the industry standards. The PRS, LLC dialysis team includes the nephrologists, renal social worker, renal dietitian, dialysis nurses, dialysis technicians and members of the PRS administration to work in concert

with the SNF to maintain and coordinate the continuum of care. We provide monthly CQI meetings to review all aspects of care for the dialysis patients, review trends and address outliers. The CQI meetings provide a forum to dialogue formally with the SNF personnel to better assure the coordination of care.

PRS, LLC serving as the dialysis provider gives our SNF partners added benefits of business development activities with:

- Nephrologists
- Payers
- discharge planners and social workers at the local hospitals
- community clinics

PRS, LLC provides on-site training to the dialysis personnel and the personnel of the SNF to facilitate the processes required assuring the continuum of care for the renal patient.

This document also serves to explain the proposed change in payor mix and profile of the patient population. The addition of dialysis therapies in the facility to address the patient requirement for rehabilitation after a hospitalization should result in the following mix:

65% Medicare, 20% Medicaid and 15% Commercial

Please see the attachment for the economic impact Proforma.

Listed below please find references of PRS current clients:

Bronzeville Park
3400 S Indiana Ave
Chicago, IL 60616
Phone: 312-842-5000 ext 137
Fax: 312-842-4764
Main phone: 312-842-5000
Administrator: Tony Prather
(Acting)

Community Nursing
1136 N Mill St.
Naperville, IL 60563
Phone: 630-544-3173
Fax: 630-416-9499
Main Phone
630-355-3300
Administrator: Larry Banks

Forest Villa Nursing
6840 West Touhy Ave
Niles, IL 60714
Phone: 847-647-6609
Fax: 847-647-6626
Main Phone: 847-647-6400
Jan Kaval Regional V.P. of
Business Development
NuCare Services

Prepared and submitted by:

Paula R. Cuellar, CEO
and
Michael Waxman, MBA Director of Corporate Marketing & Program Expansion

SECTION VIII. – GENERAL LONG TERM CARE

According to the chart in the application form for this Certificate of Need, the items that are applicable are those items that are checked under the columns “expand” and “modernize”; therefore, only items 1110.1730(b)(2), 1110.1730(b)(4), 1110.1730(d)(3), 1110.1730(f)(1), 1110.1730(f)(2 & 3), 1110.1730(f)(4), 1110.1730(g), 1110.1730(h), 1110.1730(i), 1110.1730(j), and 1110.1730(k) are applicable and will be addressed.

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

2) Service to Planning Area Residents

- A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

The primary purpose of this project is to provide the general long-term care category of service to the residents of the Applicant's geographic service area that equates to an approximate 30-minute travel time. It appears that the 30-minutes travel time contour and the areas of the 7-E Planning Area and the Will County Planning Areas approximate. However, when the adjusted travel times are considered, the true primary service area is more in-line with the 7-E Planning Area.

This project is for the replacement and expansion of additional nursing care beds; therefore, the existing facility and its resultant patient origin data shows that 84.7% of its residents come from within 30-minute travel time contour.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued ii)

However, it is just as important to note that over half, thus a majority (specifically 61.2%) of the admissions originated from within the 7-E Planning Area. A summary of this patient origin data is appended as **ATTACHMENT-28A**. Therefore, it appears that the Applicant has already proven that the primary purpose of the project is to provide necessary health care to the residents of the area in which the proposed project will be physically located.

- B) Applicants proposing to add beds to an existing general long term care service shall provide patient origin information for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the area. For all other projects, applicants shall document that at least 50% of the projected patient volume will be from residents of the area.

The proposed project is for the replacement and addition of beds to the existing facility. The patient origin data, appended as **ATTACHMENT-28A** shows that not only did 84.7% of the existing resident come from the 30-minute travel time contour, but that 61.2% of all existing residents came from the 7-E Planning Area.

- C) Applicants proposing to expand an existing general long term care service shall submit patient origin information by zip code, based upon the patient's legal residence (other than a health care facility).

The patient origin information by resident initials, zip code, and county is appended as **ATTACHMENT-28A**.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE

(Continued iii)

b) Planning Area Need – Review Criterion

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

4) Service Demand – Expansion of Bed Category of Service

The number of beds to be added at an existing facility is necessary to reduce the facility's experienced high occupancy and to meet a projected demand for service. The applicant shall document subsection (b)(4)(A) and either subsection (b)(4)(B) or (C):

A) Historical Service Demand

- i) An average annual occupancy rate that has equaled or exceeded occupancy standards for the category of service, as specified in 77 Ill. Adm. Code 1100, for each of the latest two years.

As provided herein, over the past 12 months ending July 31, 2011, McAllister Nursing & Rehab realized 35,546 patient days equating to a utilization of 87.7%. According to the 2010 and 2009 IDPH, Annual Facility Questionnaire Data, the subject nursing facility reported utilization rates of 76.5% and 68.1% respectively. This reflects an increase of 12.3% between the 2009 data and 2010 data and a 14.7% increase in utilization between 2010 data and year-to-date data ending July 3, 2011. It should also be noted that this Applicant acquired the facility in CY2008. Therefore, although it does not have the history as specified by this criterion, the Applicant has made significant strides in achieving the best utilization for the subject facility since it has been in their control. Moreover, the reason for this project is that the facility is in dire need of

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued iv)

being modernized or replaced. The resulting utilization is reflective of this situation in which the facility is considerably less marketable as is, hence the project to replace. Please refer to **ATTACHMENT-28B** for the utilization data as documented herein.

- ii) If prospective residents have been referred to other facilities in order to receive the subject services, the applicant shall provide documentation of the referrals, including completed applications that could not be accepted due to lack of the subject service and documentation from referral sources, with identification of those patients by initials and date.

Prospective residents have not been referred to other facilities by this Applicant; therefore, this item is not germane.

B) Projected Referrals

The applicant shall provide the following:

- i) Letters from referral sources (hospitals, physicians, social services and others) that attest to total number of prospective residents (by zip code of residence) who have received care at existing LTC facilities located in the area during the 12-month period prior to submission of the application. Referral sources shall verify their projections and the methodology used;

Appended as **ATTACHMENT-28C**, are referral letters from Antonio Noriega, MD and Pradeep Thapar, MD. These two physicians have stated that they collectively have referred 96-132 of McAllister's historical admissions. They have also indicated that the historical referrals are only limited by the facility's physical impediments and therefore, upon project completion, they could collectively refer between 204-324 patients

ATTACHMENT-28

SECTION VIII. - GENERAL LONG TERM CARE (Continued v)

annually. Respectively, these physicians have cited Advocate South Suburban Hospital, Advocate Christ Hospital, Palos Hospital, Ingalls Hospital, St. James Hospital and Little Company of Mary as referring hospitals to each practice.

- ii) An estimated number of prospective residents whom the referral sources will refer annually to the applicant's facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the referral sources' documented historical LTC caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share, within a 24-month period after project completion;

Appended as ATTACHMENT-28C, are referral letters from Antonio Noriega, MD and Pradeep Thapar, MD. These two physicians have stated that they collectively refer between 204-324 patients annually.

- iii) Each referral letter shall contain the referral source's Chief Executive Officer's notarized signature, the typed or printed name of the referral source, and the referral source's address; and

The referral letters appended as ATTACHMENT-28C provides the notarized signature of the referring physicians, the typed name of the referral source, and the referrals source's address.

ATTACHMENT-28

SECTION VIII. - GENERAL LONG TERM CARE (Continued vi)

Criterion 1110.1730(d)(3) - Documentation related to Cited Problems

In reviewing the rules, 77 IAC Section 1110.1730, it was found that there is no 1110.1730(d)(3) criterion. Therefore, this item would appear not to be germane. As previously documented, the subject building is an old structure that needs to be replaced. As such, the documentation consisting of the State's physical plant surveys are appended in **ATTACHMENT-11D**. Appended as **ATTACHMENT-11E** is the Architect's report on specifically what items are not in compliance and what it would take to rectify the situation.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued vii)

Criterion 1110.1730(f)(1) – Category of Service Modernization

- 1) the project involves If modernization of a category of hospital facility bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but not limited to:

A) High cost of maintenance;

According to the facility's Illinois Department of Health Care and Family Services 2010 Cost Report, this facility had operational expenses of \$236,568 listed as Maintenance. This report also cited \$199,262 in capital improvements made in since acquiring the facility. See ATTACHMENT-12A for the appropriate pages of the cost report.

B) Non-compliance with licensing or life safety codes;

In addition to the high cost of physical plant maintenance, this facility has deferred maintenance that can no longer be put off. Items of extensive expense such as automatic fire sprinkler system, nurses stations, toilet rooms, egress windows, mechanical systems, and the plumbing system are either out of compliance with current licensure code of at the end of their useful life. In order to implement the modernizations necessary to address all deficiencies identified and to maintain the same number of beds, the architect, Arthur P. Salk, Architect, P.C. has provided a narrative of all components need to be corrected along with an estimated project cost. Addressing all non-compliant areas is estimated to \$12,473,487. This number does not include any interest expense, furniture, fixtures, & equipment. The cost to modernize also does not include the approximately 15 beds that would be lost to accommodate the licensure and life safety

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued viii)

Criterion 1110.1730(f)(1) – Category of Service Modernization

standards. Please find the architect's narrative addressing the facility's areas of non-compliance, how such areas could be addressed, and the cost of addressing those concerns appended as ATTACHMENT-11E.

C) Changes in standards of care (e.g., private versus multiple bed rooms); or

The Applicant's existing facility has only 2-private resident rooms, 25-double occupancy rooms, 13-three bed ward rooms and 5-four bed ward rooms. The replacement facility will have 28 private rooms and 86 semiprivate rooms. The new construction will provide each resident room with its own bathroom whereas only approximately 60% within the existing building have or share bathrooms. As such, the Applicant is proposing to go from 4% of the facility with private rooms (2 private rooms out of 45 total bed rooms) to nearly 25% of the rooms as private (28 private rooms out of 114 total bed rooms). This includes the elimination of all three and four bed ward rooms representing a significant shift in standard of care toward one of resident dignity and privacy. Toward that end, the proposed replacement facility will create smaller neighborhoods of approximately 33 beds in each. There will also be a dedicated Medicare Rehabilitation area and dialysis area to accommodate the existing residents. Therefore, the changes in standards of care only relate to a more state-of-the-art environment which will allow for greater personalization of care.

D) Additional space for diagnostic or therapeutic purposes.

The proposed project will include additional space for in-patient and out-patient

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE

(Continued ix)

Criterion 1110.1730(f)(1) – Category of Service Modernization

physical and occupational therapy. The proposed PT/OT space will be nearly 3 times the size in all newly constructed space. This area will also have its own means of ingress and egress. In addition to the trends of personalization of care, the industry has also seen a movement in providing more extensive physical and occupational therapy space. This promotes the rehabilitation of residents and their return to their homes and productive lives. This facility also proposes to continue to provide in-home dialysis service as this Applicant has a high number of residents requiring this service.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued x)

Criterion 1110.1730(f)(2) and (3) – Category of Service Modernization

2) Documentation shall include the most recent:

- A) IDPH CMMS inspection reports; and
- B) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports.

Appended as ATTACHMENT-11D, is a copy of the latest Department of Health and Human Services Centers for Medicare & Medicaid Services inspection reports for the facility, McAllister Nursing & Rehab.

3) Other documentation shall include the following, as applicable to the factors cited in the application:

- A) Copies of maintenance reports;
- B) Copies of citations for life safety code violations; and
- C) Other pertinent reports and data.

Appended as ATTACHMENT-12A, is a copy of the Illinois Department of Health Care and Family Services Facility Cost Report for FY2010 which lists out the maintenance and capital expenditures undertaken at McAllister Nursing and Rehab. Appended as ATTACHMENT-11E, is the architect's report on the existing facility's compliance to current standards.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued xi)

Criterion 1110.1730(f)(4) – Category of Service Modernization

- 4) Projects involving the replacement or modernization of a category of service or facility shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

In the 9 months following March 2008, McAllister Nursing & Rehab experienced an average utilization rate of 67 residents or 60.3%. This occupancy rate increase to 68.1% for 2009 and 76.5% for 2010. For the 12-month period ending July 31, 2011, the facility averaged 87.7% occupancy. According to the 77 Illinois Administrative Code, Section 1100.660, the occupancy target is 90%. Due to the physical plant limitations in terms of marketability/desirability based on the age and condition of the building, this facility has not been able to maintain this occupancy target, hence the proposed project. The proposed project will provide a state-of-the-art environment for its existing residents and the residents of the 7-E Planning Area who will be in need of long-term nursing care. The Applicant's future ability to reach and maintain this level of utilization is based on its experience as an existing provider, which is further supported by the State's identified bed need calculation which currently shows a need for 339 additional beds in the 7-E Planning Area. As stated previously, there are several facilities that are at or in excess of the optimum level and nearly 2000 beds (1,955) that have restricted usage.

Finally, the Applicant has received two referral letters confirming support for the proposed project from area physician's who have historically referred residents to McAllister Nursing & Rehab. These two letters, appended as **ATTACHMENT-28C**, document that historically they have referred 8-11 patients monthly (or 96-132 annually) to the facility.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE

(Continued xii)

Criterion 1110.1730(f)(4) – Category of Service Modernization

With the replacement facility offering more amenities and with the addition of beds, it is projected that the two physicians could refer approximately 17-27 monthly (or 204-324 annually). Based on the 2010 facility admission data, these physicians would have referred the majority of patients to the facility (over 95%).

ATTACHMENT-28

SECTION VIII. - GENERAL LONG TERM CARE (Continued xiii)

g) Staffing Availability - Review Criterion

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and JCAHO staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

Appended as ATTACHMENT-28D is a staffing statement from the Applicant outlining the current and proposed staffing situation and outlook for recruiting additional staff. Appended within this attachment is also the existing and proposed staffing pattern.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued xiv)

h) Performance Requirements – Facility Size

The maximum size of a general long term care facility is 250 beds, unless the applicant documents that a larger facility would provide personalization of patient care and documents provision of quality care based on the experience of the applicant and compliance with IDPH's licensure standards (77 Ill. Adm. Code: Chapter I, Subchapter c – Long-Term Care Facilities) over a two-year period of time.

This item is not applicable as the Applicant is proposing only 200 nursing care beds.

SECTION VIII. – GENERAL LONG TERM CARE (Continued xv)

i) Community Related Functions – Review Criterion

The applicant shall document cooperation with and the receipt of the endorsement of community groups in the town or municipality where the facility is or is proposed to be located, such as, but not limited to, social, economic or governmental organizations or other concerned parties or groups. Documentation shall consist of copies of all letters of support from such organizations.

Appended as **ATTACHMENT-28E**, are six letters of support from with the community. Specifically, the support comes from U.S. Representative Jesse L. Jackson, Jr., State Senator Maggie Crotty representing the 19th District, Advocate Christ Medical Center, Vitas Healthcare Corporation of Illinois, the Mayor of Country Club Hills and Advocate South Suburban Hospital.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued xvi)

j) Zoning – Review Criterion

The applicant shall document one of the following:

- 1) The property to be utilized has been zoned for the type of facility to be developed;
- 2) Zoning approval has been received; or
- 3) A variance in zoning for the project is to be sought.

The Applicant currently has a 111 bed nursing care facility on the site known as McAllister Nursing & Rehab located in Tinley Park, Planning Area 7-E. This project will be an on-site replacement. Therefore, the project is currently zoned and remains so. However, the facility site is in the process of being annexed into the City of Country Club Hills. The required letter from the City Manager is appended as **ATTACHMENT-28F**.

ATTACHMENT-28

SECTION VIII. – GENERAL LONG TERM CARE (Continued xvii)

k) Assurances

- 1) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

Appended as **ATTACHMENT-28F**, is the above referenced and requested assurance letter.

ATTACHMENT-28

McAllister Nursing Rehab
 Patient Origin Analysis
 2009 2010

ZIP Code	# of residents	Residents within 30-min	Residents within 7-E
34607	1	0	0
49057	1	0	0
60126	1	0	0
60141	1	0	0
60162	1	0	0
60163	1	0	0
60164	1	0	0
60169	1	0	0
60401	1	1	0
60406	1	1	1
60409	4	4	4
60411	3	3	3
60415	1	1	1
60417	1	1	0
60419	2	2	2
60423	6	6	0
60425	1	1	1
60426	4	4	4
60429	10	10	10
60430	4	4	4
60439	1	1	1
60441	1	1	0
60443	10	10	10
60446	1	0	0
60448	1	1	0
60451	3	3	0
60452	7	7	7
60455	1	1	1
60459	2	2	2
60461	2	2	2
60462	8	8	8
60463	1	1	1
60465	2	2	2
60466	5	5	0
60467	1	1	1
60471	2	2	2
60473	1	1	1
60475	3	3	3
60477	15	15	15
60478	12	12	12
60487	1	1	1
60490	1	0	0
60491	1	1	0
60525	1	1	1
60602	1	0	0
60612	1	0	0
60617	2	2	0
60619	3	3	0
60620	3	3	0
60628	4	4	0
60629	1	1	0
60633	2	2	0
60634	1	0	0
60640	1	0	0
60643	3	3	0
60653	1	0	0
60655	1	1	0
60657	1	0	0
60803	2	2	2
60805	1	1	1
60827	1	1	1
60901	1	0	0
60950	2	2	0
64128	1	0	0
	162	144	104
Unknown	8		
	170	84.7%	61.2%

McAllister Nursing Rehab
Historical Utilization and Admissions

PT. Days/Utilization Admits/ALOS	10-Jul	10-Aug	10-Sep	10-Oct	10-Nov	10-Dec	11-Jan	11-Feb	11-Mar	11-Apr	11-May	11-Jun	11-Jul	
	3,051	3,229	2,883	2,995	2,854	2,957	2,954	2,684	3,060	2,937	3,055	2,966	2,972	35,546
	19	17	15	17	16	22	17	11	15	15	14	11	9	179
														87.7%
														198.6

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2009 MCALLISTER NURSING & REHAB TIMLEY PARK

MCALLISTER NURSING & REHAB
 16300 SOUTH LAVERGNE AVENUE
 TIMLEY PARK, IL 60477
 Facility ID 6005904
 Planning Service Area 705

RESIDENTS BY PRIMARY DIAGNOSIS

DIAGNOSIS	RESIDENTS
Neoplasms	2
Endocrine/Metabolic	0
Blood Disorders	0
Neurological	3
Alzheimer Disease	21
Mental Illness	8
Developmental Disability	4
Circulatory System	1
Respiratory System	5
Digestive System	2
Genitourinary System	1
Skin Disorders	5
Musculoskeletal Disorders	0
Injuries and Poisonings	13
Other Medical Conditions	15
TOTALS	90

RESIDENTS BY PAYMENT SOURCE AND LEVEL OF CARE

LEVEL OF CARE	Medicaid	Medicare	Other	Private	Charity	TOTALS
Nursing Care	10	71	0	0	0	90
Skilled Under 22	0	0	0	0	0	0
Intermediate DD	0	0	0	0	0	0
Skilled Care	0	0	0	0	0	0
TOTALS	10	71	0	0	0	90

RESIDENTS BY RACE/ETHNICITY GROUP/PKNO

RACE	Nursing	Skilled	CF/DD	Shelter	TOTALS
Asian	0	0	0	0	0
Armed. Indian	0	0	0	0	0
Black	29	0	0	0	29
Hispanic/Pac. Isl.	0	0	0	0	0
White	60	0	0	0	60
Race Unknown	1	0	0	0	1
TOTAL	90	0	0	0	90

NET REVENUE BY PAYOR SOURCE (Fiscal Year Data)

Medicaid	Other Public	Private Insurance	Private Pay	Charity Care
32.6%	51.7%	0.0%	7.3%	8.3%
1,036,839	2,581,619	0	368,910	412,531

RESIDENTS BY AGE GROUP, SEX AND LEVEL OF CARE - DECEMBER 31, 2009

AGE GROUPS	Male	Female	Male	Female	Male	Female	TOTAL
Under 18	0	0	0	0	0	0	0
18 to 44	1	1	0	0	0	0	2
45 to 59	6	7	0	0	0	0	13
60 to 74	3	3	0	0	0	0	6
75 to 84	4	10	0	0	0	0	14
85+	11	18	0	0	0	0	29
TOTALS	32	58	0	0	0	0	90

BY LEVEL OF CARE PROVIDED AND PATIENT PAYMENT SOURCE

LEVEL OF CARE	Medicaid	Other Public	Private Insurance	Private Pay	Charity	Set Up	Penk Beds
Nursing Care	4500	15.6%	20100	48.6%	0	3000	68.1%
Skilled Under 22	0	0.0%	0	0.0%	0	0	0.0%
Intermediate DD	0	0.0%	0	0.0%	0	0	0.0%
Skilled Care	0	0.0%	0	0.0%	0	0	0.0%
TOTALS	4500	15.6%	20100	48.6%	0	3000	68.1%

LICENSED BEDS, BEDS IN USE, MEDICARE/MEDICAID CERTIFIED BEDS

LEVEL OF CARE	BEDES	SETUP	USED	BEDES	IN USE	BEDES	CERTIFIED
Nursing Care	111	111	90	111	79	111	82
Skilled Under 22	0	0	0	0	0	0	87
Intermediate DD	0	0	0	0	0	0	79
Skilled Care	0	0	0	0	0	0	90
TOTAL BEDS	111	111	90	111	79	111	0

ILLINOIS LONG-TERM CARE PROFILE-CALENDAR YEAR 2009 MCALLISTER NURSING & REHAB TIMLEY PARK

MCALLISTER NURSING & REHAB
 16300 SOUTH LAVERGNE AVENUE
 TIMLEY PARK, IL 60477
 Facility ID 6005904
 Planning Service Area 705

ADMISSION RESTRICTIONS

RESTRICTION	Count
Aggressive/Anti-Social	0
Chronic Alcoholism	1
Developmentally Disabled	0
Drug Addiction	1
Medicaid Recipient	0
Medicare Recipient	0
Mental Illness	0
Non-Amputatory	0
Non-Hipble	0
Public Aid Recipient	0
Under 65 Years Old	0
Unable to Self-Medicare	0
Verbalizer Dependent	1
Infectious Diseases w/ Isolation	0
Other Restrictions	0
No Restrictions	0
TOTALS	3

ADMISSIONS AND DISCHARGES - 2009

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

ADMISSIONS AND DISCHARGES - 2009 (Continued)

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

ADMISSIONS AND DISCHARGES - 2009 (Continued)

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

ADMISSIONS AND DISCHARGES - 2009 (Continued)

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

ADMISSIONS AND DISCHARGES - 2009 (Continued)

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

ADMISSIONS AND DISCHARGES - 2009 (Continued)

LEVEL OF CARE	Admissions	Discharges
Nursing Care	82	87
Skilled Under 22	0	0
Intermediate DD	0	0
Skilled Care	0	0
TOTALS	82	87

Antonio Noriega, MD
13348 South Cicero Ave.
Crestwood, IL 60445
(708) 371-1190

February 10, 2011

To whom it may Concern:

As Medical Director and attending physician of McAllister Nursing and Rehab Center, I fully endorse and support the proposed construction of the 200 bed facility. A health care structure such as the proposal is needed and will afford the senior community quality choices for their health care needs.

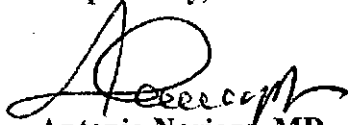
Along with the team of physicians in my group, Specifically Dr. Thapar, Dr. Shehata, Dr. Sunkara, Dr. Harris, we have referred 30-40% of our patients to McAllister Nursing and Rehab. Due to the success of McAllister and their quality of care, our physician group shall continue to promote and refer our patients to McAllister. With new amenities proposed, I am confident there will be a substantial increase in our referrals to McAllister. Currently, I am referring 5 – 7 residents monthly and with more available beds will be able to double that amount.

Advocate South Suburban Hospital is within minutes of this facility and the main referring hospital for our group. However, there are also existing relationships with Advocate Christ Hospital, Palos Hospital, Ingalls Hospital and Little Company of Mary Hospital.

I am confident with the quality of care and professionalism McAllister provides, the success in keeping the census at maximum levels is evident.

I look forward in seeing the completion of the project and wish McAllister my best regards in their effort of obtaining the Certificate of Need.

Respectfully,


Antonio Noriega, MD
Medical Director

Pradeep Thapar, M.D.
1835 Dixie Hwy. Suite 100
Flossmoor, IL 60422
708-799-8384

March 9, 2011

As Attending Psychiatrist of McAllister Nursing and Rehabilitation Center, I fully endorse and support the proposed construction of the 200 bed facility. A health care structure such as the one proposed is needed and will afford the senior community quality choices for their health care services.

I currently have privileges at Advocate Christ Hospital, South Suburban Hospital, St. James Hospital and Little Company of Mary Hospital. McAllister has developed direct communication with the Social Service Department with these hospitals and does receive referrals from them.

Historically, I have referred a minimum of 3 to 4 residents per month. However, with the prospect of a new facility and the accommodations it will offer, I am confident the referrals will increase to 7 to 10 per month.

I am know the quality of care and professionalism McAllister provides, so the success in keeping the census at maximum levels is evident.

I am looking forward to seeing this project become a reality and McAllister the best in their effort of obtaining the Certificate of Need.

Respectfully submitted,



Pradeep Thapar MD

McAllister Nursing & Rehab, LLC
 18300 S. Lavergne ave.
 Tinley Park, IL 60477
 708-798-2272

PROJECTED BUDGETED STAFFING PATTERN

● Director of Nursing	1
● Assistant Director of Nursing	1
● Nursing Scheduler	1
● Nursing RN/LPN	17
● Nursing Administration	1
● MDS/Coordinator/Careplan Coordinator	1
● Treatment Nurse	1.5
● Restorative Rehab Nurse	1
● Certified Nurses Assistants	34
● Rehab Aides	5
● Occupational Therapists	2
● Physical Therapists	2
● Speech Therapists	1.5
● Activities	6
● Administrative Assistant	1
● Administrator	1
● Admissions/Marketing	2
● Central Supply	1
● Dietary	9
● Housekeeping	9.5
● Human Resources/Clerical	1
● Laundry	3.65
● Maintenance	2
● Medical Records	1
● Receptionist	1.6
● Social Service & Assistant	2
TOTAL	109.75

McAllister Nursing & Rehab, LLC
18300 S. Lavergne
Tinley Park, IL 60477
708-798-2272

EXISTING BUDGETED STAFF PATTERN

● Administrator	1
● Assistant Administrator	1
● Director of Nursing	1
● Assistant Director of Nursing	1
● MDS/Careplan Coordinator	1
● Nursing RN/LPN	14
● Certified Nursing Assistant	27.5
● Admissions/Marketing	2
● Dietary	9
● Occupational Therapists	1.2
● Occupational Therapy Aides	2
● Speech Therapist	.5
● Qualified Activity Professional	1
● Activity Staff	3.5
● Social Services	1
● Housekeeping	7.50
● Maintenance	1
● Medical Records	1
● Clerical	1
● Receptionist	2
● Business Office	2
Total	79.2

 Advocate
Christ Medical Center
Hope Children's Hospital

4440 West 95th Street || Oak Lawn, IL 60453 || T 708.684.8000 || advocatehealth.com

March 25, 2011

Mr. Dale Galassie
Acting Chairperson
Illinois Department of Public Health
Health Facilities Planning Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Mr. Galassie:

McAllister Nursing Homes recently communicated to Advocate Christ Medical Center / Advocate Hope Children's Hospital their plans for the construction of a new nursing facility in our mutually shared service area.

Advocate Christ Medical Center / Advocate Hope Children Hospital partners with the top-rated nursing homes in the region. Provided McAllister Nursing Homes continues to deliver high quality care to the communities we serve, Advocate Christ Medical Center / Advocate Hope Children's hospital will work with the nursing home.

Sincerely,



Jeffrey So
Director
Business Development/Community Relations

A faith-based health system serving individuals, families and communities

Recipient of the Magnet award for excellence in nursing services by the American Nurses Credentialing Center



ATTACHMENT-28E



Advocate South Suburban Hospital

17800 South Kedzie Avenue || Hazel Crest, IL 60429 || T 708.799.8000 || advocatehealth.com

February 1, 2011

Mr. Dale Galassie
Acting Chairperson
Illinois Department Of Public Health
Health Facilities Planning Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

Dear Mr. Galassie:

McAllister Nursing Homes recently communicated to Advocate South Suburban Hospital their construction of a new nursing facility in the mutually shared service area. Even though Advocate South Suburban Hospital currently operates an inpatient skilled nursing facility on campus, we believe that the services are different and consequently we do not believe the infrastructure would have an adverse impact on our function.

Advocate South Suburban Hospital partners with the top-rated nursing homes in the region. Provided McAllister Nursing Homes continues to deliver high quality care to the community, Advocate South Suburban will work with the nursing home.

Sincerely,



Michael Englehart
President
Advocate South Suburban Hospital

JESSE L. JACKSON, JR.
2ND DISTRICT, ILLINOIS

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEES:

LABOR-HEALTH AND
HUMAN SERVICES-EDUCATION

FOREIGN OPERATIONS, EXPORT FINANCING
AND RELATED PROGRAMS

Congress of the United States
House of Representatives
Washington, DC 20515-1302

May 23, 2011

Mayor Dwight Welch
City of Country Club Hills
4200 West 183rd Street
Country Club Hills, Illinois 60478-5338

Dear Mayor Welch:

I write to express my support for the McAllister Nursing and Rehabilitation Center's proposal to expand health care services for senior citizens in Country Club Hills and the surrounding south suburbs.

There is a growing population of seniors in my district, and these seniors have a growing need for health care services. This facility would meet a critical demand for new services for local seniors as well as their families. I am confident that McAllister has the commitment, experience and expertise to provide these services, and thus I fully support their efforts.

Sincerely,



Jesse L. Jackson, Jr.
Member of Congress

9 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-1302
(202) 225-0773

71216 YATES BLVD
CHICAGO, IL 60648
(773) 734-9800

17926 SOUTH HALSTED
HOMERWOOD, IL 60430
(708) 766-8000

THIS MAILING WAS PREPARED, PUBLISHED, AND MAILED AT TAXPAYER EXPENSE

ATTACHMENT-28F

8525 West 183rd Street www.VITAS.com
Suite 101
Tinley Park, IL 60487

March 23, 2011

VIA U.S. MAIL

**Ms. Geri Wagner
McAllister Nursing and Rehab
18300 So. LaVergne Ave.
Tinley Park, IL 60477**

RE: CON Letter of Support

Dear Ms. Wagner:

I am writing to express support for McAllister Nursing and Rehab's ("McAllister") Certificate of Need application to construct a new 200 bed facility. Vitas Healthcare Corporation of Illinois ("Vitas") has a longstanding relationship with McAllister that we wish to further develop as the population ages and the need for hospice care for patients in the area continues to grow.

Additional access to quality health care services is essential to promoting quality healthcare services in Tinley Park. This project will not only enhance the availability of services which McAllister provides, it will also provide an enhanced state of the art environment for our mutual patient population.

We are proud to support McAllister with the development of the new facility as the community will benefit from this commitment by McAllister. Thank you for your consideration.

Sincerely yours,

VITAS HEALTHCARE CORPORATION
OF ILLINOIS

By: *Norene Scheck, M.M.*

Norene Scheck
General Manager

VITAS®

Innovative
Hospice Care®

U.S. Regulatory Correspondence | CON letter of support, McAllister, 3.22.2011

ATTACHMENT-28F

Capitol Office:

122 State Capitol
Springfield, Illinois 62706
(217) 782-9595
(217) 558-6006 Fax

District Office:

5119 W. 159th St.
1st Floor East
Oak Forest, Illinois 60452
(708) 687-9696
(708) 687-9801 Fax



ILLINOIS STATE SENATE

MAGGIE CROTTY
STATE SENATOR • 19TH DISTRICT

COMMITTEES:

Elections - Chairperson
Local Government - Vice Chair
Joint Committee on
Administrative Rules - Co-Chair
Higher Education
Labor
Revenue

COMMISSION:

Joint Commission on
Government Reform

February 10, 2010

McAlister Nursing & Rehabilitation Center
Attn: Eli Atkin, Administrator
18300 S. Laverne Ave.
Tinley Park, IL 60477

To Whom It May Concern:

I am writing this letter in strong support to McAllister Nursing & Rehabilitation Center in their efforts to construct a new, state-of-the art facility to better service the health and care needs of the growing senior population of the City of Country Club Hills. I truly believe that this new structure – a four story, 200 bed structure complete with one and two bed units, inpatient and outpatient rehabilitation services, dialysis center, and other valuable amenities will be an invaluable asset to many of my senior citizen constituents and their families, providing greater service, convenience, and affordability to the existing state of nursing and rehabilitation services currently available in Country Club Hills.

In addition, I believe that proper care and concern for local area senior citizens is of utmost importance. As our senior population continues to grow, new and better health care services are more critical than ever to the success of any community. I am, therefore, very excited at the prospect of this much needed expansion. I am also proud to lend my complete support to McAllister Nursing and Rehabilitation Center as it expands to meet the needs of a grateful community

Sincerely,

A handwritten signature in cursive script that reads "Maggie Crotty".

Maggie Crotty
Assistant Majority Leader
State Senator ~ 19th District

4200 Main Street
Country Club Hills, IL 60478

(708) 798-2618
Fax: (708) 798-7352

February 4, 2011

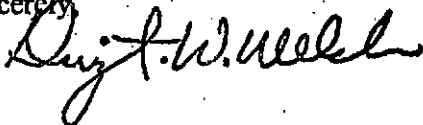
Eli Atkin, Owner
McAlister Nursing & Rehabilitation Center
18300 South Lavergne Avenue
Tinley Park, IL 60477

To Whom It May Concern:

With this letter, I hereby pledge my full support to McAllister Nursing & Rehabilitation Center in their efforts to construct a new, state-of-the-art facility to better service the health and care needs of the growing senior population of Country Club Hills. I believe that this new structure—a four-story, 200-bed structure complete with one and two-bed units, inpatient and outpatient rehabilitation services, dialysis center, and other valuable amenities—will be an invaluable asset to our City, providing greater service, convenience, and affordability to the existing state of nursing and rehabilitation services currently available in Country Club Hills.

In addition, care and concern for our senior citizens has long been a top priority of the City of Country Club Hills, and, as our senior population continues to grow, new and better health care services are more critical than ever to the success of our community. We are very excited at the prospect of this much-needed expansion, and I am proud to lend my complete support to McAllister Nursing and Rehabilitation Center as it expands to meet the needs of a grateful community.

Sincerely,



Dwight W. Welch, Mayor
City of Country Club Hills

**COUNTRY
CLUB
HILLS**

MAYOR DWIGHT WELCH

The Crossroads of Opportunity



4200 Main Street
Country Club Hills, IL 60478

(708) 798-2816
Fax: (708) 798-7352

February 1, 2011

Eli Atkin, Owner
McAlister Nursing & Rehabilitation
18300 South Lavergne Avenue
Tinley Park, IL 60477

Dear Ms. Atkin:

Thank you for your interest in annexing McAllister Nursing & Rehabilitation into the City of Country Club Hills. We are thrilled that you have decided to join our community officially and are very excited at the prospect of your proposed expansion in the future. In the mean time, my staff and I look forward to working with you to make this transition as effortless as possible.

In order to expedite the annexation process, I invite you to please contact our Building Commissioner Gino Bozzo at your earliest convenience. Mr. Bozzo can be reached at in his office at 708-798-2616 ext. 2237 or via cellular phone at 708-473-1183. You will also need to take the following steps before we can move forward:

- Complete and return the enclosed forms
- Submit a site plan for review
- Pay an Engineering and Processing Fee of \$10,000.00

Thank you for your time and cooperation as we begin to undertake this annexation process. Once again, the City of Country Club Hills is delighted at the prospect of formally welcoming McAllister Nursing & Rehabilitation into our community, and we look forward to an enduring partnership that will enhance the health and care needs of our community's senior citizens for years to come.

Sincerely,

Henrietta Turner, City Manager
City of Country Club Hills

Cc: Lawrence Schwartz, Attorney
Cc: John Murphy, Attorney →

ATTACHMENT-28F



McAllister

Nursing & Rehabilitation

Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

July 7, 2011

RE: McAllister Nursing and Rehabilitation Center, LLC
Certificate of Need Application

Dear Ms. Avery,

This letter is to attest that McAllister Nursing & Rehabilitation Center, LLC, by the second year of operation after project completion, will achieve and maintain 90% occupancy. Our ability to maintain this occupancy level could be affected by factors outside our control, such as natural disasters, physical plant problems, regulatory or reimbursement changes, or other demographic issues outside our control.

Sincerely yours,

Donna Atkin
Owner

ATTACHMENT-39 AVAILABILITY OF FUNDS



FIRSTMERIT.

31 January 2011

McAllister Nursing & Rehabilitation, LLC
18300 S. Laverne Ave
Tinley Park, IL 60477

Re: McAllister Nursing Home
Tinley Park, Illinois

Dear Joel Atkin,

I am pleased to inform you that FirstMerit hereby offers their intent to finance the above referenced project. Our intention to finance the project relies upon the accuracy of all facts, statements and financial information that has been and will be submitted as part of the request to make the loan.

FirstMerit would consider a construction loan of approximately \$23 million that will represent no more than 90% of the allowable costs of \$26 million. After the property achieves stabilization, the construction loan will roll automatically upon completion of construction into a 40 year fixed rate, fully amortizing non-recourse permanent loan. Current rates applicable to this type of financing are approximately 5.75% for both the construction loan and permanent loans.

All instruments, forms, documents, statements, agreements, and writing in conjunction with this loan must be acceptable in form and substance to Lender and Lender's Counsel.

Sincerely,

FirstMerit Bank, N.A.



Timothy Fossa
Senior Vice President
Chicago Commercial Healthcare

FirstMerit Bank, N.A./ 101 N. Wacker Dr. Ste 160/ Chicago, IL 60606/ 312-263-2893/ Fax 312-263-2960

ATTACHMENT - 39

AMORTIZATION SCHEDULE - Normal Amortization

	Date	Loan	Payment	Interest	Principal	Balance
Loan	1/1/2011	850,000.00				850,000.00
1	2/1/2011		4,072.92	4,072.92	0.00	850,000.00
Loan	2/1/2011	850,000.00		0.00	0.00	1,700,000.00
2	3/1/2011		8,145.83	8,145.83	0.00	1,700,000.00
Loan	3/1/2011	1,500,000.00		0.00	0.00	3,200,000.00
3	4/1/2011		15,333.33	15,333.33	0.00	3,200,000.00
Loan	4/1/2011	2,000,000.00		0.00	0.00	5,200,000.00
4	5/1/2011		24,916.67	24,916.67	0.00	5,200,000.00
Loan	5/1/2011	2,100,000.00		0.00	0.00	7,300,000.00
5	6/1/2011		34,979.17	34,979.17	0.00	7,300,000.00
Loan	6/1/2011	2,300,000.00		0.00	0.00	9,600,000.00
6	7/1/2011		46,000.00	46,000.00	0.00	9,600,000.00
Loan	7/1/2011	2,300,000.00		0.00	0.00	11,900,000.00
7	8/1/2011		57,020.83	57,020.83	0.00	11,900,000.00
Loan	8/1/2011	2,100,000.00		0.00	0.00	14,000,000.00
8	9/1/2011		67,083.33	67,083.33	0.00	14,000,000.00
Loan	9/1/2011	1,700,000.00		0.00	0.00	15,700,000.00
9	10/1/2011		75,229.17	75,229.17	0.00	15,700,000.00
Loan	10/1/2011	1,700,000.00		0.00	0.00	17,400,000.00
10	11/1/2011		83,375.00	83,375.00	0.00	17,400,000.00
Loan	11/1/2011	1,500,000.00		0.00	0.00	18,900,000.00
11	12/1/2011		90,562.50	90,562.50	0.00	18,900,000.00
Loan	12/1/2011	1,300,000.00		0.00	0.00	20,200,000.00
2011 Totals		20,200,000.00	506,718.75	506,718.75	0.00	
12	1/1/2012		96,791.67	96,791.67	0.00	20,200,000.00
Loan	1/1/2012	1,000,000.00		0.00	0.00	21,200,000.00
13	2/1/2012		101,583.33	101,583.33	0.00	21,200,000.00
Loan	2/1/2012	1,100,000.00		0.00	0.00	22,300,000.00
14	3/1/2012		118,833.94	106,854.17	11,979.77	22,288,020.23
15	4/1/2012		118,833.94	106,796.76	12,037.18	22,275,983.05
16	5/1/2012		118,833.94	106,739.09	12,094.85	22,263,888.20
17	6/1/2012		118,833.94	106,681.13	12,152.81	22,251,735.39
18	7/1/2012		118,833.94	106,622.90	12,211.04	22,239,524.35
19	8/1/2012		118,833.94	106,564.39	12,269.55	22,227,254.80
20	9/1/2012		118,833.94	106,505.60	12,328.34	22,214,926.46
21	10/1/2012		118,833.94	106,446.52	12,387.42	22,202,539.04
22	11/1/2012		118,833.94	106,387.17	12,446.77	22,190,092.27
23	12/1/2012		118,833.94	106,327.53	12,506.41	22,177,585.86
2012 Totals		2,100,000.00	1,386,714.40	1,264,300.26	122,614.14	
24	1/1/2013		118,833.94	106,267.60	12,566.34	22,165,019.52
25	2/1/2013		118,833.94	106,207.39	12,626.55	22,152,392.97
26	3/1/2013		118,833.94	106,146.88	12,687.06	22,139,705.91
27	4/1/2013		118,833.94	106,086.09	12,747.85	22,126,958.06
28	5/1/2013		118,833.94	106,025.01	12,808.93	22,114,149.13
29	6/1/2013		118,833.94	105,963.63	12,870.31	22,101,278.82
30	7/1/2013		118,833.94	105,901.96	12,931.98	22,088,346.84
31	8/1/2013		118,833.94	105,840.00	12,993.94	22,075,352.90
32	9/1/2013		118,833.94	105,777.73	13,056.71	22,062,296.69
33	10/1/2013		118,833.94	105,715.17	13,118.77	22,049,177.92
34	11/1/2013		118,833.94	105,652.31	13,181.63	22,035,996.29
35	12/1/2013		118,833.94	105,589.15	13,244.79	22,022,751.50
2013 Totals		0.00	1,426,007.28	1,271,172.92	154,834.36	
36	1/1/2014		118,833.94	105,525.68	13,308.26	22,009,443.24
37	2/1/2014		118,833.94	105,461.92	13,372.02	21,996,071.22
38	3/1/2014		118,833.94	105,397.84	13,436.10	21,982,635.12
39	4/1/2014		118,833.94	105,333.46	13,500.48	21,969,134.64
40	5/1/2014		118,833.94	105,268.77	13,565.17	21,955,569.47
41	6/1/2014		118,833.94	105,203.77	13,630.17	21,941,939.30
42	7/1/2014		118,833.94	105,138.46	13,695.48	21,928,243.82
43	8/1/2014		118,833.94	105,072.83	13,761.11	21,914,482.71
44	9/1/2014		118,833.94	105,006.90	13,827.04	21,900,655.67
45	10/1/2014		118,833.94	104,940.64	13,893.30	21,886,762.37
46	11/1/2014		118,833.94	104,874.07	13,959.87	21,872,802.50
47	12/1/2014		118,833.94	104,807.18	14,026.76	21,858,775.74
2014 Totals		0.00	1,426,007.28	1,262,031.52	163,975.75	
48	1/1/2015		118,833.94	104,739.97	14,093.97	21,844,681.77
49	2/1/2015		118,833.94	104,672.43	14,161.51	21,830,520.26

50	3/1/2015	118,833.94	104,604.58	14,229.36	21,816,290.90
51	4/1/2015	118,833.94	104,536.39	14,297.55	21,801,993.35
52	5/1/2015	118,833.94	104,467.88	14,366.06	21,787,627.29
53	6/1/2015	118,833.94	104,399.05	14,434.89	21,773,192.40
54	7/1/2015	118,833.94	104,329.88	14,504.06	21,758,688.34
55	8/1/2015	118,833.94	104,260.38	14,573.56	21,744,114.78
56	9/1/2015	118,833.94	104,190.55	14,643.39	21,729,471.39
57	10/1/2015	118,833.94	104,120.38	14,713.56	21,714,757.83
58	11/1/2015	118,833.94	104,049.88	14,784.06	21,699,973.77
59	12/1/2015	118,833.94	103,979.04	14,854.90	21,685,118.87
2015 Totals		0.00	1,426,007.28	1,252,350.41	173,656.87
60	1/1/2016	118,833.94	103,907.85	14,926.08	21,670,192.79
61	2/1/2016	118,833.94	103,836.34	14,997.60	21,655,195.19
62	3/1/2016	118,833.94	103,764.48	15,069.46	21,640,125.73
63	4/1/2016	118,833.94	103,692.27	15,141.67	21,624,984.06
64	5/1/2016	118,833.94	103,619.72	15,214.22	21,609,769.84
65	6/1/2016	118,833.94	103,546.81	15,287.13	21,594,482.71
66	7/1/2016	118,833.94	103,473.56	15,360.38	21,579,122.33
67	8/1/2016	118,833.94	103,399.96	15,433.98	21,563,688.35
68	9/1/2016	118,833.94	103,326.01	15,507.93	21,548,180.42
69	10/1/2016	118,833.94	103,251.70	15,582.24	21,532,598.18
70	11/1/2016	118,833.94	103,177.03	15,656.91	21,516,941.27
71	12/1/2016	118,833.94	103,102.01	15,731.93	21,501,209.34
2016 Totals		0.00	1,426,007.28	1,242,097.75	183,909.53
72	1/1/2017	118,833.94	103,026.63	15,807.31	21,485,402.03
73	2/1/2017	118,833.94	102,950.88	15,883.06	21,469,518.97
74	3/1/2017	118,833.94	102,874.78	15,959.16	21,453,559.81
75	4/1/2017	118,833.94	102,798.31	16,035.63	21,437,524.18
76	5/1/2017	118,833.94	102,721.47	16,112.47	21,421,411.71
77	6/1/2017	118,833.94	102,644.26	16,189.68	21,405,222.03
78	7/1/2017	118,833.94	102,566.69	16,267.25	21,388,954.78
79	8/1/2017	118,833.94	102,488.74	16,345.20	21,372,609.58
80	9/1/2017	118,833.94	102,410.42	16,423.52	21,356,186.06
81	10/1/2017	118,833.94	102,331.72	16,502.22	21,339,683.84
82	11/1/2017	118,833.94	102,252.65	16,581.29	21,323,102.55
83	12/1/2017	118,833.94	102,173.20	16,660.74	21,306,441.81
2017 Totals		0.00	1,426,007.28	1,231,239.75	194,767.53
84	1/1/2018	118,833.94	102,093.37	16,740.57	21,289,701.24
85	2/1/2018	118,833.94	102,013.15	16,820.79	21,272,880.45
86	3/1/2018	118,833.94	101,932.55	16,901.39	21,255,979.06
87	4/1/2018	118,833.94	101,851.57	16,982.37	21,238,996.69
88	5/1/2018	118,833.94	101,770.19	17,063.75	21,221,932.94
89	6/1/2018	118,833.94	101,688.43	17,145.51	21,204,787.43
90	7/1/2018	118,833.94	101,606.27	17,227.67	21,187,559.76
91	8/1/2018	118,833.94	101,523.72	17,310.22	21,170,249.54
92	9/1/2018	118,833.94	101,440.78	17,393.16	21,152,856.38
93	10/1/2018	118,833.94	101,357.44	17,476.50	21,135,379.88
94	11/1/2018	118,833.94	101,273.70	17,560.24	21,117,819.64
95	12/1/2018	118,833.94	101,189.55	17,644.39	21,100,175.25
2018 Totals		0.00	1,426,007.28	1,219,740.72	206,266.56
96	1/1/2019	118,833.94	101,105.01	17,728.93	21,082,446.32
97	2/1/2019	118,833.94	101,020.06	17,813.88	21,064,632.44
98	3/1/2019	118,833.94	100,934.70	17,899.24	21,046,733.20
99	4/1/2019	118,833.94	100,848.93	17,985.01	21,028,748.19
100	5/1/2019	118,833.94	100,762.75	18,071.19	21,010,677.00
101	6/1/2019	118,833.94	100,676.16	18,157.78	20,992,519.22
102	7/1/2019	118,833.94	100,589.15	18,244.79	20,974,274.43
103	8/1/2019	118,833.94	100,501.73	18,332.21	20,955,942.22
104	9/1/2019	118,833.94	100,413.89	18,420.05	20,937,522.17
105	10/1/2019	118,833.94	100,325.61	18,508.31	20,919,013.86
106	11/1/2019	118,833.94	100,236.94	18,597.00	20,900,416.86
107	12/1/2019	118,833.94	100,147.83	18,686.11	20,881,730.75
2019 Totals		0.00	1,426,007.28	1,207,562.78	218,444.50
108	1/1/2020	118,833.94	100,058.29	18,775.65	20,862,955.10
109	2/1/2020	118,833.94	99,968.33	18,865.61	20,844,089.49
110	3/1/2020	118,833.94	99,877.93	18,956.01	20,825,133.48
111	4/1/2020	118,833.94	99,787.10	19,046.84	20,806,086.64
112	5/1/2020	118,833.94	99,695.83	19,138.11	20,786,948.53
113	6/1/2020	118,833.94	99,604.13	19,229.81	20,767,718.72
114	7/1/2020	118,833.94	99,511.99	19,321.95	20,748,396.77

115	8/1/2020	118,833.94	99,419.40	19,414.54	20,728,982.23
116	9/1/2020	118,833.94	99,326.37	19,507.57	20,709,474.66
117	10/1/2020	118,833.94	99,232.90	19,601.04	20,689,873.62
118	11/1/2020	118,833.94	99,138.98	19,694.96	20,670,178.66
119	12/1/2020	118,833.94	99,044.61	19,789.33	20,650,389.33
2020 Totals		0.00	1,426,007.28	1,194,665.86	231,341.42
120	1/1/2021	118,833.94	98,949.78	19,884.16	20,630,505.17
121	2/1/2021	118,833.94	98,854.50	19,979.44	20,610,525.73
122	3/1/2021	118,833.94	98,758.77	20,075.17	20,590,450.56
123	4/1/2021	118,833.94	98,662.58	20,171.36	20,570,279.20
124	5/1/2021	118,833.94	98,565.92	20,268.02	20,550,011.18
125	6/1/2021	118,833.94	98,468.80	20,365.14	20,529,646.04
126	7/1/2021	118,833.94	98,371.22	20,462.72	20,509,183.32
127	8/1/2021	118,833.94	98,273.17	20,560.77	20,488,622.55
128	9/1/2021	118,833.94	98,174.65	20,659.29	20,467,963.26
129	10/1/2021	118,833.94	98,075.66	20,758.28	20,447,204.98
130	11/1/2021	118,833.94	97,976.19	20,857.75	20,426,347.23
131	12/1/2021	118,833.94	97,876.25	20,957.69	20,405,389.54
2021 Totals		0.00	1,426,007.28	1,181,007.49	244,999.79
132	1/1/2022	118,833.94	97,775.82	21,058.12	20,384,331.42
133	2/1/2022	118,833.94	97,674.92	21,159.02	20,363,172.40
134	3/1/2022	118,833.94	97,573.53	21,260.41	20,341,911.99
135	4/1/2022	118,833.94	97,471.66	21,362.28	20,320,549.71
136	5/1/2022	118,833.94	97,369.30	21,464.64	20,299,085.07
137	6/1/2022	118,833.94	97,266.45	21,567.49	20,277,517.58
138	7/1/2022	118,833.94	97,163.11	21,670.83	20,255,846.75
139	8/1/2022	118,833.94	97,059.27	21,774.67	20,234,072.08
140	9/1/2022	118,833.94	96,954.93	21,879.01	20,212,193.07
141	10/1/2022	118,833.94	96,850.09	21,983.85	20,190,209.22
142	11/1/2022	118,833.94	96,744.75	22,089.19	20,168,120.03
143	12/1/2022	118,833.94	96,638.91	22,195.03	20,145,925.00
2022 Totals		0.00	1,426,007.28	1,166,542.74	259,464.54
144	1/1/2023	118,833.94	96,532.56	22,301.38	20,123,623.62
145	2/1/2023	118,833.94	96,425.70	22,408.24	20,101,215.38
146	3/1/2023	118,833.94	96,318.32	22,515.62	20,078,699.76
147	4/1/2023	118,833.94	96,210.44	22,623.50	20,056,076.26
148	5/1/2023	118,833.94	96,102.03	22,731.91	20,033,344.35
149	6/1/2023	118,833.94	95,993.11	22,840.83	20,010,503.52
150	7/1/2023	118,833.94	95,883.66	22,950.28	19,987,553.24
151	8/1/2023	118,833.94	95,773.69	23,060.25	19,964,492.99
152	9/1/2023	118,833.94	95,663.20	23,170.74	19,941,322.25
153	10/1/2023	118,833.94	95,552.17	23,281.77	19,918,040.48
154	11/1/2023	118,833.94	95,440.61	23,393.33	19,894,647.15
155	12/1/2023	118,833.94	95,328.52	23,505.42	19,871,141.73
2023 Totals		0.00	1,426,007.28	1,151,224.01	274,783.27
156	1/1/2024	118,833.94	95,215.89	23,618.05	19,847,523.68
157	2/1/2024	118,833.94	95,102.72	23,731.22	19,823,792.46
158	3/1/2024	118,833.94	94,989.01	23,844.93	19,799,947.53
159	4/1/2024	118,833.94	94,874.75	23,959.19	19,775,988.34
160	5/1/2024	118,833.94	94,759.94	24,074.00	19,751,914.34
161	6/1/2024	118,833.94	94,644.59	24,189.35	19,727,724.99
162	7/1/2024	118,833.94	94,528.68	24,305.26	19,703,419.73
163	8/1/2024	118,833.94	94,412.22	24,421.72	19,678,998.01
164	9/1/2024	118,833.94	94,295.20	24,538.74	19,654,459.27
165	10/1/2024	118,833.94	94,177.62	24,656.32	19,629,802.95
166	11/1/2024	118,833.94	94,059.47	24,774.47	19,605,028.48
167	12/1/2024	118,833.94	93,940.76	24,893.18	19,580,135.30
2024 Totals		0.00	1,426,007.28	1,135,000.85	291,006.43
168	1/1/2025	118,833.94	93,821.48	25,012.46	19,555,122.84
169	2/1/2025	118,833.94	93,701.63	25,132.31	19,529,990.53
170	3/1/2025	118,833.94	93,581.20	25,252.74	19,504,737.79
171	4/1/2025	118,833.94	93,460.20	25,373.74	19,479,364.05
172	5/1/2025	118,833.94	93,338.62	25,495.32	19,453,868.73
173	6/1/2025	118,833.94	93,216.45	25,617.49	19,428,251.24
174	7/1/2025	118,833.94	93,093.70	25,740.24	19,402,511.00
175	8/1/2025	118,833.94	92,970.37	25,863.57	19,376,647.43
176	9/1/2025	118,833.94	92,846.44	25,987.50	19,350,659.93
177	10/1/2025	118,833.94	92,721.91	26,112.03	19,324,547.90
178	11/1/2025	118,833.94	92,596.79	26,237.15	19,298,310.75
179	12/1/2025	118,833.94	92,471.07	26,362.87	19,271,947.88

2025 Totals		0.00	1,426,007.28	1,117,819.86	308,187.42	
180	1/1/2026		118,833.94	92,344.75	26,489.19	19,245,458.69
181	2/1/2026		118,833.94	92,217.82	26,616.12	19,218,842.57
182	3/1/2026		118,833.94	92,090.29	26,743.65	19,192,098.92
183	4/1/2026		118,833.94	91,962.14	26,871.80	19,165,227.12
184	5/1/2026		118,833.94	91,833.38	27,000.56	19,138,226.56
185	6/1/2026		118,833.94	91,704.00	27,129.94	19,111,096.62
186	7/1/2026		118,833.94	91,574.00	27,259.94	19,083,836.68
187	8/1/2026		118,833.94	91,443.38	27,390.56	19,056,446.12
188	9/1/2026		118,833.94	91,312.14	27,521.80	19,028,924.32
189	10/1/2026		118,833.94	91,180.26	27,653.68	19,001,270.64
190	11/1/2026		118,833.94	91,047.75	27,786.18	18,973,484.46
191	12/1/2026		118,833.94	90,914.61	27,919.33	18,945,565.13
2026 Totals		0.00	1,426,007.28	1,099,624.53	326,382.75	
192	1/1/2027		118,833.94	90,780.83	28,053.11	18,917,512.02
193	2/1/2027		118,833.94	90,646.41	28,187.53	18,889,324.49
194	3/1/2027		118,833.94	90,511.35	28,322.59	18,861,001.90
195	4/1/2027		118,833.94	90,375.63	28,458.31	18,832,543.59
196	5/1/2027		118,833.94	90,239.27	28,594.67	18,803,948.92
197	6/1/2027		118,833.94	90,102.26	28,731.68	18,775,217.24
198	7/1/2027		118,833.94	89,964.58	28,869.36	18,746,347.88
199	8/1/2027		118,833.94	89,826.25	29,007.69	18,717,340.19
200	9/1/2027		118,833.94	89,687.26	29,146.68	18,688,193.51
201	10/1/2027		118,833.94	89,547.59	29,286.35	18,658,907.16
202	11/1/2027		118,833.94	89,407.26	29,426.68	18,629,480.48
203	12/1/2027		118,833.94	89,266.26	29,567.68	18,599,912.80
2027 Totals		0.00	1,426,007.28	1,080,354.95	345,652.33	
204	1/1/2028		118,833.94	89,124.58	29,709.36	18,570,203.44
205	2/1/2028		118,833.94	88,982.22	29,851.72	18,540,351.72
206	3/1/2028		118,833.94	88,839.19	29,994.75	18,510,356.97
207	4/1/2028		118,833.94	88,695.46	30,138.48	18,480,218.49
208	5/1/2028		118,833.94	88,551.05	30,282.89	18,449,935.60
209	6/1/2028		118,833.94	88,405.94	30,428.00	18,419,507.60
210	7/1/2028		118,833.94	88,260.14	30,573.80	18,388,933.80
211	8/1/2028		118,833.94	88,113.64	30,720.30	18,358,213.50
212	9/1/2028		118,833.94	87,966.44	30,867.50	18,327,346.00
213	10/1/2028		118,833.94	87,818.53	31,015.41	18,296,330.59
214	11/1/2028		118,833.94	87,669.92	31,164.02	18,265,166.57
215	12/1/2028		118,833.94	87,520.50	31,313.35	18,233,853.22
2028 Totals		0.00	1,426,007.28	1,059,947.70	366,059.58	
216	1/1/2029		118,833.94	87,370.55	31,463.39	18,202,389.83
217	2/1/2029		118,833.94	87,219.78	31,614.16	18,170,775.67
218	3/1/2029		118,833.94	87,068.30	31,765.64	18,139,010.03
219	4/1/2029		118,833.94	86,916.09	31,917.85	18,107,092.18
220	5/1/2029		118,833.94	86,763.15	32,070.79	18,075,021.39
221	6/1/2029		118,833.94	86,609.48	32,224.46	18,042,796.93
222	7/1/2029		118,833.94	86,455.07	32,378.87	18,010,418.06
223	8/1/2029		118,833.94	86,299.92	32,534.02	17,977,884.04
224	9/1/2029		118,833.94	86,144.03	32,689.91	17,945,194.13
225	10/1/2029		118,833.94	85,987.39	32,846.55	17,912,347.58
226	11/1/2029		118,833.94	85,830.00	33,003.94	17,879,343.64
227	12/1/2029		118,833.94	85,671.85	33,162.09	17,846,181.55
2029 Totals		0.00	1,426,007.28	1,038,335.61	387,671.67	
228	1/1/2030		118,833.94	85,512.95	33,320.99	17,812,860.56
229	2/1/2030		118,833.94	85,353.29	33,480.65	17,779,379.91
230	3/1/2030		118,833.94	85,192.86	33,641.08	17,745,738.83
231	4/1/2030		118,833.94	85,031.67	33,802.27	17,711,936.56
232	5/1/2030		118,833.94	84,869.70	33,964.24	17,677,972.32
233	6/1/2030		118,833.94	84,706.95	34,126.99	17,643,845.33
234	7/1/2030		118,833.94	84,543.43	34,290.51	17,609,554.82
235	8/1/2030		118,833.94	84,379.12	34,454.82	17,575,100.00
236	9/1/2030		118,833.94	84,214.02	34,619.92	17,540,480.08
237	10/1/2030		118,833.94	84,048.13	34,785.81	17,505,694.27
238	11/1/2030		118,833.94	83,881.45	34,952.49	17,470,741.78
239	12/1/2030		118,833.94	83,713.97	35,119.97	17,435,621.81
2030 Totals		0.00	1,426,007.28	1,015,447.54	410,559.74	
240	1/1/2031		118,833.94	83,545.69	35,288.25	17,400,333.56
241	2/1/2031		118,833.94	83,376.60	35,457.34	17,364,876.22
242	3/1/2031		118,833.94	83,206.70	35,627.24	17,329,248.98

243	4/1/2031	118,833.94	83,035.98	35,797.96	17,293,451.02
244	5/1/2031	118,833.94	82,864.45	35,969.89	17,257,481.53
245	6/1/2031	118,833.94	82,692.10	36,141.84	17,221,339.69
246	7/1/2031	118,833.94	82,518.92	36,315.02	17,185,024.67
247	8/1/2031	118,833.94	82,344.91	36,489.03	17,148,535.64
248	9/1/2031	118,833.94	82,170.07	36,663.87	17,111,871.77
249	10/1/2031	118,833.94	81,994.39	36,839.55	17,075,032.22
250	11/1/2031	118,833.94	81,817.86	37,018.08	17,038,016.14
251	12/1/2031	118,833.94	81,640.49	37,193.45	17,000,822.69
2031 Totals		0.00	1,426,007.28	991,208.16	434,799.12
252	1/1/2032	118,833.94	81,462.28	37,371.66	16,963,451.03
253	2/1/2032	118,833.94	81,283.20	37,550.74	16,925,900.29
254	3/1/2032	118,833.94	81,103.27	37,730.67	16,888,169.62
255	4/1/2032	118,833.94	80,922.48	37,911.46	16,850,258.16
256	5/1/2032	118,833.94	80,740.82	38,093.12	16,812,165.04
257	6/1/2032	118,833.94	80,558.29	38,275.65	16,773,889.39
258	7/1/2032	118,833.94	80,374.89	38,459.05	16,735,430.34
259	8/1/2032	118,833.94	80,190.60	38,643.34	16,696,787.00
260	9/1/2032	118,833.94	80,005.44	38,828.50	16,657,958.50
261	10/1/2032	118,833.94	79,819.38	39,014.56	16,618,943.94
262	11/1/2032	118,833.94	79,632.44	39,201.50	16,579,742.44
263	12/1/2032	118,833.94	79,444.60	39,389.34	16,540,353.10
2032 Totals		0.00	1,426,007.28	965,537.69	460,469.59
264	1/1/2033	118,833.94	79,255.86	39,578.08	16,500,775.02
265	2/1/2033	118,833.94	79,066.21	39,767.73	16,461,007.29
266	3/1/2033	118,833.94	78,875.66	39,958.28	16,421,049.01
267	4/1/2033	118,833.94	78,684.19	40,149.75	16,380,899.26
268	5/1/2033	118,833.94	78,491.81	40,342.13	16,340,557.13
269	6/1/2033	118,833.94	78,298.50	40,535.44	16,300,021.69
270	7/1/2033	118,833.94	78,104.27	40,729.67	16,259,292.02
271	8/1/2033	118,833.94	77,909.11	40,924.83	16,218,367.19
272	9/1/2033	118,833.94	77,713.01	41,120.93	16,177,246.26
273	10/1/2033	118,833.94	77,515.97	41,317.97	16,135,928.29
274	11/1/2033	118,833.94	77,317.99	41,515.95	16,094,412.34
275	12/1/2033	118,833.94	77,119.06	41,714.88	16,052,697.46
2033 Totals		0.00	1,426,007.28	938,351.64	487,655.64
276	1/1/2034	118,833.94	76,919.18	41,914.76	16,010,782.70
277	2/1/2034	118,833.94	76,718.33	42,115.61	15,968,667.09
278	3/1/2034	118,833.94	76,516.53	42,317.41	15,926,349.68
279	4/1/2034	118,833.94	76,313.76	42,520.18	15,883,829.50
280	5/1/2034	118,833.94	76,110.02	42,723.92	15,841,105.58
281	6/1/2034	118,833.94	75,905.30	42,928.64	15,798,176.94
282	7/1/2034	118,833.94	75,699.60	43,134.34	15,755,042.60
283	8/1/2034	118,833.94	75,492.91	43,341.03	15,711,701.57
284	9/1/2034	118,833.94	75,285.24	43,548.70	15,668,152.87
285	10/1/2034	118,833.94	75,076.57	43,757.37	15,624,395.50
286	11/1/2034	118,833.94	74,866.90	43,967.04	15,580,428.46
287	12/1/2034	118,833.94	74,656.22	44,177.72	15,536,250.74
2034 Totals		0.00	1,426,007.28	909,560.56	516,446.72
288	1/1/2035	118,833.94	74,444.53	44,389.41	15,491,861.33
289	2/1/2035	118,833.94	74,231.84	44,602.10	15,447,259.23
290	3/1/2035	118,833.94	74,018.12	44,815.82	15,402,443.41
291	4/1/2035	118,833.94	73,803.37	45,030.57	15,357,412.84
292	5/1/2035	118,833.94	73,587.60	45,246.34	15,312,166.50
293	6/1/2035	118,833.94	73,370.80	45,463.14	15,266,703.36
294	7/1/2035	118,833.94	73,152.95	45,680.99	15,221,022.37
295	8/1/2035	118,833.94	72,934.07	45,899.87	15,175,122.50
296	9/1/2035	118,833.94	72,714.13	46,119.81	15,129,002.69
297	10/1/2035	118,833.94	72,493.14	46,340.80	15,082,661.89
298	11/1/2035	118,833.94	72,271.09	46,562.85	15,036,099.04
299	12/1/2035	118,833.94	72,047.97	46,785.97	14,989,313.07
2035 Totals		0.00	1,426,007.28	879,069.61	546,937.67
300	1/1/2036	118,833.94	71,823.79	47,010.15	14,942,302.92
301	2/1/2036	118,833.94	71,598.53	47,235.41	14,895,067.51
302	3/1/2036	118,833.94	71,371.20	47,461.74	14,847,605.77
303	4/1/2036	118,833.94	71,144.78	47,689.16	14,799,916.61
304	5/1/2036	118,833.94	70,916.27	47,917.67	14,751,998.94
305	6/1/2036	118,833.94	70,686.66	48,147.28	14,703,851.66
306	7/1/2036	118,833.94	70,455.06	48,377.98	14,655,473.68
307	8/1/2036	118,833.94	70,224.14	48,609.80	14,606,863.88

308	9/1/2036	118,833.94	69,991.22	48,842.72	14,558,021.16
309	10/1/2036	118,833.94	69,757.18	49,076.76	14,508,944.40
310	11/1/2036	118,833.94	69,522.03	49,311.91	14,459,632.49
311	12/1/2036	118,833.94	69,285.74	49,548.20	14,410,084.29
2036 Totals		0.00	1,426,007.28	846,778.50	579,228.78
312	1/1/2037	118,833.94	69,048.32	49,785.62	14,360,298.67
313	2/1/2037	118,833.94	68,809.76	50,024.18	14,310,274.49
314	3/1/2037	118,833.94	68,570.07	50,263.87	14,260,010.62
315	4/1/2037	118,833.94	68,329.22	50,504.72	14,209,505.90
316	5/1/2037	118,833.94	68,087.22	50,746.72	14,158,759.18
317	6/1/2037	118,833.94	67,844.05	50,989.89	14,107,769.29
318	7/1/2037	118,833.94	67,599.73	51,234.21	14,056,535.08
319	8/1/2037	118,833.94	67,354.23	51,479.71	14,005,055.37
320	9/1/2037	118,833.94	67,107.56	51,726.38	13,953,328.99
321	10/1/2037	118,833.94	66,859.70	51,974.24	13,901,354.75
322	11/1/2037	118,833.94	66,610.66	52,223.28	13,849,131.47
323	12/1/2037	118,833.94	66,360.42	52,473.52	13,796,667.95
2037 Totals		0.00	1,426,007.28	812,580.94	613,426.34
324	1/1/2038	118,833.94	66,108.99	52,724.95	13,743,933.00
325	2/1/2038	118,833.94	65,856.35	52,977.59	13,690,955.41
326	3/1/2038	118,833.94	65,602.49	53,231.45	13,637,723.96
327	4/1/2038	118,833.94	65,347.43	53,486.51	13,584,237.45
328	5/1/2038	118,833.94	65,091.14	53,742.80	13,530,494.65
329	6/1/2038	118,833.94	64,833.62	54,000.31	13,476,494.33
330	7/1/2038	118,833.94	64,574.87	54,259.07	13,422,235.26
331	8/1/2038	118,833.94	64,314.88	54,519.06	13,367,716.20
332	9/1/2038	118,833.94	64,053.64	54,780.30	13,312,935.90
333	10/1/2038	118,833.94	63,791.15	55,042.79	13,257,893.11
334	11/1/2038	118,833.94	63,527.40	55,306.54	13,202,586.57
335	12/1/2038	118,833.94	63,262.39	55,571.55	13,147,015.02
2038 Totals		0.00	1,426,007.28	776,364.35	649,642.93
336	1/1/2039	118,833.94	62,996.11	55,837.83	13,091,177.19
337	2/1/2039	118,833.94	62,728.56	56,105.38	13,035,071.81
338	3/1/2039	118,833.94	62,459.72	56,374.22	12,978,697.59
339	4/1/2039	118,833.94	62,189.59	56,644.35	12,922,053.24
340	5/1/2039	118,833.94	61,918.17	56,915.77	12,865,137.47
341	6/1/2039	118,833.94	61,645.45	57,188.49	12,807,948.98
342	7/1/2039	118,833.94	61,371.42	57,462.52	12,750,486.46
343	8/1/2039	118,833.94	61,096.08	57,737.86	12,692,748.60
344	9/1/2039	118,833.94	60,819.42	58,014.52	12,634,734.08
345	10/1/2039	118,833.94	60,541.43	58,292.51	12,576,441.57
346	11/1/2039	118,833.94	60,262.12	58,571.82	12,517,869.75
347	12/1/2039	118,833.94	59,981.46	58,852.48	12,459,017.27
2039 Totals		0.00	1,426,007.28	738,009.53	687,997.75
348	1/1/2040	118,833.94	59,899.46	59,134.48	12,399,882.79
349	2/1/2040	118,833.94	59,416.11	59,417.83	12,340,464.96
350	3/1/2040	118,833.94	59,131.39	59,702.55	12,280,762.41
351	4/1/2040	118,833.94	58,845.32	59,988.62	12,220,773.79
352	5/1/2040	118,833.94	58,557.87	60,276.07	12,160,497.72
353	6/1/2040	118,833.94	58,269.05	60,564.89	12,099,932.83
354	7/1/2040	118,833.94	57,978.84	60,855.10	12,039,077.73
355	8/1/2040	118,833.94	57,687.25	61,146.69	11,977,931.04
356	9/1/2040	118,833.94	57,394.25	61,439.69	11,916,491.35
357	10/1/2040	118,833.94	57,099.85	61,734.09	11,854,757.26
358	11/1/2040	118,833.94	56,804.05	62,029.89	11,792,727.37
359	12/1/2040	118,833.94	56,506.82	62,327.12	11,730,400.25
2040 Totals		0.00	1,426,007.28	687,390.26	728,617.02
360	1/1/2041	118,833.94	56,208.17	62,625.77	11,667,774.48
361	2/1/2041	118,833.94	55,908.09	62,925.85	11,604,848.63
362	3/1/2041	118,833.94	55,606.57	63,227.37	11,541,621.26
363	4/1/2041	118,833.94	55,303.60	63,530.34	11,478,090.92
364	5/1/2041	118,833.94	54,999.19	63,834.75	11,414,258.17
365	6/1/2041	118,833.94	54,693.31	64,140.63	11,350,115.54
366	7/1/2041	118,833.94	54,385.97	64,447.97	11,285,667.57
367	8/1/2041	118,833.94	54,077.16	64,756.78	11,220,910.79
368	9/1/2041	118,833.94	53,766.86	65,067.08	11,155,843.71
369	10/1/2041	118,833.94	53,455.08	65,378.86	11,090,464.85
370	11/1/2041	118,833.94	53,141.81	65,692.13	11,024,772.72
371	12/1/2041	118,833.94	52,827.04	66,006.90	10,958,765.82
2041 Totals		0.00	1,426,007.28	654,372.85	771,634.43

372	1/1/2042	118,833.94	52,510.75	66,323.19	10,892,442.63
373	2/1/2042	118,833.94	52,192.95	66,640.99	10,825,801.64
374	3/1/2042	118,833.94	51,873.63	66,960.31	10,758,841.33
375	4/1/2042	118,833.94	51,552.78	67,281.16	10,691,560.17
376	5/1/2042	118,833.94	51,230.39	67,603.55	10,623,956.62
377	6/1/2042	118,833.94	50,906.46	67,927.48	10,556,029.14
378	7/1/2042	118,833.94	50,580.97	68,252.97	10,487,776.17
379	8/1/2042	118,833.94	50,253.93	68,580.01	10,419,196.16
380	9/1/2042	118,833.94	49,925.31	68,908.63	10,350,287.53
381	10/1/2042	118,833.94	49,595.13	69,238.81	10,281,048.72
382	11/1/2042	118,833.94	49,263.36	69,570.58	10,211,478.14
383	12/1/2042	118,833.94	48,930.00	69,903.94	10,141,574.20
2042 Totals		0.00	1,426,007.28	688,815.66	817,191.62
384	1/1/2043	118,833.94	48,595.04	70,238.90	10,071,335.30
385	2/1/2043	118,833.94	48,258.48	70,575.46	10,000,759.84
386	3/1/2043	118,833.94	47,920.31	70,913.63	9,929,846.21
387	4/1/2043	118,833.94	47,580.51	71,253.43	9,858,592.78
388	5/1/2043	118,833.94	47,239.09	71,594.85	9,786,997.93
389	6/1/2043	118,833.94	46,896.03	71,937.91	9,715,060.02
390	7/1/2043	118,833.94	46,551.33	72,282.61	9,642,777.41
391	8/1/2043	118,833.94	46,204.98	72,628.96	9,570,148.45
392	9/1/2043	118,833.94	45,856.96	72,976.98	9,497,171.47
393	10/1/2043	118,833.94	45,507.28	73,326.66	9,423,844.81
394	11/1/2043	118,833.94	45,155.92	73,678.02	9,350,166.79
395	12/1/2043	118,833.94	44,802.88	74,031.06	9,276,135.73
2043 Totals		0.00	1,426,007.28	560,568.81	865,438.47
396	1/1/2044	118,833.94	44,448.15	74,385.79	9,201,749.94
397	2/1/2044	118,833.94	44,091.72	74,742.22	9,127,007.72
398	3/1/2044	118,833.94	43,733.58	75,100.36	9,051,907.36
399	4/1/2044	118,833.94	43,373.72	75,460.22	8,976,447.14
400	5/1/2044	118,833.94	43,012.14	75,821.80	8,900,625.34
401	6/1/2044	118,833.94	42,648.83	76,185.11	8,824,440.23
402	7/1/2044	118,833.94	42,283.78	76,550.16	8,747,890.07
403	8/1/2044	118,833.94	41,916.97	76,916.97	8,670,973.10
404	9/1/2044	118,833.94	41,548.41	77,285.53	8,593,687.57
405	10/1/2044	118,833.94	41,178.09	77,655.85	8,516,031.72
406	11/1/2044	118,833.94	40,805.99	78,027.95	8,438,003.77
407	12/1/2044	118,833.94	40,432.10	78,401.84	8,359,601.93
2044 Totals		0.00	1,426,007.28	509,473.48	916,533.80
408	1/1/2045	118,833.94	40,056.43	78,777.51	8,280,824.42
409	2/1/2045	118,833.94	39,678.95	79,154.99	8,201,669.43
410	3/1/2045	118,833.94	39,299.67	79,534.27	8,122,135.16
411	4/1/2045	118,833.94	38,918.56	79,915.38	8,042,219.78
412	5/1/2045	118,833.94	38,535.64	80,298.30	7,961,921.48
413	6/1/2045	118,833.94	38,150.87	80,683.07	7,881,238.41
414	7/1/2045	118,833.94	37,764.27	81,069.67	7,800,168.74
415	8/1/2045	118,833.94	37,375.81	81,458.13	7,718,710.61
416	9/1/2045	118,833.94	36,985.49	81,848.45	7,636,862.16
417	10/1/2045	118,833.94	36,593.30	82,240.64	7,554,621.52
418	11/1/2045	118,833.94	36,199.23	82,634.71	7,471,986.81
419	12/1/2045	118,833.94	35,803.27	83,030.67	7,388,956.14
2045 Totals		0.00	1,426,007.28	455,361.49	970,645.79
420	1/1/2046	118,833.94	35,405.41	83,428.53	7,305,527.61
421	2/1/2046	118,833.94	35,005.65	83,828.29	7,221,699.32
422	3/1/2046	118,833.94	34,603.98	84,229.96	7,137,469.36
423	4/1/2046	118,833.94	34,200.37	84,633.57	7,052,835.79
424	5/1/2046	118,833.94	33,794.84	85,039.10	6,967,796.69
425	6/1/2046	118,833.94	33,387.36	85,446.58	6,882,350.11
426	7/1/2046	118,833.94	32,977.93	85,856.01	6,796,494.10
427	8/1/2046	118,833.94	32,566.53	86,267.41	6,710,226.69
428	9/1/2046	118,833.94	32,153.17	86,680.77	6,623,545.92
429	10/1/2046	118,833.94	31,737.82	87,096.12	6,536,449.80
430	11/1/2046	118,833.94	31,320.49	87,513.45	6,448,936.35
431	12/1/2046	118,833.94	30,901.15	87,932.79	6,361,003.56
2046 Totals		0.00	1,426,007.28	398,054.70	1,027,952.58
432	1/1/2047	118,833.94	30,479.81	88,354.13	6,272,649.43
433	2/1/2047	118,833.94	30,056.45	88,777.89	6,183,871.94
434	3/1/2047	118,833.94	29,631.05	89,202.89	6,094,669.05
435	4/1/2047	118,833.94	29,203.62	89,630.32	6,005,038.73

436	5/1/2047	118,833.94	28,774.14	90,059.80	5,914,978.93
437	6/1/2047	118,833.94	28,342.61	90,491.33	5,824,487.60
438	7/1/2047	118,833.94	27,909.00	90,924.94	5,733,562.66
439	8/1/2047	118,833.94	27,473.32	91,360.62	5,642,202.04
440	9/1/2047	118,833.94	27,035.55	91,798.39	5,550,403.65
441	10/1/2047	118,833.94	26,595.68	92,238.26	5,458,165.39
442	11/1/2047	118,833.94	26,153.71	92,680.23	5,365,485.16
443	12/1/2047	118,833.94	25,709.62	93,124.32	5,272,360.84
2047 Totals		0.00	1,426,007.28	337,364.56	1,088,642.72
444	1/1/2048	118,833.94	25,263.40	93,570.54	5,178,790.30
445	2/1/2048	118,833.94	24,815.04	94,018.90	5,084,771.40
446	3/1/2048	118,833.94	24,364.53	94,469.41	4,990,301.99
447	4/1/2048	118,833.94	23,911.86	94,922.08	4,895,379.91
448	5/1/2048	118,833.94	23,457.03	95,376.91	4,800,003.00
449	6/1/2048	118,833.94	23,000.01	95,833.93	4,704,169.07
450	7/1/2048	118,833.94	22,540.81	96,293.13	4,607,875.94
451	8/1/2048	118,833.94	22,079.41	96,754.53	4,511,121.41
452	9/1/2048	118,833.94	21,615.79	97,218.15	4,413,903.26
453	10/1/2048	118,833.94	21,149.95	97,683.99	4,316,219.27
454	11/1/2048	118,833.94	20,681.88	98,152.06	4,218,067.21
455	12/1/2048	118,833.94	20,211.57	98,622.37	4,119,444.84
2048 Totals		0.00	1,426,007.28	273,091.28	1,152,916.00
456	1/1/2049	118,833.94	19,739.01	99,094.93	4,020,349.91
457	2/1/2049	118,833.94	19,264.18	99,569.76	3,920,780.15
458	3/1/2049	118,833.94	18,787.07	100,046.87	3,820,733.28
459	4/1/2049	118,833.94	18,307.68	100,526.26	3,720,207.02
460	5/1/2049	118,833.94	17,825.99	101,007.95	3,619,199.07
461	6/1/2049	118,833.94	17,342.00	101,491.94	3,517,707.13
462	7/1/2049	118,833.94	16,855.68	101,978.26	3,415,728.87
463	8/1/2049	118,833.94	16,367.03	102,466.91	3,313,261.96
464	9/1/2049	118,833.94	15,876.05	102,957.89	3,210,304.07
465	10/1/2049	118,833.94	15,382.71	103,451.23	3,106,852.84
466	11/1/2049	118,833.94	14,887.00	103,946.94	3,002,905.90
467	12/1/2049	118,833.94	14,388.92	104,445.02	2,898,460.88
2049 Totals		0.00	1,426,007.28	205,023.32	1,220,983.96
468	1/1/2050	118,833.94	13,888.46	104,945.48	2,793,515.40
469	2/1/2050	118,833.94	13,385.59	105,448.35	2,688,067.05
470	3/1/2050	118,833.94	12,880.32	105,953.62	2,582,113.43
471	4/1/2050	118,833.94	12,372.63	106,461.31	2,475,652.12
472	5/1/2050	118,833.94	11,862.50	106,971.44	2,368,680.68
473	6/1/2050	118,833.94	11,349.93	107,484.01	2,261,196.67
474	7/1/2050	118,833.94	10,834.90	107,999.04	2,153,197.63
475	8/1/2050	118,833.94	10,317.41	108,516.53	2,044,681.10
476	9/1/2050	118,833.94	9,797.43	109,036.52	1,935,644.59
477	10/1/2050	118,833.94	9,274.96	109,558.98	1,826,085.61
478	11/1/2050	118,833.94	8,749.99	110,083.95	1,716,001.66
479	12/1/2050	118,833.94	8,222.51	110,611.43	1,605,390.23
2050 Totals		0.00	1,426,007.28	132,936.63	1,293,070.63
480	1/1/2051	118,833.94	7,692.49	111,141.45	1,494,248.78
481	2/1/2051	118,833.94	7,159.94	111,674.00	1,382,574.78
482	3/1/2051	118,833.94	6,624.84	112,209.10	1,270,365.68
483	4/1/2051	118,833.94	6,087.17	112,746.77	1,157,618.91
484	5/1/2051	118,833.94	5,546.92	113,287.02	1,044,331.89
485	6/1/2051	118,833.94	5,004.09	113,829.85	930,502.04
486	7/1/2051	118,833.94	4,458.66	114,375.28	816,126.76
487	8/1/2051	118,833.94	3,910.61	114,923.33	701,203.43
488	9/1/2051	118,833.94	3,359.93	115,474.01	585,729.42
489	10/1/2051	118,833.94	2,806.62	116,027.32	469,702.10
490	11/1/2051	118,833.94	2,250.66	116,583.28	353,118.82
491	12/1/2051	118,833.94	1,692.03	117,141.91	235,976.91
2051 Totals		0.00	1,426,007.28	56,593.96	1,369,413.32
492	1/1/2052	118,833.94	1,130.72	117,703.22	118,273.69
493	2/1/2052	118,833.94	560.25	118,273.69	0.00
2052 Totals		0.00	237,667.88	1,690.97	235,976.91
Grand Totals		22,300,000.00	57,745,384.95	33,445,384.95	22,300,000.00

Last interest amount decreased by 6.48 due to rounding.

ATTACHMENT-39 AVAILABILITY OF FUNDS

ASSETS FUNDED BY LEASE:

**INSERT COPY OF THE BUILDING LEASE CONTAINED IN THE
MCALLISTER DOCUMENTS**

SECOND AMENDMENT TO LEASE AGREEMENT

THIS SECOND AMENDMENT ("*Amendment*") TO LEASE AGREEMENT dated October 15, 2007, as amended by the First Amendment dated effective as of march 19, 2008, (collectively, the "*Agreement*" or "*Lease*") is made and entered into effective as of July 6, 2011 by and between MCALLISTER PROPERTIES, LLC, an Illinois Limited Liability Company, as owner and lessor, ("*Lessor*,"), and MCALLISTER NURSING & REHAB, LLC, an Illinois Limited Liability Company, as lessee/tenant (hereinafter "*Lessee*" or "*Tenant*").

WITNESSETH

WHEREAS, as of the effective date hereof, Lessor is the owner in fee simple title of the real property ("*Real Property*") and the improvements ("*Improvements*") located thereon commonly known as 18300 S. Laverne Ave., Tinley Park, Cook County, IL 60477, all as more fully described on Exhibit "A" attached hereto and incorporated by reference herein and made a part hereof as if fully set forth herein, and the fixtures ("*Fixtures*") and personal property ("*Personal Property*") not belonging to residents thereof located therein and/or thereon (hereinafter the Real Property, Improvements, Fixtures and Personal Property are collectively referred to as "*Property*" or "*Premises*");

WHEREAS, Lessee is leasing the Property pursuant to the Lease;

WHEREAS, the parties hereto hereby desire to amend, modify, alter, and change the Lease as hereinafter set forth;

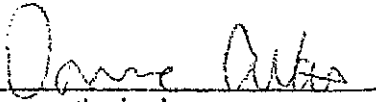
NOW, THEREFORE, in consideration of Ten (\$10.00) Dollars in hand paid, each to the other, the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged by the parties hereto, the parties hereby agree as follows:

1. Notwithstanding anything to the contrary contained elsewhere in the Lease, from and after the date on which Facility is first licensed for more than 111 skilled and/or intermediate beds the monthly Base Rent shall automatically be amended, modified, altered, changed and increased to be equal to the then current monthly debt service of Lessor plus 1/12th of the annual real estate tax assessment as set forth in the Lease, plus the Taxes and Assessments as set forth in the Lease plus One Thousand (\$1,000.00) Dollars/month.
2. Except only to the extent that they are inconsistent with, contradict and/or conflict with the terms, conditions and provisions of this Amendment, all other terms, provisions and conditions of the Lease are hereby incorporated by reference herein and made a part hereof as if fully set forth herein and are hereby republished, readopted, ratified and reaffirmed.

[SIGNATURES APPEAR ON FOLLOWING PAGE]

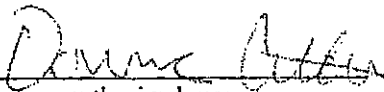
LESSOR:

**MCALLISTER PROPERTIES, LLC, an
Illinois Limited Liability Company**

By: 
an authorized manager

LESSEE:

**MCALLISTER NURSING &
REHAB, LLC, an Illinois Limited
Liability Company**

By: 
an authorized manager

FIRST AMENDMENT TO LEASE AGREEMENT

THIS FIRST AMENDMENT ("*Amendment*") TO LEASE AGREEMENT ("*Agreement*" or "*Lease*") dated October 15, 2007 is made and entered into effective as of March 19, 2008 by and between MCALLISTER PROPERTIES, LLC, an Illinois Limited Liability Company, as owner and lessor, ("*Lessor*,") and MCALLISTER NURSING & REHAB, LLC, an Illinois Limited Liability Company, as lessee/tenant (hereinafter "*Lessee*" or "*Tenant*").

WITNESSETH

WHEREAS, as of the effective date hereof, Lessor is the owner in fee simple title of the real property ("*Real Property*") and the improvements ("*Improvements*") located thereon commonly known as 18300 S. Lavergne Ave., Tinley Park, Cook County, IL 60477, all as more fully described on Exhibit "A" attached hereto and incorporated by reference herein and made a part hereof as if fully set forth herein, and the fixtures ("*Fixtures*") and personal property ("*Personal Property*") not belonging to residents thereof located therein and/or thereon (hereinafter the Real Property, Improvements, Fixtures and Personal Property are collectively referred to as "*Property*" or "*Premises*");

WHEREAS, Lessee desires to lease the Property from Lessor; and

WHEREAS, Lessor is willing to allow Lessee to lease the Property, all subject to, in accordance with and on the terms, provisions and conditions hereinafter set forth;

WHEREAS, by original Lease dated October 15, 2007 effective December 1, 2007 the parties have entered into a written Ten (10) year lease of the Property;

WHEREAS, the parties hereto hereby desire to amend, modify, alter, change and correct the effective date of the Lease and its Commencement Date, as defined therein and a technical omission;

NOW, THEREFORE, in consideration of Ten (\$10.00) Dollars in hand paid, each to the other, the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged by the parties hereto, the parties hereby agree as follows:

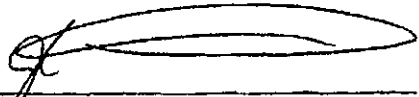
1. Notwithstanding anything to the contrary contained elsewhere in the Lease, both the effective date thereof and the Commencement Date, as defined therein, shall be March 19, 2008, and all references therein to the Effective Date and/or the Commencement Date shall be deemed, interpreted and construed to mean March 19, 2008. Except only as modified by this Amendment, the remaining terms, provisions and conditions of the Lease are hereby incorporated by reference herein and made a part hereof as if fully set forth herein, and ratified, re-adopted, reaffirmed and republished.

[SIGNATURES APPEAR ON FOLLOWING PAGE]

LESSOR:

**MCALLISTER PROPERTIES, LLC, an
Illinois Limited Liability Company**

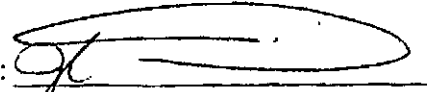
By: _____


an authorized manager

LESSEE:

**MCALLISTER NURSING &
REHAB, LLC, an Illinois Limited
Liability Company**

By: _____


an authorized manager

LEASE AGREEMENT

THIS LEASE AGREEMENT ("*Agreement*" or "*Lease*") is made and entered into effective as of October 15, 2007 by and between MCALLISTER PROPERTIES, LLC, an Illinois Limited Liability Company, as owner and lessor, ("*Lessor*,"") and MCALLISTER NURSING & REHAB, LLC, an Illinois Limited Liability Company, as lessee/tenant (hereinafter "*Lessee*" or "*Tenant*").

WITNESSETH

WHEREAS, as of the effective date hereof, Lessor is the owner in fee simple title of the real property ("*Real Property*") and the improvements ("*Improvements*") located thereon commonly known as 18300 S. Lavergne Ave., Tinley Park, Cook County, IL 60477, all as more fully described on Exhibit "A" attached hereto and incorporated by reference herein and made a part hereof as if fully set forth herein, and the fixtures ("*Fixtures*") and personal property ("*Personal Property*") not belonging to residents thereof located therein and/or thereon (hereinafter the Real Property, Improvements, Fixtures and Personal Property are collectively referred to as "*Property*" or "*Premises*");

WHEREAS, Lessee desires to lease the Property from Lessor; and

WHEREAS, Lessor is willing to allow Lessee to lease the Property, all subject to, in accordance with and on the terms, provisions and conditions hereinafter set forth;

NOW, THEREFORE, in consideration of Ten (\$10.00) Dollars in hand paid, each to the other, the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged by the parties hereto, the parties hereby agree as follows:

1. GRANT OF LEASE; TERM; USE. From and after December 1, 2007 ("*Commencement Date*") until that date which is 11:59 p.m. on the day immediately preceding the Tenth (10th) anniversary of the Commencement Date, unless extended and/or sooner terminated in accordance with terms, provisions and conditions hereof, (hereinafter said time period is referred to as the "*Term*"), Lessor shall let to Lessee and Lessee shall lease from Lessor and occupy the Property for the rent and subject to all of the terms, provisions, conditions, representations, warranties, guaranties, indemnities, duties and obligations hereinafter set forth and the permitted exceptions ("*Permitted Exceptions*") set forth on Exhibit "B" attached hereto and incorporated by reference herein and made a part hereof as if fully set forth herein. During the Term hereof, Lessee shall operate on the Property a nursing home ("*Facility*") fully and unconditionally licensed for 97 skilled and/or intermediate beds fully and unconditionally certified for participation in the Medicaid Program, U.S. Code Title XIX in full compliance with all applicable federal and state codes, statutes, law, rules, regulations and minimum standards, and that also fully and completely comply with all applicable zoning, building, safety, life safety, occupational safety and environmental and hazardous/toxic material/substance laws, and no other activities of any nature whatsoever. Upon the effective date ("*Termination Date*") of the termination of this Agreement for any reason whatsoever, except by exercise and closing of any option to purchase and/or right of first refusal to purchase the same, if any, including but not limited to expiration of the Term by lapse of time and/or an Event of Default and the exercise by Lessor of any of its remedies hereunder, Lessee shall, in all events and circumstances of any and every nature whatsoever, deliver and surrender full and complete possession and control of the Property to Lessor in broom clean condition and in the same state of repair as it was in at the commencement of the Term, only ordinary wear and tear excepted, and free and clear of any and all liens and/or encumbrances of any and every nature whatsoever directly and/or indirectly arising from any acts and/or omissions of Lessee and fully and unconditionally licensed for 97 skilled and/or intermediate beds fully and unconditionally certified for participation in the Medicaid Program, U.S. Code Title XIX. The date on which Lessee first surrenders full and complete possession and control of the Property in full and complete accordance and compliance herewith shall be the "*Surrender Date*."

2. RENT - TAXES AND ASSESSMENTS. Lessee shall pay to Lessor, or as Lessor shall direct, in advance, on the first (1st) day of each and every month of the Term as fixed monthly rental (hereinafter "*Fixed Monthly Rental*", "*Fixed Monthly Rent*" or "*Base Rent*") for the Real Property and the Personal Property over and above all other and additional payments (Taxes and Assessments and Expenses, all as hereinafter defined) to be made by Lessee

as provided in this Lease, the following amounts without any right of any nature whatsoever to credit, deduction, withholding and/or set-off for any reason whatsoever, which covenant to pay Rent is absolute, unconditional, irrevocable and independent of each and every other covenant hereof:

<u>Period</u>	<u>Base Rent</u>
during the first 24 months of the Term	\$38,333.33/month
from the 25 th month to the 120 th month	\$41,666.67/month

Except only as otherwise explicitly set forth herein with specificity and particularity, if at all, the Rent (hereinafter and hereinafter the Fixed Monthly Rent, and the Taxes and Assessments and Expenses, all as hereinafter defined, are collectively referred to as "*Rent*") specified herein shall be "net, net, net" to the Lessor in each year during the Term of this Lease. The Lessee shall pay all costs, expenses, liabilities, claims and obligations of any and every kind whatsoever, including but not limited to all repair, replacement and/or capital improvement reserves, impounds and/or escrow, general real estate taxes and [special] assessments, telephone, internet, cable and/or satellite TV, water, sewer, gas, electricity, heat, waste disposal service, cleaning, security and all other utility services of any and every nature whatsoever ("*Taxes and Assessments*"), relating to the Premises and Personal Property which may arise during the Term of this Lease, whether they become due during or after the Term of this Lease, except for any principal and interest payments due with respect to any mortgage obligations. Simultaneously with the payment of each month's Base Rent, Lessee shall also timely pay to Lessor 1/12th of 110% of the last ascertainable general real estate tax bill as and for additional rent. Lessee does hereby indemnify, save, defend, protect and hold harmless the Lessor from and against any and all such taxes, assessments, costs, expenses, liabilities, claims and obligations, including but not limited to attorneys' fees in connection therewith. In the event the same is permitted under Lessor's mortgage ("*Mortgage*") against the Premise, and then only in strict, full and complete compliance with the terms, provisions and conditions thereof regarding the same, all of which are hereby incorporated by reference herein and made a part hereof as if fully set forth herein, and Mortgagee's and Lessor's prior written consent, Lessee may elect to deposit with Lessor 150% of all contested taxes and/or assessments and thereafter contest any said general real estate tax and/or assessment, provided that at all times during said contest Lessee has on deposit with Lessor not less than 150% of all taxes, interest, fines and/or penalties then claimed from time to time to be accrued, due and owing and/or a lien upon the Real Property. (In the event of any inconsistency, conflict and/or contradiction between the terms, provisions and conditions of the prior sentence as to requirements for pursuing tax contests and the terms, provisions, conditions and requirements of the Mortgage for the same which are incorporated by reference herein, those terms, provisions, conditions and requirements which provide Lessor the greatest protection and most security shall prevail over, govern, control and supersede any and all conflicting, contradictory and/or inconsistent, terms, provisions, conditions and/or requirements wherever they be set out.) Except only as may be delayed by a tax contest permitted hereunder, Lessee shall timely pay any and all Taxes and Assessments as and when they each become due and payable before any fine, penalty and/or interest attaches thereto for the non-payment and/or late payment thereof. Taxes and Assessments for the first and last year of the Term shall be prorated between the parties based on the number of annual calendar days of Lessee's actual possession of the Premises in the first and last years, respectively of the Term. It is further agreed by the parties that after service of notice or the commencement of any suit or after final judgment for possession of the Property, Lessor may receive and collect any and all full and/or partial payment of Rent due, and the full and/or partial payment and acceptance of said Rent shall not waive or affect in any manner whatsoever said notice, suit or judgment and/or any of Lessor's rights, privileges and/or remedies. No payment by Lessee or receipt by Lessor of an amount less than full payment of Rent then due and payable, whether before or after default, shall be deemed to be other than on account of the Rent then due and payable, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as Rent be deemed an accord and satisfaction, and Lessor may accept such check or payment without prejudice to Lessor's right to recover the balance of such Rent or pursue any other remedy provided for in this Lease or available at law or in equity. Unless directed otherwise, Rent shall be paid to Lessor at c/o 9777 Greenwood., Niles, IL 60714.

3. **LATE FEE.** In the event that Lessor's actual receipt of the Rent is late and overdue by three (3) or more calendar days ("*Late Rent*"), Lessee shall pay to Lessor simultaneously with the payment thereof a sum ("*Late Fee*") equal to five (5%) percent of the Late Rent, not as a penalty, but solely as and for reimbursement of the cost of processing the Late Rent payment. Payment and acceptance of the Late Fee shall not be deemed a waiver of any Event of Default for the non-payment of Rent. The failure to timely pay any Late Fee when and as due shall be a separate and

independent Event of Default entitling Lessor to exercise any and all remedies for the non-payment of Rent. No failure by Lessor to insist upon the strict performance by Lessee of Lessee's obligations to pay late charges in any particular instance shall constitute a waiver by Lessor of its rights to enforce the provisions of this Article in any instance thereafter occurring.

4. **SECURITY DEPOSIT.** To secure the faithful performance by Lessee of all of the covenants, conditions and agreements set forth in this Lease to be performed by it, including, without limitation, foregoing such covenants, conditions and agreements in this Lease which become applicable upon its termination by re-entry or otherwise, Lessee has deposited with Lessor and Lessor acknowledges receipt from Lessee of a security deposit ("*Security Deposit*") in the initial amount equal to One (1) month's then current Fixed Monthly Rent on the understanding:

A. that the Security Deposit or any portion thereof may be applied, in Lessor's sole, exclusive, absolute and unreviewable discretion to: (i) the curing of any Default that may exist, without prejudice to any other remedy or remedies which the Lessor may have on account thereof; (ii) to reimburse Lessor for any and all damage to any and/or all of the Property; and/or (iii) to reimburse Lessor for any and all other damages suffered and/or incurred by it and accruing as a direct and/or indirect result of Lessee's Default under this Lease, including but not limited to attorneys fees; and upon such application Lessee shall pay Lessor not later than five (5) business days after the date of demand the full amount so applied which shall be added to the Security Deposit so the same will be restored to its total aggregate balance immediately prior to Lessor's application of any portion thereof as aforesaid, and at all times be equal to not less than the Base Rent then in effect;

B. that should the Premises be conveyed by Lessor, the Security Deposit or any balance thereof may be turned over to the Lessor's grantee, and if the same be turned over as aforesaid, Lessee hereby releases Lessor from any and all liability with respect to the Security Deposit and its application or return, and Lessee agrees to look solely to such grantee for such application or return; and,

C. that the Security Deposit shall not be considered as advance payment of Rent or a measure of damages for any default by Lessee, nor shall it be a bar or defense to any actions by Lessor against Lessee.

Upon each anniversary of the Commencement Date during the Term of this Lease, the Lessee shall immediately pay to Lessor an additional sum equal to 3.42% of the prior Lease year's Fixed Monthly Rent as and for an additional Security Deposit, so that the Lessor shall at all times during the Term hold as a Security Deposit a total aggregate amount equal to not less than One (1) month's current Fixed Monthly Base Rent during the then current year of the Lease Term. Unless specifically required by unwaivable provision of Illinois law to the contrary, Lessor shall not be required to segregate the Security Deposit from any other funds of Lessor and/or pay Lessee any interest thereon, and may, in its sole, exclusive, absolute and unreviewable discretion, co-mingle the Security Deposit with any other funds of Lessor and in all events any and all interest earned thereon shall be the sole and exclusive property of Lessor and belong to and be retained by Lessor. Upon the Termination of this Lease and the timely Surrender of the Property in same condition as it was originally on the Commencement Date, only ordinary wear and tear excepted, in broom clean condition, and in full and complete accordance with all the terms, provisions and conditions hereof, Lessor shall within Forty-Five (45) days refund to Lessee the principal amount of the Security Deposit then held by Lessor, less any and all damages, costs and expenses, including but not limited to attorneys' fees, if any, suffered and/or incurred by Lessor and directly and/or indirectly referring to, relating to, pertaining to, stemming from, arising out and/or connected with any act and/or omission of Lessee hereunder. In no event and under no circumstances of any nature whatsoever shall Lessee ever use and/or apply, and/or seek to use and/or apply, the Security Deposit as, to and/or for all and/or any portion of the last month's (and/or any month's) Rent due under the Lease.

5. **LIENS; LESSOR'S RIGHT TO PERFORM.** At all times during the Term and at the termination of this Agreement and Lessee's surrender of possession and control of the Property to Lessor, and at all times thereafter, the Property shall be and remain free and clear of any and all liens and/or encumbrances of any and every nature whatsoever, including but not limited to mechanics' liens, directly and/or indirectly referring to, relating to, pertaining to, stemming from arising out of and/or connected with any act, omission, contract and/or agreement of Lessee, and in the case of the filing of any such lien Lessee will promptly pay the same. In the event the same is permitted under

Lessor's Mortgage, and then only in strict, full and complete compliance with the terms, provisions and conditions thereof regarding the same, all of which are hereby incorporated by reference herein and made a part hereof as if fully set forth herein, and Mortgagee's and Lessor's prior-written consent, Lessee may elect to deposit with Lessor 150% of all contested liens and thereafter contest any said lien, provided that at all times during said contest Lessee has on deposit with Lessor not less than 150% of all liens and all interest, fines and/or penalties then claimed from time to time to be accrued, due and owing thereon and/or a lien upon the Real Property. (In the event of any inconsistency, conflict and/or contradiction between the terms, provisions and conditions of the prior sentence as to requirements for pursuing lien contests and the terms, provisions, conditions and requirements of the Mortgage for the same which are incorporated by reference herein, those terms, provisions, conditions and requirements which provide Lessor the greatest protection and most security shall prevail over, govern, control and supersede any and all conflicting, contradictory and/or inconsistent, terms, provisions, conditions and/or requirements wherever they be set out.) If a default in the payment of the foregoing shall continue for thirty (30) days after written notice thereof from Lessor to Lessee, the Lessor shall have the right and privilege, but not the duty or obligation, at Lessor's sole, exclusive, absolute and unreviewable discretion and option, of paying the same or any portion thereof without inquiry as to the validity thereof, and the amounts so paid, including but not limited to expenses, interest at the Default Rate and attorneys' fees, shall be so much additional indebtedness hereunder due and immediately owing from Lessee to Lessor and shall be repaid to Lessor immediately on rendition of a bill therefor.

6. **CONDITION OF PREMISES - "AS IS/WHERE IS"**. EXCEPT AS OTHERWISE EXPRESSLY SET FORTH ELSEWHERE HEREIN WITH SPECIFICITY, IF AT ALL, LESSOR HEREBY EXPRESSLY DISCLAIMS ANY AND ALL WARRANTIES, EXPRESS AND/OR IMPLIED, OF ANY AND EVERY NATURE WHATSOEVER, INCLUDING SPECIFICALLY BUT NOT LIMITED TO ANY AND ALL EXPRESS AND/OR IMPLIED WARRANTIES OF COMPLIANCE WITH ANY AND ALL "SUPER FUND," "SUPERLIEN," ENVIRONMENTAL AND/OR HAZARDOUS AND/OR TOXIC SUBSTANCE AND/OR MATERIAL LAWS, AND ANY AND ALL IMPLIED WARRANTIES OF HABITABILITY, MERCHANTABILITY AND/OR OF FITNESS FOR A PARTICULAR PURPOSE, AS TO ALL PROPERTY, REAL AND/OR PERSONAL, INCLUDING BUT NOT LIMITED TO ALL STRUCTURAL COMPONENTS AND/OR SYSTEMS, INCLUDING BUT NOT LIMITED TO THE ROOF, FOUNDATION AND SUPPORTING WALLS, ALL MECHANICAL EQUIPMENT, INCLUDING BUT NOT LIMITED TO THE ELEVATORS, IF ANY, HVAC, BOILERS, ALL PLUMBING, SPRINKLER, LIFE SAFETY, FIRE ALARM AND ELECTRICAL SYSTEMS, CIRCUIT BREAKERS AND PANELS, AND APPLIANCES, IF ANY OF THE FOREGOING, WHICH IS/ARE THE SUBJECT OF THIS LEASE. Lessee acknowledges and agrees that it has had sufficient opportunity and access to the Property to conduct such inspections and due diligence (collectively, "*Due Diligence*") as Lessee in its sole and exclusive judgment, based upon its extensive experience in operating nursing home care facilities, has deemed necessary and appropriate, including but not limited to inspections of all environmental conditions, of all structural components and/or systems, including but not limited to the roof and foundation, all mechanical equipment, including but not limited to the elevators, if any, HVAC, pipes, boilers, all plumbing, sprinkler, life safety, fire alarm and electrical systems, circuit breakers and panels and appliances, and: (A) is satisfied with the results of its Due Diligence and the condition of the Property; (B) has not relied on any representation and/or warranty, express and/or implied, of any nature whatsoever by Lessor and/or its directors, officers, employees, independent contractors and/or agents as to the condition thereof, including specifically but not limited to the environmental condition, and/or any representation that Lessor would perform any repair(s); and (C) knowingly, intelligently, freely and voluntarily, with a full understanding of the meaning and consequences thereof and the intent to be validly and legally bound by the same and that the same be enforceable against it, absolutely, unconditionally and irrevocably accepts the Property in "AS IS/WHERE IS" condition with all faults and defects, patent and latent, of any and every nature whatsoever, and that such condition was satisfactory.

7. **REPAIRS AND MAINTENANCE**. Lessor may, in its sole, exclusive, absolute and unreviewable discretion, but shall not under any circumstance of any nature whatsoever be required to incur any expense for repairing any Improvements. At all times during the Term hereof and until the Termination Date, Lessee shall be solely and exclusively, absolutely, unconditionally and irrevocably liable and responsible for all costs and expenses (hereinafter "*Expenses*"), ordinary and/or extraordinary, foreseen and/or unforeseen, of any and every nature whatsoever of maintaining and repairing the Property, including but not limited to all structural and nonstructural, exterior and interior, including but not limited to the all glass, appliances, plumbing, electrical, heating, ventilation and air conditioning, roof

and foundation, replacing, repairing and restoring necessary to that end. Lessee shall keep the Property, including but not limited to the adjoining sidewalks, alleyways and parking lots, in a clean and healthful condition in accordance with all applicable laws, and will remove all snow and ice as appropriate. Lessee shall at all times keep in effect, maintain, repair and replace at its sole cost and expense all telephone, internet, water, gas, electricity, fire alarm, waste disposal, cleaning and security services, and electrical, fire alarm, plumbing, sprinkler, boiler, pipes, mains, heating, ventilating and air conditioning equipment, and Lessor shall not be liable for any interruption and/or discontinuance of any utility services to the Premises and/or the Facility. If Lessee refuses or neglects to repair and/or maintain the Premises and/or any of the structural and/or non-structural components of the Premises and/or to repair and/or replace any aforesaid utility equipment by it to be maintained, repaired or replaced hereunder, and to maintain, repair and/or replace said utility and/or equipment to the reasonable satisfaction of Lessor as soon as reasonably possible, Lessor, after written notice to Lessee, except in case of an emergency for the protection of the residents of the Facility in which event prior notice shall not be required, may, but under no circumstance of any nature whatsoever, including but not limited to an emergency situation for the protection of the residents of the Facility, shall Lessor be required to, make and perform such maintenance, repair and/or replacement of such equipment, without liability to Lessee and/or its employees, for and/or on account of any loss, cost, damage or expense that may accrue to any of them by reason of Lessor's making of such maintenance, repair and/or replacement, and upon Lessor's completion of the same, Lessee shall promptly pay Lessor all of its costs and expenses so incurred, including but not limited to attorneys' fees, plus interest thereon at the Default Rate within Ten (10) calendar days of the date of Lessor's demand accompanied by bills for Lessor's costs. It shall be the unconditional and irrevocable duty, obligation and responsibility of Lessee and Lessee absolutely, unconditionally and irrevocably promises, covenants, agrees, represents, warrants and guarantees that it shall, at its sole and exclusive Expense, surrender and deliver possession of the Property to Lessor in the same condition and repair the Property was in at the commencement of the Term, only ordinary wear and tear excepted. All replacing, repairing and restoring required of Lessee shall (in the reasonable opinion of Lessor) be of comparable usefulness, quality and value at least equal to the original work and shall, in all events, be in compliance with all standards and requirements of law, licenses, permits and municipal ordinances, including but not limited to all building and fire safety codes and all environmental and hazardous material laws. Lessee shall not permit any mechanics' lien or liens to be placed upon any and/or all of the Property for any reason whatsoever. Notwithstanding the foregoing to the contrary, Lessee shall not alter or add to the Premises (vs. repair and/or maintain) without Lessor's prior express written consent which consent may be granted, withheld and/or conditioned in any manner whatsoever for any reason and/or no reason whatsoever in Lessor's sole, exclusive, absolute and unreviewable discretion. All alterations, improvements and additions to the Premises shall be in quality, class and value at least equal to the original work and shall become the property of the Lessor and shall meet all building, life safety and fire codes, and all other applicable statutes, codes, rules, regulations, laws and ordinances. Any individual and/or related series of alterations, improvements, additions and/or changes in or to the Premises, the cost of which in the aggregate are in excess of \$50,000.00 in a Twelve (12) month period beginning with the first such alteration, improvement, addition and/or change or which changes the general nature and character of the Facility, or such lesser amount as set forth in any Mortgage, shall be subject to and made in accordance with the procedures for the repair and/or restoration of the Premises, the cost of which exceeds \$50,000.00 all as set forth in paragraphs 8(C) - (E) of this Lease. Any and all alterations and/or additions shall be the sole property of Lessor and shall remain at the Termination and Surrender hereof.

8. INSURANCE.

A. At all times during the Term hereof and until the Termination Date, Lessee shall be solely and exclusively, absolutely, unconditionally and irrevocably liable and responsible for all costs and expenses of keeping and maintaining insurance on the Property, and shall keep and maintain in full force and effect for the benefit of both Lessee and Lessor, and any mortgagee of Owner, as their respective interests appear at least the following insurance with such companies as Lessor may reasonable approve:

i. fire and casualty insurance with extended coverage and/or all risk endorsement, malicious mischief and vandalism and windstorm. All such insurance shall, at all times, be maintained: (i) in an amount at least equal to the greater of the current insurance coverage of the Property; or (ii) the amount required by any mortgagee of the Property, but (iii) in all events and circumstances of any and every nature whatsoever at least equal to the full replacement value of the Property. Such insurance shall at all times be payable to Lessor and Lessee as their interests may appear, and shall contain a standard mortgagee loss-payable clause.

ii. . . . public liability insurance, in amounts reasonable acceptable to Lessor, naming Lessor, Lessee and any and all mortgagees as insureds and insuring them against claims for personal injury, or property damage occurring upon, in or about the Property, or in or upon the adjoining streets, sidewalks, passageways and areas.

iii. . . . boiler explosion insurance on all steam boiler, pressure vessels and piping, against any loss or damage which may result from any accident or casualty in connection with any boiler used in the Property, whereby any person or persons may be injured or killed or property damaged in or about the Property; fire sprinkler insurance; and flood insurance; under the terms of which Lessor, Lessee and all mortgagees will be indemnified, as their interests may appear.

iv. . . . If at any time there be any passenger and/or freight elevator on the Premises carry and maintain elevator liability insurance in an amount and form, and with companies, reasonably satisfactory to Lessor; and

v. . . . Professional Malpractice insurance in the amount of not less than \$1,000,000.00 per occurrence, \$3,000,000.00 per aggregate per location.

vi. . . . At all times during the Term Lessee shall keep in effect business interruption insurance with a loss of Rents endorsement naming Lessor as an insured in an amount at least sufficient to cover: (i) the aggregate of the cost of all Taxes and Assessments due during the period of the next succeeding twelve (12) months following the occurrence of the business interruption; (ii) the cost of all insurance premiums for insurance required to be carried by Lessee for such twelve (12) month period; and (iii) the aggregate of the amount of the Fixed Monthly Rent for the next succeeding twelve (12) month period. All proceeds of the loss of Rents endorsement shall be applied, first, to the payment of any and all Fixed Monthly Rent payments for the next succeeding twelve (12) months; second to the payment of any Taxes and Assessments and insurance deposits required for the next succeeding twelve (12) months.

vii. . . . The insurance policies required under this paragraph 8 shall not under any circumstances be canceled, terminated, reduced or materially modified without at least Thirty (30) calendar days prior written notice to Lessor, and also, if and as required by the respective mortgage, all mortgagees.

viii. . . . copies of Certificates or Binders of all insurance policies required by this paragraph 8 shall be delivered to Lessor not later than the Commencement Date.

ix. . . . Lessee shall not conduct and/or engage in, nor allow any other person and/or entity to conduct and/or engage in, any activity at the Property that will increase the rate of insurance thereon.

B. . . . In the event that any part of the improvements located on the Premises or the Personal Property shall be damaged or destroyed by fire or other casualty (any and all such events being called a "*Casualty*"), the Lessor is hereby authorized, at its option, to negotiate, settle and compromise any and all claims for any and all insurance proceeds relating to any and all Casualties and/or to commence, appear in and prosecute, in its own or the Lessee's name, any action or proceedings relating to any collection of insurance proceeds, and to settle or compromise any claim in connection therewith; provided that so long as no Default or Event of Default then exists, Lessee shall be entitled to participate in any such action or proceedings and may, without Lessor's consent, settle or compromise any claim so long as such settlement and compromise results in a payment to Lessor sufficient to pay in full all cost of repairing, restoring and/or rebuilding the Property, plus all Rent for the entire period during which repairs, restoring and/or rebuilding are being performed, whether or not then due, and Lessee directs Lessor to apply the proceeds of such settlement or compromise for such purpose. All such insurance claims, proceeds, damages and rights of action and the right thereto are hereby assigned by the Lessee to the Lessor, which, after deducting therefrom all its expenses, including attorney's fees, may, for the purpose of repairing, rebuilding and/or restoring, release any moneys so received by it without affecting the lien of this Lease or apply the same in such manner as the Lessor shall determine to the reduction of the sums secured hereby, whether then matured or to mature in the future, and any balance of such moneys then remaining shall be paid to Lessee. The Lessee agrees to execute such further assignments of any compensations, damages, claims, rights of action and proceeds as the Lessor may require.

C. In the event that any part of the improvements located on the Premises or the Personal Property shall be damaged or destroyed by Casualty, Lessee shall promptly replace, repair and restore the same as nearly as possible to the condition it was in immediately prior to such Casualty, in accordance with all of the terms, covenants and conditions and other requirements of this Lease and the Superior Documents applicable in the event of such Casualty. The Demised Premises and the Personal Property shall be so replaced, repaired and restored as to be of at least equal quality and value and substantially the same character as prior to such Casualty. If the estimated cost of any such restoring, replacing or repairing is greater than Fifty Thousand (\$50,000.00) Dollars, or such lesser amount as set forth in the Mortgage, the plans and specifications for same shall be first submitted to and approved in writing by Lessor, which approval shall not be unreasonably withheld, and Lessee shall immediately select an independent, licensed architect, approved by Lessor (which approval will not be unreasonably withheld) who shall be in charge of such repairing, restoring or replacing, and, prior to beginning any such restoration, replacement or repair Lessee shall deliver to Lessor to be approved by Lessor (which approval will not be unreasonably withheld) a no lien contract (including a requirement for both a performance and a fidelity bond) made with a reputable and responsible licensed builder or contractor providing for the completion of the contract work, and the payment for all work, labor and materials necessary to complete such work through a title company standard construction escrow. Lessee covenants that it will give to Lessor prompt written notice of any Casualty affecting the Demised Premises in excess of Fifty Thousand (\$50,000.00) Dollars. Notwithstanding anything to the contrary in this Lease, there shall be no abatement or other adjustment of Rent as a result of such Casualty. Notwithstanding anything to the contrary contained anywhere else herein, prior to Lessor disbursing any insurance proceeds to Lessee, Lessor shall from time to time fully reimburse itself for any and all costs and expenses, including but not limited to attorneys' fees, accountants and appraisers, Lessor suffered and/or incurred directly and/or indirectly in connection with obtaining, holding/managing/administering and/or disbursing the insurance funds.

D. Insurance proceeds payable on account of any and all Casualties shall be the sole and exclusive property of Lessor and Lessee shall not have any right, title and/or interest in, to and/or under said proceeds and/or any Claim therein, provided, however, that so long as Lessee is not in Default hereunder and/or no event has occurred which with the passage of time or giving of notice could mature into an Event of Default and subject to the rights of all Superior Interest Holders, Lessor shall, in accordance with the terms, provisions and conditions of this Lease, make the same available to Lessee to pay for the repair, renewal, restoration and/or replacement of the Property. In the event the amount of such insurance proceeds exceeds Fifty Thousand (\$50,000.00) Dollars, such insurance proceeds as may be paid to Lessee and Lessor and which are not required to be deposited with Mortgagee shall be deposited with Lessor or with a trustee, if Lessee so desires, to be held and disbursed for the repairing, rebuilding, restoring or replacing of the Demised Premises or any portion thereof, or any improvements from time to time situated thereon or therein in accordance with the pertinent provisions of this Lease and the Mortgage.

E. No sums shall be paid by Lessor toward such repairing, rebuilding, restoring or replacing unless it shall be first made to appear to the reasonable satisfaction of Lessor that Lessee is not otherwise in default under this Lease. In the event there is any amount required in excess of the amount received from such insurance policies, Lessee shall first deposit such excess funds with Lessor so that the total amount available will be sufficient to complete such repairing, rebuilding, restoring or replacing in accordance with the provisions of this Lease and the Mortgage and any plans and specifications submitted in connection therewith, free from any liens or encumbrances of any kind whatsoever, and the funds held by Lessor shall be disbursed only upon the presentment of architect's or general contractor's certificates, waivers of lien, contractor's sworn statements, and other evidence of cost and payments as may be reasonably required. No insurance proceeds shall be paid by Lessor toward such repairing, rebuilding, restoring or replacing unless it shall be first made to appear to the reasonable satisfaction of Lessor that Lessee shall have expended all funds necessary to complete such repairing, restoring, renewal or replacement in excess of the insurance proceeds. Funds on deposit with Lessor shall be disbursed in the following order: first, all funds deposited by Lessee; second, all insurance proceeds.

F. Lessor shall not be required to expend any of its own funds to repair the Property.

G. Lessee shall not obtain or carry separate insurance concurrent in form or contributing in the event of loss with that required under this Lease unless Lessor and all superior interest holders are included therein as additional insureds with losses payable as in this Lease provided, and Lessee shall immediately deliver copies of any

and all of the same to Lessor. If Lessor is ever required by any Mortgagee to escrow insurance premiums for the Demised Premises, then simultaneously with the payment of each month's Base Rent, Lessee shall also timely pay to Lessor 1/12th of 110% of all of the last ascertainable insurance premium bills for all aforesaid required insurance as and for additional rent.

H. Notwithstanding anything to the contrary contained elsewhere herein, including specifically but not limited to paragraphs 5 and 12, in the event that Lessee fails to timely provide any replacement insurance required under this paragraph 8 not later than fifteen (15) days prior to the expiration and/or cancellation date of the then current policy, then upon ten (10) days prior written notice to Lessor and Lessee's failure to cure, Lessor may, but shall not be obligated to purchase said insurance, and the cost of the same plus interest thereon at the Default Rate shall be immediately due and payable upon Lessor's written demand therefor accompanied by a copy of an invoice or premium statement for the same.

I. Notwithstanding anything to the contrary contained elsewhere herein, if at all, Lessee hereby indemnifies, saves, protects, defends and holds harmless Lessor from and against any and all Claims, as hereinafter defined in paragraph 18 hereof, of any and every nature whatsoever accruing during the Term hereof and directly and/or indirectly referring to, relating to, pertaining to, stemming from, arising out and/or connected with: Lessee's use and occupancy of the Property; Lessee's operation thereof of a nursing home facility; and/or, any act and/or omission of any nature whatsoever of Lessee. If required by Lessor's mortgagor, simultaneously with the payment of each month's Base Rent, Lessee shall also timely pay to Lessor 1/12th of 110% of the last ascertainable total aggregate bill for all insurance premiums as and for additional rent.

9. **CONDEMNATION.** In the event of a condemnation or taking of the entire Premises by a public or quasi-public authority, this Lease shall terminate as of the date title vests in the public or quasi-public authority. In the event of a taking or condemnation of ten percent (10%) or more (but less than the whole) of the Improvements and without regard to whether the Premises are part of such taking or condemnation, Lessor may, in its sole, exclusive, absolute and unreviewable discretion, elect to terminate this Lease by giving notice to Lessee within sixty (60) days of Lessor receiving notice of such condemnation. All compensation awarded for any condemnation shall be the sole and exclusive property of Lessor, whether such damages shall be awarded as a compensation for diminution in the value of the leasehold or to the fee of the Premises, and Lessee hereby absolutely, unconditionally and irrevocably assigns to Lessor all of Lessee's right, title and interest in and to any and all such compensation; *provided, however*, that in the event this Lease is terminated, Lessee shall be entitled to make a separate claim for the taking of Lessee's personal property (excluding fixtures), and for costs of moving. To secure this covenant, Lessee hereby absolutely, unconditionally and irrevocably nominates and appoints Lessor as his attorney-in-fact with full power of substitution to sign his name to any assignment of any award to Lessee and thereby to validly and legally bind Lessee as a result thereof and that the same shall be enforceable against him as if he had personally signed his name thereto. This power-of-attorney is coupled with an interest and is irrevocable without the prior express written consent of Lessor which may be granted, withheld and/or conditioned in any manner whatsoever for an reason and/or no reason whatsoever, in Lessor's sole, exclusive, absolute and unreviewable discretion. Notwithstanding anything herein to the contrary, any condemnation award to Lessee shall be available only to the extent such award is payable separately to Lessee and does not diminish in any manner whatsoever the award [that would otherwise be] available to Lessor or any Lender of Lessor and such award shall be limited to the amount of Rent actually paid by Lessee to Lessor for the period of time for which the award is given. Any additional portion of such award shall belong to Lessor. If less than ten (10%) percent of all of the Premises are taken by the exercise of the power of eminent domain or sold under eminent domain proceedings and if such exercise affected the improvements located on the Premises, the Lessor, subject to the consent and approval and such other requirements contained in its Mortgage, shall receive the entire condemnation award and shall with reasonable diligence restore or rebuild to the extent reasonably practicable any improvements located upon the Demised Premises affected by the taking, but shall not be obligated to spend for such restoration any amount in excess of the amount awarded or paid to Lessor by the condemnor for such purpose and made available to the Lessor by the Mortgagee for such purpose. In the event the amount awarded and made available shall be insufficient to completely repair and restore the Demised Premises without the contribution of additional funds by Lessor and/or Lessee, and neither party elects to furnish such additional funds needed, then Lessor or Lessee shall have the right, which right must be exercised by written notice to the other party received not later than Forty-Five (45) days after the first to occur of the date of taking of possession or the conveyance of title to the condemnor, to terminate this Lease on the terms and conditions set forth herein.

10. **TRANSFER OF RIGHT OF POSSESSION.**

Notwithstanding anything to the contrary contained elsewhere herein, Lessee shall not under any circumstances and/or in any event of any nature whatsoever sell, assign, lease, transfer, gift, mortgage, pledge and/or hypothecate, directly and/or indirectly, in whole and/or in part, in a single transaction and/or as a series and/or part of a series of transactions, (collectively all of the aforesaid are hereinafter referred to as "**Transfer**") in any manner whatsoever all and/or any portion of Lessee's right, title and/or interest in this Agreement, nor any of Lessee's rights to occupy, use, possess and/or control the Property, nor a direct and/or indirect controlling equity interest in Lessee without Lessor's prior express written consent. Lessee shall promptly and timely provide Lessor such resumes, financial information and such other information detailing the qualifications and experience of any proposed transferee as Lessor in its sole, absolute and unreviewable discretion may request, and the cost of Lessor's (and Lessor's Mortgagee's, if applicable) review ("**Review**") of the aforesaid, including but not limited to its accountants' and attorneys' fees, shall be paid by Lessee to Lessor not later than Seven (7) calendar days after demand. The payment in full of the aforesaid costs and fees shall be a pre-condition to Lessor's consent, and in the event the Transfer fails to occur, Lessee's failure to pay Lessor the costs and fees, including but not limited to attorneys' fees, of Lessor's Review not later than Seven (7) calendar days after demand shall be an Event of Default hereunder, as hereinafter defined. Lessee acknowledges and agrees that Lessor has specifically chosen Lessee to operate the Property based upon the skill and expertise of Lessee and its principals in operating skilled and/or intermediate care nursing home facilities in the State of Illinois, and upon the character and reputation of such principals. Any transferee approved by Lessor shall, at a minimum: (a) have a net worth equal to that of Lessee and the principals of Lessee; (b) possess skill and experience at least equal to Lessee and its principals as demonstrated by the successful and profitable operation of Illinois skilled and/or intermediate care nursing home facility for at least each of the Three (3) calendar years immediately prior to the year of the proposed Transfer; (c) be of character and reputation commensurate with that of the principals of Lessee; and (d) obtain the consent of Lessor's Mortgagee. Notwithstanding anything to the contrary contained in the foregoing sentence, except as expressly set forth elsewhere herein, if at all, Lessor may grant or withhold its consent to any Transfer for any reason, and/or no reason, whatsoever and/or condition the same in any manner whatsoever except for an increase in Rent. No Transfer shall relieve Lessee of any of its duties and/or obligations under this Lease which shall remain in full force and effect, and the acts and/or omissions of any transferee shall, in all events and circumstances of every nature whatsoever, be deemed and construed to be the acts and/or omissions hereunder of Lessee, and if any act or omission of any transferee would be an Event of Default hereunder if it were performed or omitted directly by Lessee, then it shall, indeed, be an Event of Default hereunder by Lessee as if it had been directly performed or omitted by Lessee. Any violation or breach or attempted violation or breach of the provisions of this paragraph by Lessee, or any acts inconsistent herewith shall vest no right, title or interest herein or hereunder or in the Property, in any such transferee, and such act(s) shall automatically be deemed an immediate Default under this Lease. All transferees, if any, shall be bound by the provisions of this paragraph and shall, subject to the conditions hereof, obtain the consent of Lessor to any and/or all subsequent Transfers, or such Transfers shall automatically, without notice, demand and/or right to cure, immediately be deemed an Event of Default hereunder.

11. **RIGHT OF ACCESS, INSPECTION AND TESTING.**

Notwithstanding anything to the contrary contained elsewhere herein, at any and all times during the Term hereof and/or during any period in which Lessee withholds any possession and/or control from Lessor, Lessor shall, on not less than 24 hours oral or written notice to Lessee, have the absolute, unconditional and irrevocable right of access to the Property and to examine and/or exhibit the same, and also to conduct such inspections of any and every nature whatsoever and such tests of/on the Property, including but not limited to any and all soil, Phase I and/or engineering tests of any nature whatsoever, which Lessor in its sole and absolute discretion deems appropriate; provided, however, that Lessor shall take reasonable steps to minimize any interference with Lessee's use of the Property and/or disruption of Lessee's activities thereon and shall indemnify, protect, defend, save and hold harmless Lessee from and against any and all damage of the Property caused directly by Lessor's agents and/or injury to persons as a direct result of the acts and/or omissions of its agents. At all times, Lessee shall allow Lessor to place "For Sale" signs/notices on the Property and will not interfere with the same.

12. **EVENTS OF DEFAULT.**

12.1 The following acts or events shall automatically, without any further notice and/or cure rights/period of any nature whatsoever except only as specifically and expressly set forth in this paragraph 12, be deemed to be an immediate default (hereinbefore or hereinafter "**Default**" or "**Event of Default**") on the part of the Lessee: (A) without notice or demand, the failure of Lessee to pay when due any Rent payment, or any part thereof,

or any other sum or sums of money due or payable to the Lessor under the provisions of this Lease whether said sum is specifically denominated as Rent, reimbursement, indemnity or payment for some other purpose; (B) except as specifically set forth elsewhere herein, the failure of Lessee to perform or the violation by Lessee of, any of its non-monetary promises, agreements, covenants, terms, conditions, provisions, representations, warranties, guaranties, indemnities, duties and/or obligations contained in this Lease, if such failure or violation shall not be cured within the shorter of: (i) Thirty (30) calendar days after notice thereof by Lessor to Lessee; (ii) Seven (7) calendar days less than such time as Lessor is permitted by the Superior Document to cure such violation; (iii) such shorter time as expressly set forth elsewhere in this Lease regarding specific duties, obligations, covenants and/or agreements of Lessee; or (iv) such shorter or greater time as permitted by a Governmental Authority having jurisdiction; provided in all events: (a) that Lessee's license and certification remain in effect at all times during said cure period; (b) that if a greater period is permitted by a Governmental Authority Lessee first obtain Lessor's written consent to permit such greater time to cure, which consent may be withheld, granted or conditioned in Lessor's sole, exclusive, absolute and unreviewable discretion for any reason or no reason, whatsoever; (c) that if a greater period is permitted by a Governmental Authority Lessee first obtain Lessor's Superior Interest Holder's written consent to permit such greater time to cure without declaring a default under the Superior Document; and (d) that the Lessee shall during such Thirty (30) calendar day period commence to cure such failure or violation and diligently pursue said cure to its conclusion; (C) the failure of Lessee to comply, or the violation by Lessee of, any of the terms, conditions or provisions of any Superior Document relating to the Demised Premises (except for supply of information or documentation exclusively in Lessor's possession and control and except for those terms, conditions or provisions requiring payment of either Prime Rent, installment purchase price or Mortgage principal and interest payments), if such failure or violation shall not be cured within the earlier of: (i) Thirty (30) calendar days after Notice; or, (ii) if applicable, Seven (7) calendar days less than such time as Lessor is permitted by the Superior Document to cure such violation, if at all; (D) the making by Lessee and/or any Lessee Guarantor, if any, of an assignment for the benefit of its/his creditors or a common law composition of creditors; (E) if at any time Lessee and/or any Lessee Guarantor admits in writing its/his inability to pay any of its/his debts in accordance with their respective terms, and/or its/his insolvency; and or proceedings are instituted in a court of competent jurisdiction for the voluntary or involuntary reorganization, liquidation or dissolution of the Lessee and/or any Lessee Guarantor or for its/his adjudication as a bankrupt or insolvent, or for the appointment of a receiver or custodian of the property of Lessee and/or any Guarantor, or of Lessee, and, *only* as to any involuntary proceedings (and not applying to any voluntary proceedings), said involuntary proceedings are not completely dismissed and any receiver, trustee or liquidator appointed therein is not completely discharged within Thirty (30) calendar days after the institution of said involuntary proceedings; (F) the levying of a writ of execution, garnishment or attachment on or against any of the property of Lessee and/or any Lessee Guarantor which is not discharged or stayed by action of said party contesting same, within Thirty (30) calendar days after such levy, garnishment or attachment (provided if the stay is vacated or ended, this paragraph shall again apply); (G) the sale of the interest of Lessee in the Demised Premises under execution or other legal process; (H) the failure of Lessee to replace, within Thirty (30) calendar days after notice by Lessor to Lessee, a substantial portion of the Personal Property previously removed by Lessee with property of a similar character, quality, usefulness and value at least equal to that of the removed Property when it was new, free and clear of any and all liens, encumbrances, security agreements and/or financing statements; (I) without notice from Lessor and without any right to cure or contest as otherwise set forth in paragraph 12.4 hereof, the failure of Lessee to give written notice to Lessor not later than Seven (7) calendar days after receipt by Lessee from any Governmental Authority, or any officer acting on behalf thereof, of any Notice which Lessee is required to provide to Lessor, without request, pursuant to paragraph 15(F) hereof; (J) subject to the right to contest set forth in paragraph 12.4 hereof, the failure on the part of Lessee during the Term of this Lease to cure or abate any violation claimed by any Governmental Authority, or any officer acting on behalf thereof, of any code, statute, law, ordinance, order, rule, regulation or standard pertaining to the operation of the nursing home located on Demised Premises, and within the time permitted by such Authority for such cure or abatement; (K) subject to Lessee's right to contest as provided in paragraph 12.4 hereof, the institution of any proceedings against Lessee by any Governmental Authority either: (i) to terminate, cancel, revoke, not renew or to demand the surrender of any license granted to Lessee for the operation of a 111 skilled or intermediate bed nursing home within the Demised Premises; or (ii) to decertify or terminate the nursing home operated on the Demised Premises from participation in the Medicare and/or Medicaid reimbursement program; (L) the abandonment of the Demised Premises by Lessee; (M) the direct or indirect solicitation of any residents of the Facility and/or their families by the Lessee, or any principal or agent thereof, for the purpose of transferring such resident to any other nursing home where such transfer is not required by law, or to maintain the health and well being of the residents in question or for the protection of person or property as permitted under the Nursing Home Care Reform Act, as amended from time to time

and then in effect; (N) the removal for other than a short term period, not to exceed One (1) month in actuality and/or intent, and other than for an emergency situation which situation shall not be directly or indirectly caused by any act and/or omission of Lessee, by any local, state or federal Governmental Authority having jurisdiction over the operation of the nursing home located on the Demised Premises of Five (5%) percent or more of the patients located in the Facility, unless such removal is the result of the exercise of eminent domain; (O) the failure of Lessee to timely indemnify, save, protect, defend and hold harmless Lessor from and against, and to pay when due, any and/or all indemnified Claims, including but not limited to any and all Recoupments, Repayments and/or CMP's imposed and/or accruing after the Commencement Date directly and/or indirectly as a result of any act and/or omission of Lessee, its employees, agents and/or independent contractors, including but not limited to the entire amount of any and all CMP's initially assessed and/or imposed at and/or for any time during the Term of this Lease and which continue to accrue and/or be imposed beyond the Term of this Lease until the acts and/or omissions initially giving rise to the CMP's have been cured/corrected; (P) except in strict accordance with paragraph 10 hereof, without Lessor's prior written consent, which consent may be unreasonably withheld: (i) the Transfer of any equity interest of any nature whatsoever in Lessee and/or, if Lessee is a trust, Lessee's beneficiary and/or the beneficial interest in said trust; and/or, (ii) the attempted assignment of this Lease, subletting and/or transfer of possession and/or management and/or control of the Demised Premises; and/or (Q) the occurrence of any Event of Default listed in this paragraph 12 by any party to whom the Demised Premises has been Transferred in accordance with paragraph 10.

12.2 Notwithstanding anything to the contrary contained elsewhere herein, including specifically but not limited to paragraphs 12.1(C), 12.1(J) and 12.1(K) and 12.4 hereof, the receipt by Lessee of written notice from any Governmental Authority having jurisdiction over the Facility that said Authority is suspending, terminating, canceling, rescinding, revoking, not renewing and/or demanding the surrender of, and/or intending to suspend, terminate, cancel, rescind, revoke, not renew and/or demand the surrender of (hereinafter all of the aforesaid are collectively referred to as "*Terminate*"), any and/or all licenses, permits and/or certifications necessary to operate the Facility as a long term care facility duly licensed for 97 skilled and/or intermediate care beds and fully certified to participate in the Medicaid/Medicare programs (hereinafter collectively "*Licenses*"), which notice, and/or any attachment thereto and/or accompanying notice, on its face does not specifically and expressly provide Lessee an opportunity, means and method of curing or correcting any and/or all alleged violations, excluding post-Termination cure rights, and thereby preserving (both during the pendency of said cure/correction and thereafter) Lessee's right to keep and maintain all said Licenses validly in full force and effect shall automatically and without notice and/or demand of any nature whatsoever by Lessor be an immediate Event of Default under this Lease without any right to cure the same, entitling Lessor to immediately and without notice of any nature whatsoever exercise any and/or all available remedies hereunder and/or in law and/or equity, including specifically but not limited to immediate possession and control of the Property *unless* Lessee shall at all times satisfy each and every one of the following terms, provisions and conditions: (i) within Twenty-Four (24) hours of its receipt of any aforesaid notice from any Governmental Authority Lessee shall fax a copy of the same to Lessor and to Lessor's attorney with a statement indicating its intent to enjoin the Termination; (ii) within the lesser of Five (5) calendar days after its receipt of any aforesaid notice from any Governmental Authority, or such shorter time as is necessary to prevent any temporary and/or permanent Termination of any and/or all Licenses, Lessee shall institute an action in any court of competent jurisdiction seeking to enjoin the Governmental Authority from Terminating any and/or all Licenses and also to enjoin the Governmental Authority from informing the residents of the Facility and/or their families and/or the public of its actions and/or intent to Terminate the License, and thereafter diligently pursue the same to its conclusion, including but not limited to any and all appeals thereof, and at all times during the pendency of said action the Governmental Authority shall, in fact, be enjoined, restrained and/or stayed from Terminating any and/or all Licenses and from informing the residents of the Facility, their families and the public of its actions and/or intent to Terminate the License; (iii) Lessee shall deliver to Lessor and to Lessor's attorneys a copy of said action, duly filed and served on the appropriate Governmental Authority, within Twenty-Four (24) hours of said filing and service, respectively, and also deliver to Lessor and Lessor's attorneys within Twenty-Four (24) hours of its entry a stamped copy of the initial court order (hereinafter "*Order*") enjoining, restraining and/or staying the Governmental Authority as aforesaid during the pendency of the action and/or denying the same and also any and all subsequent court order(s) (hereinafter "*Subsequent Order*") referring to, relating to, pertaining to, connected with, affirming, extending, renewing, modifying, amending, altering, changing, correcting, clarifying, striking and/or vacating the Order and/or any other Subsequent Order, in whole and/or in part, and/or not renewing or not extending, vacating and/or dissolving, in whole and/or in part, any injunction, restraining order and/or stay contained in the Order and/or any other Subsequent Order and/or dismissing said action; and (iv) Lessee shall continue at all times to lawfully operate the Facility; in which case,

and only in which case, except as set forth in the following sentence of this paragraph, it shall not be an automatic and immediate Event of Default hereunder. Notwithstanding anything to the contrary contained elsewhere herein, including specifically but not limited to the previous sentence of this paragraph, in the event that Lessee does timely serve Lessor and Lessor's attorneys with a copy of the notice, action, Order and all Subsequent Orders, and timely institutes an action to enjoin the Governmental Authority, the Governmental Authority is enjoined, restrained and/or stayed and Lessee continues at all times to lawfully operate the Facility, all as aforesaid, immediately upon the final determination of said action in favor of the Governmental Authority, and/or if at any time during the pendency of said action the Governmental Authority is not enjoined, restrained and/or stayed from acting to Terminate any and/or all Licenses and from informing the residents of the Facility, their families and the public of its actions and/or intent to Terminate the License, and/or if Lessee at any time ceases to lawfully operate the Facility and/or Lessee fails to provide Lessor a detailed written status report as to the progress and status of the action and/or the status of the Order and/or Subsequent Order within Three (3) business days of Lessor's written request for the same, then it shall automatically, without notice of any nature whatsoever, be an immediate Event of Default hereunder without any right to cure and entitling Lessor to immediately and without notice of any nature whatsoever exercise any and/or all of its remedies hereunder and/or in law and/or in equity, including specifically but not limited to its right to immediate possession and control of the Property. Lessee shall permit, but may not require, Lessor, at Lessor's sole and exclusive election, to join and/or intervene in any and/or all actions, causes, causes of action, suits and/or lawsuits to enjoin, restrain and/or stay any Governmental Authority as aforesaid, including but not limited to any and all appeals of any and/or all of the foregoing, and Lessee hereby indemnifies, saves, protects and holds harmless Lessor from and against any and/or all Claims fees, costs and/or expenses, including but not limited to any and/or all of Lessor's attorney fees, referring to, relating to, pertaining to, arising out of and/or connected therewith. Time is of the essence as to each and every term, provision, condition, duty, obligation, promise, covenant, agreement, representation and/or warranty contained in this paragraph. The parties hereto mutually acknowledge and agree that in the event of Lessee's breach of any of its duties, obligations, promises, covenants, agreements, representations and/or warranties contained in this paragraph and/or of any term, provision and/or condition of this paragraph Lessor shall be seriously and irreparably harmed thereby in that the value of the Property as a viable and ongoing business will be seriously and materially diminished, and in consideration of Lessor entering into this Lease and in order to preserve and/or protect the value of the Property as an ongoing business Lessee hereby irrevocably, absolutely and unconditionally **WAIVES AND RELEASES** any and all defenses it might have to the immediate enforcement by Lessor of any and all of its remedies hereunder and/or in law and/or equity for any breach by Lessee of any of its duties, obligations, promises, covenants, agreements, representations and/or warranties contained in this paragraph and/or of any term, provision and/or condition of this paragraph.

12.3 A. Notwithstanding anything to the contrary contained elsewhere herein, in all events and circumstances of any and every nature whatsoever in the event that Lessee breaches the same term, provision, condition, promise, covenant, agreement, representation, warranty, indemnity, guaranty, duty and/or obligation (hereinafter collectively "**Condition**") under this Agreement more than Two (2) times in any Twelve (12) consecutive month period, whether or not said breaches have previously been cured as otherwise allowed hereunder or waived, then immediately and automatically upon Lessee's Third (3rd), and/or subsequent, such breach, (hereinafter Lessee's Third (3rd) and/or subsequent such breach is a "**Repeat Default**"), if any, of any Condition within any said Twelve (12) consecutive month period Lessee shall not be entitled to any right of any nature whatsoever to cure the Repeat Default and/or any other Event of Default hereunder and hereby irrevocably, absolutely and unconditionally **WAIVES AND RELEASES** any and all rights hereunder and/or in law and/or equity to cure the Repeat Default and all other Events of Default hereunder and Lessor may, but need not, immediately and without further notice or demand of any nature whatsoever exercise any and all remedies it chooses against Lessee.

B. Except as to paragraph 12.1(A) hereof which shall prevail over, supersede and control the terms, conditions and provisions of paragraph 12.1(C) hereof, notwithstanding anything to the contrary contained elsewhere in this paragraph 12.1, in the event of any conflict between any other terms, conditions and/or provision hereof and the provisions of paragraph 12.1(C) hereof, the terms, conditions and/or provisions which provide Lessor the maximum protection shall prevail over, supersede and control any term, condition and/or provision which provides Lessor less protection.

12.4 Notwithstanding anything to the contrary contained elsewhere herein except paragraphs 12.1(I), 12.2 and ~~12.3~~ which shall in all events of any and every nature whatsoever described therein prevail over, supersede, control and govern any terms in this paragraph which conflict with, contradict and/or are inconsistent with the terms, provisions and/or conditions thereof, Lessee shall, if permitted by and then only subject to and in compliance with the terms and conditions of all Superior Documents, have the right upon written notice thereof to the Lessor, to contest by appropriate administrative and legal proceedings, diligently conducted in good faith, the validity or application of any law, regulation or rule mentioned herein, including but not limited to any reduction in the number of licensed beds, and to delay compliance therewith pending the prosecution of such proceedings including but not limited to any proceeding pursuant to paragraphs 12.1(J) and 12.1(K) hereof and to which paragraphs 12.1(I), 12.2 and/or 12.3 do not apply, during which contest, notwithstanding anything to the contrary contained elsewhere herein, Lessee shall not be in Default hereunder; provided, however, that (i) no civil or criminal liability would thereby be imposed upon or satisfied out of the Premises; (ii) that the Mortgage and Mortgagee shall permit such contest and Lessee shall at all times conduct the same in full and complete accordance with all of the terms, provisions and conditions of the Mortgage; (iii) Lessee shall continue at all times to operate the Premises as a skilled and/or intermediate care nursing home licensed for 111 beds or such lesser number of beds than the maximum allowed under the law based upon the physical structure of the Premises during the period of such contest; and (iv) that Lessee shall at all times keep Lessor thoroughly informed as to the status of such contest, and in all events shall report the status of said contest to Lessor within Three (3) business days of Lessor's request for the same.

12.5 No waiver of any Default(s) hereunder shall be valid, binding or enforceable against the Non-Defaulting Party unless said waiver is in writing signed by the Non-Defaulting Party, nor shall any waiver constitute or be deemed, interpreted or construed to be a continuing waiver or a waiver of any (other) Default(s), except those Defaults specifically described with particularity therein, even though another Default be similar or identical to the waived Default and/or be prior to, contemporaneous with or subsequent to the date of the waived Default. Any written waiver by the Non-Defaulting Party shall be strictly and narrowly interpreted and construed in accordance with its terms and in favor of the Non-Defaulting Party so as to provide the Non-Defaulting Party the broadest and maximum amount of protection. No extension of time for performance of any specific or particular duties, obligations or acts shall be deemed an extension of the time for performance of any other duties, obligations or acts, whether or not they be similar and/or identical to the specific duties, obligations or acts for which an extension was previously granted. Nor shall the Non-Defaulting Party's failure to take a particular action or assert a particular privilege or right granted it hereunder and/or in law and/or equity, absent a written waiver of the same, be deemed, interpreted or construed to be a waiver of said action, privilege or right. No custom, usage, practice, course of conduct and/or course of dealing shall be deemed, interpreted or construed to establish any rights in the Defaulting Party and/or to be binding upon and/or enforceable against the Non-Defaulting Party, and/or to be a waiver by the Non-Defaulting Party of any privilege or right which would otherwise accrue to the Non-Defaulting Party absent said custom, usage, practice, course of conduct and/or course of dealing. The Non-Defaulting Party shall not be estopped for any reason whatsoever from asserting any privilege or right, and/or be subject to any defense of Laches and/or the lack of due diligence in the exercise and/or enforcement of any of its privileges or rights hereunder.

13. **REMEDIES.** Notwithstanding anything to the contrary contained elsewhere in this Lease, in the event that Lessee fails and/or refuses to deliver and surrender to Lessor sole, exclusive, full, complete and total possession and control of the Property not later than the Termination Date, the parties hereto mutually acknowledge and agree each to the other that in addition to, and not in lieu, place, stead, substitution and/or replacement of any other remedy contained herein and/or in law and/or equity, including but not limited to actual, compensatory damages, Lessor shall also proximately suffer real and actual damages (hereinafter "**Liquidated Damages**") for, *inter alia*, its inability to occupy and use or relet the Property, as well as attorneys' fees suffered and/or incurred by Lessor in connection with this Agreement, and that although these Liquidated Damages are not speculative but rather are real, actual and proximate, they are, nevertheless, not capable of precise or definite calculation. Therefore, the parties have agreed, after a fair and arms-length negotiation in which each party was ably represented by experienced legal counsel and after taking into account all relevant factors, that in addition to, and not in lieu, place, stead, substitution and/or replacement of any other remedy contained herein and/or in law and/or equity, including but not limited to actual, compensatory damages, their reasonable best commercial estimate of Lessor's Liquidated Damages is the sum of double the total amount of all monthly Rent (hereinafter the "**Amount of Liquidated Damages**") for each and every month and/or portion thereof from and after the Termination Date until and including the actual Surrender Date that Lessee and/or any tenant claiming by,

through and/or under Lessee fails and/or refuses to surrender and deliver to Lessor any portion of the Property. The parties also mutually acknowledge and agree each to the other that the Liquidated Damages and the Amount of Liquidated Damages are indeed liquidated damages and are reasonable and not a forfeiture and/or a penalty, that they are not unconscionable or oppressive, that they do not "shock the conscience" and that this contract (and/or this provision of this contract) is not a contract of adhesion. The provisions of the two previous sentences shall not under any circumstances of any nature whatsoever be held, deemed, interpreted and/or construed as any waiver by Lessor of any right of reentry as hereinafter set forth; nor shall the receipt of any said [Amount of] Liquidated Damages and/or any part thereof, or any other act in apparent affirmance of any tenancy, operate as a waiver of the right to forfeit this Lease and the Term hereby granted for the period still unexpired, for a breach of any of the covenants herein. To further secure Lessor's remedies, set forth herein, for the payment of the Rent reserved hereunder, Lessee hereby grants to Lessor a first and priority lien upon all accounts receivable of Lessee whether now or hereafter acquired and all personal property which Lessee now owns and/or may hereafter acquire or have an interest in, including but not limited all of Lessee's property which is by law subject to any distraint for rent. Lessee agree to execute such security agreements and/or financing statements and/or UCC1's as Lessor may request to evidence and perfect its first priority security interest as aforesaid, and Lessee shall pay all fees, costs and expenses of recording and/or filing the same. In addition to, and not in lieu, place, stead, replacement and/or substitution of any other remedy set forth herein, including but not limited to the Liquidated Damages, Lessee hereby indemnifies, defends, saves, protects and holds harmless Lessor from and against One Hundred (100%) percent of any and all manner whatsoever of tort, contract, common law, statutory, civil and/or criminal actions, causes, causes of action, claims, consent decrees, court orders, damages, including but not limited to actual, compensatory, consequential, statutory, treble and/or punitive damages, debts, demands, injuries, investigations, lawsuits, proceedings, suits, liabilities, liens, mechanics' and/or workmen's liens, encumbrances, financing statements, security agreements, security interests, losses, monies, sums, sums of money, interest, fines, penalties, taxes, pro-rations, Rents, settlements, recaptures, recoveries, recoupments, repayments, set-offs, withholdings, accounts, bills, invoices, statements, bonds, reckonings, specialties, controversies, breaches, defaults, acts, omissions, specific performance and other injunctive relief, agreements, covenants, promises, representations, warranties, guaranties, indemnities, duties, obligations, privileges, rights, title, interests, variances, trespasses, fees, charges, costs, expenses, judgments, attachments, citations, garnishments, levies and/or executions, of any and every nature whatsoever, whether general and/or special, ordinary and/or extraordinary, direct and/or indirect, suspected and/or unsuspected, known and/or unknown, foreseen and/or unforeseen, whether liquidated, fixed and/or contingent, including but not limited to any and all rights of subrogation, contribution and/or indemnification, whether in law and/or in equity, judicial and/or administrative, including but not limited to attorneys fees, including specifically but not limited to attorneys' fees in any enforcement and/or collection action and/or in preparation therefor whether or not resulting in any litigation and/or in any bankruptcy (including but not limited to any proceeding to dissolve, lift, vacate and/or modify, in whole and/or in part, any automatic stay) and/or appellate proceedings, owed, suffered or incurred, accrued and/or accruing and whether or not asserted, threatened, alleged or litigated (hereinafter all of the aforesaid are collectively referred to as "*Claims*"), and based upon, referring to, relating to, pertaining to, resulting from, stemming from, arising out of and/or connected with breach, violation and/or Default hereunder, including but not limited to the Taxes and Assessments and Expenses of operating, repairing and maintaining the Property, including but not limited to insurance thereon, and Lessor's attorneys' fees. Lessor's remedies hereunder shall be cumulative, and not mutually exclusive, and the election by Lessor of any particular remedy, including but not limited to Liquidated Damages and/or injunctive relief/specific performance, shall not bar, prevent or preclude and/or be deemed, interpreted and/or construed to bar, prevent and/or preclude Lessor from simultaneously, contemporaneously, successively and/or consecutively pursuing any other remedy, including but not limited to Liquidated Damages and/or injunctive relief/specific performance. No abandonment by Lessor of the exercise of any particular privilege, right or remedy shall bar, prevent or preclude it from subsequently exercising said privilege, right and/or remedy again. Lessor shall not be estopped for any reason whatsoever from asserting any privilege, right and/or remedy, and/or be subject to any defense of Laches and/or the lack of due diligence in the exercise and/or enforcement of any of its privileges, rights and/or remedies hereunder. No waiver of any privilege, right and/or remedy hereunder shall be valid, binding or enforceable against Lessor unless said waiver is in writing signed by the Lessor, nor shall any waiver constitute or be deemed, interpreted or construed to be a continuing waiver or a waiver of any (other) privilege(s), right(s) and/or remedy(ies), except those privileges, rights and/or remedies specifically described with particularity therein, even though another privilege, right and/or remedy be similar or identical to the waived privilege, right and/or remedy and/or be taken prior to, contemporaneous with and/or subsequent to the date of the waiver of a privilege, right and/or remedy. Any written waiver by Lessor shall be strictly and narrowly interpreted and construed in accordance with its terms and in favor of Lessor so as to provide

Lessor the broadest and maximum amount of protection. Nor shall Lessor's failure to take a particular action or assert a particular privilege, right or remedy granted it hereunder and/or in law and/or equity, absent a written waiver of the same, be deemed, interpreted or construed to be a waiver of said action, privilege, right or remedy. No custom, usage, practice, course of conduct and/or course of dealing shall be deemed, interpreted or construed to establish any rights in Lessee and/or to be binding upon and/or enforceable against Lessor, and/or to be a waiver by Lessor of any privilege, right and/or remedy which would otherwise accrue to Lessor absent said custom, usage, practice, course of conduct and/or course of dealing. Notwithstanding anything to the contrary contained elsewhere herein, in addition to and not in lieu, place, stead and/or substitution of any other privilege, right and/or remedy contained elsewhere herein, in the event of an Event of Default hereunder, Lessee hereby indemnifies, defends, saves, protects and holds harmless Lessor from and against any and all costs, expenses and fees of enforcement and/or collection, including specifically but not limited to all reasonable attorneys' fees in connection therewith, including but not limited to all reasonable attorneys' fees suffered and/or incurred by Lessor and referring to, relating to, pertaining to, stemming from arising out of and/or in connection with any appellate and/or bankruptcy proceeding, including but not limited to any proceeding to dissolve, vacate, lift and/or modify, in whole and/or in part, any automatic stay. Lessor shall not, under any circumstances of any nature whatsoever, be required to post any bond and/or surety of any nature whatsoever in order to pursue any injunctive relief and/or claim therefor and/or any appeal of any nature whatsoever, any and all such requirements being hereby **WAIVED AND RELEASED** by Lessee.

14. **LESSEE'S ENVIRONMENTAL REPRESENTATIONS.** Notwithstanding anything to the contrary contained elsewhere herein, in addition to and not in lieu, place, stead, substitution and/or replacement of any other representation, warranty, promise, covenant, agreement, duty, obligation and indemnity of Lessee contained herein, Lessee represents and warrants that during the Term hereof the Lessee's conduct of its business and operation of the nursing home care facility, and the Property, including but not limited to the Real Property owned by the Owner and leased hereby to Lessee, including but not limited to the soil and ground water thereof, shall at all times comply with all environmental codes, statutes, laws, orders, rules, regulations, plans, policies and/or decrees of the United States and/or the State of Illinois, including but not limited to: the National Environmental Policy Act, (42 U.S.C. §§4901 *et seq.*, "**NEPA**"); Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, (42 U.S.C. §§9601, *et seq.*, "**CERCLA**"); the Superfund Amendments and Reauthorization Act of 1986, (42 U.S.C. §§9671, *et seq.*, "**SARA**"); the Hazardous Materials Transportation Act, (49 U.S.C. §§1801, *et seq.*, "**HMTA**"); the Toxic Substances Control Act, (15 U.S.C. §§2601, *et seq.*, "**TSCA**"); the Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. §§6901, *et seq.*, "**RCRA**"), including but not limited to the Hazardous and Solid Waste Amendments of 1984; the Federal Insecticide, Fungicide and Rodenticide Act (7 U.S.C. §§136, *et seq.*, "**FIFRA**"); the Clean Air Act, (42 U.S.C. §§7401, *et seq.*, "**CAA**"); the Clean Water Act, (33 U.S.C. §§1251, *et seq.*, "**CWA**"); the Water Quality Act of 1987 ("**WQA**"); the Safe Drinking Water Act, (42 U.S.C. §§300(f), *et seq.*, "**SDWA**"); the Marine Protection, Research and Sanctuaries Act, (33 U.S.C. §§1401, *et seq.*, "**MPRSA**"); the Rivers and Harbors Act, (33 U.S.C. §§401, *et seq.*, "**RHA**"); the Coastal Zone Management Act (16 U.S.C. §§1451-1464, "**CZMA**"); the Federal Water Pollution Control Act, as amended, (33 U.S.C. §§1252, *et seq.*, "**FWPCA**"); the Federal Emergency Planning and Community Right-To-Know Act of 1986, as amended (42 U.S.C. §§11001, *et seq.*, "**FEPCRKA**"); the Radon Gas and Indoor Air Quality Research Act, ("**RGIAQRA**"); the Atomic Energy Act, 42 U.S.C. §§2011, *et seq.*, "**AEA**"); the Nuclear Waste Policy Act of 1982, (42 U.S.C. §§10101, *et seq.*, "**NWPA**"); the Occupational Safety and Health Act (29 U.S.C. §§651 *et seq.*, "**OSHA**"); OSHA Hazard Communication Standard, (29 C.F.R. §§1910.1200, *et seq.*, "**OSHAHCS**"); the Illinois Environmental Protection Act, (415 ILCS 5/1, *et seq.*, "**IEPA**"); the Illinois Emergency Planning and Community Right-To-Know Act of 1991, (430 ILCS 100/1, *et seq.*, "**IEPCRKA**"), and any so-called "Superlien Law" and the rules, regulations and standards of the United States and/or Illinois Environmental Protection Agencies, the Illinois Pollution Control Board, the Illinois Department of Natural Resources and/or the U.S. Army Corps of Engineers, all as amended to the date hereof and as may hereinafter from time to time be amended, (hereinafter all of the aforesaid are collectively referred to as "**Hazardous Materials Laws**"), respectively, relating to industrial hygiene, the environmental conditions on the Real Property and/or the presence, use, generation, manufacture, handling, storage, maintenance, treatment, release, spillage, discharge, emission, leakage, migration, transportation and/or disposal, and/or threatened release, spillage, discharge, emission, leakage, migration, transportation and/or disposal (as all the foregoing are and/or may hereafter be defined in any Hazardous Materials Law) of any and/or all pollutants, contaminants, particulates, gaseous emission, liquid and/or solid waste, hazardous and/or toxic waste, hazardous and/or toxic substances and/or hazardous and/or toxic material; of any and every nature whatsoever, including without limitation any substances now or hereafter defined as or included in the definition of pollutants, contaminants, particulates, gaseous

emission, liquid and/or solid waste, toxic and/or hazardous substances, wastes and/or materials (hereinafter collectively "**Hazardous Materials**") and/or any Hazardous Materials Laws, including specifically but not limited to all Hazardous Materials Laws governing and/or pertaining to infectious substances, flammable explosives, methane, hydrocarbons and/or like substances and their additives and/or constituents, radioactive materials, asbestos and/or asbestos containing materials in any form, radon, urea formaldehyde foam insulation, arsenic, mercury, mercury compounds, lead, lead compounds, other hazardous metallic substances and/or heavy and/or toxic metals, lead-based paint (*i.e.*, paint containing more than 0.5% lead by dry weight), tremolite, anthophyllite, actinolite, polychlorinated biphenyl compounds, chlorofluorocarbons, oil or petroleum or chemical distillates, products and/or by-products, pesticides, aboveground and/or underground storage tanks, and on the Surrender Date no condition shall exist at the Real Property, including the soil and ground water thereof, which, with the giving of Notice and/or passage of time, would and/or could constitute a violation of any Hazardous Material Law.

15. LESSEE'S ADDITIONAL COVENANTS, REPRESENTATIONS AND WARRANTIES: LESSOR'S RELIANCE. Lessee absolutely, unconditionally and irrevocably represents and warrants to Lessor:

A. Lessee is an Illinois limited liability company duly organized and validly existing and in good standing under the laws of the State of Illinois.

B. Lessee has full right and power to enter into, or perform his obligations under this Lease and has taken all requisite action to authorize the execution, delivery and performance of this Lease and has the full power and authority to lease the Premises and operate the repair facility. The execution and delivery of this Lease by Lessee is legally binding upon Lessee and no approval or consent of any person other than Lessee is necessary in connection with the performance by Lessee of his obligations hereunder or, if necessary, all consents shall be obtained by Lessee at his sole cost and expense and delivered to Lessor at or prior to Closing. All other agreements, certificates and instruments contemplated by this Lease to be executed and delivered by Lessee have been or will be, at or prior to the Commencement Date, duly executed and delivered by Lessee and constitute legal, valid and binding obligations of Lessee enforceable in accordance with their terms against Lessee. Neither the execution or delivery of this Lease nor the consummation of the transactions contemplated by Lessee will: (i) conflict with or constitute a violation or termination of any provision of any contracts and other agreements to which Lessee is a party or by which it is bound or to which its properties or assets are subject; or (ii) violate any law, regulation, judgment, rule, order, decree or any other restriction of any kind or character applicable to Lessee or any of his properties or assets.

C. Throughout the Term of this Lease, Lessee, at its sole cost and expense, will obey, observe and promptly comply with all present and future codes, statutes, laws, ordinances, orders, injunctions, decrees, writs, awards, rules, regulations and requirements, including but not limited to all Hazardous Materials Laws of any and all federal, state and/or municipal Governmental Authorities having jurisdiction over the Premises and/or the operation thereof as a licensed 111 skilled and/or intermediate care bed nursing home unconditionally certified for full participation in the Medicaid/Medicare programs, which may be applicable to the Personal Property and the nursing home and the Premises, including but not limited to wages, hours, hiring, retirement, promotions, working conditions, non-discrimination, health, safety, pensions, employee benefits, and including but not limited to the sidewalks, alleyways, passageways, vacant land, parking spaces, curb cuts and/or curbs adjoining the Demised Premises, whether or not such statute, code, law, ordinance, order, injunction, writ, award, decree, rule, regulation or requirement shall necessitate structural changes or improvements, and subject to Lessee's right to contest set forth herein and only in full accordance with the procedures, terms, provisions and conditions set forth therein for conducting said contest.

D. Lessee will not suffer any act to be done or any condition to exist on the Demised Premises which may be dangerous, including but not limited to the violation of any Hazardous Materials Law, or which may, in law, constitute a public or private nuisance or which may void or make voidable any insurance then in force on the Demised Premises, or increase the premium for any insurance on the Demised Premises.

E. Lessee shall likewise at its sole cost and expense observe and comply with the requirements of all policies of public liability and fire insurance and all other policies of insurance at any time in force with respect to the Demised Premises, notwithstanding that any policy may necessitate structural changes or improvements in any buildings, improvements or structures located on the Demised Premises.

F. Lessee shall promptly apply for and procure, and keep in good standing and in full force and effect, all necessary licenses, permits and certifications required by any and all Governmental Authorities having jurisdiction thereof for the purpose of maintaining and operating on the Premises a 111 skilled and/or intermediate bed nursing home which at all times shall be qualified to and shall participate in the Medicaid/Medicare reimbursement program.

G. Upon request of Lessor, Lessee will deliver or mail to Lessor wherever Rent is then paid, within Seven (7) calendar days of receipt thereof, copies of all exit interviews, inspection reports and surveys which may have an adverse affect on Lessee's licensure status and/or Medicare and/or Medicaid Certification, and administrative hearing and/or court action from all state, federal and local governmental bodies regarding the Demised Premises or the nursing home operated thereon. Without request, Lessee shall in all events notify a principal of Lessor, or if Lessor's principals are unavailable, Lessor's attorney, within Seven (7) calendar days after Lessee's receipt thereof of any and/or all of the following notices ("**Notices**") from any Governmental Authority: (i) any and all Notices of any State "A" level violation; (ii) any and all Notices of a repeat State "B" level violation; (iii) any and all Notices of "immediate jeopardy" and/or of "Substandard Quality of Care" (as defined by federal regulations, *i.e.*, deficiencies under 42 CFR 483.13, 483.15 and/or 483.25 with scope and severity levels of F, H, I, J, K or L); (iv) any and all Notices of conditional license; (v) any and all receipts of a conditional license; (vi) any and all Notices of revocation, termination, cancellation, surrender and/or of Non-renewal of any license; (vii) any and all Notices of intent to revoke, terminate, cancel, not renew and/or seek the surrender of any license; (viii) any and all Notices of conditional certification and/or intent to conditionally certify Lessee; (ix) any and all Notices of intent to terminate Lessee's participation in the Medicare and/or Medicaid programs; (x) any and all Notices of Lessee's termination of participation in the Medicare and/or Medicaid programs; (xi) any and all Notices of intent to decertify Lessee from participation in the Medicare and/or Medicaid programs; (xii) any and all Notices of decertification of Lessee's participation in the Medicare and/or Medicaid programs and/or the termination of any payments thereunder; (xiii) any and all Notices of intent to impose and/or the imposition of any Civil Monetary Penalty, and/or any fine in excess of \$5,000.00 in the aggregate for any survey cycle; (xiv) any and all Notices of intent to cease payment after a certain date for any new Medicaid and/or Medicare patients admitted after said date; (xv) any and all Notices of intent to place, and/or the placement of, a State Monitor in the Facility; and/or (xvi) any and all Notices to transfer and/or of intent to transfer any and/or all Medicaid/Medicare residents on and/or after a certain date. In addition, Lessee shall, simultaneously with their submission to the appropriate Governmental Authority, send to Lessor copies of: (a) any and all plans of correction for all violations giving rise to any and/or all Notices of which Lessee is required by this paragraph to notify Lessor; (b) any and all requests for informal dispute resolution and/or for hearings/contests referring to said Notices; and, (c) except as set forth otherwise in this Lease, within Seven (7) calendar days of their receipt by Lessee, all exit interviews and notices of violations referring to, relating to, pertaining to, arising out of and/or connected with any and all surveys in follow up to the original survey(s) giving rise to any and all aforesaid Notices and/or any follow-up survey thereto which failed to show substantial compliance with all codes, laws, statutes, ordinances, rules, regulations and/or standards governing the operation of the Facility and/or which failed to "close the survey cycle" and the final survey which "closes the survey cycle." Lessee shall at all times keep Lessor fully informed as to its progress in correcting and/or contesting any and all violations which gave rise to any and/or all aforesaid Notices, and Lessee's progress towards otherwise resolving all issues that might lead to any adverse consequence referred to in any aforesaid Notice.

H. Notwithstanding anything to the contrary contained elsewhere in this Lease, Lessee shall at all times and in all respects, at its own cost and expense, fully, timely and faithfully comply with and observe each and all of the conditions, covenants, and provisions, (except for delivery of information or documentation in Lessor's possession or control and except for those requiring payment of prime rent or principal and interest) required on the part of the Lessor under the Prime Lease, if any, Sale Contract, if any, Mortgage (and to any renewals, modifications, amendments, extensions, replacements, refinancings and/or consolidations thereof) and U.S. Department of Housing and Urban Development regulatory agreement, if any, (also a Superior Document) to which this Lease is subordinate or to which it later may become subordinate, including, without limitation, such conditions, covenants and provisions thereof as relate to the care, maintenance, repair, reserves, deposits, escrows, impounds, insurance, restoration, preservation, condemnation and/or transfer of the Demised Premises and/or Lessee and financial reports, notwithstanding that such conditions, covenants and provisions may require compliance and observance to a standard or degree in excess of and/or more burdensome and/or costly than that required by the provisions of this Lease, or may require performance not required by the provisions of this Lease, and shall not do or permit to be done anything which would constitute a breach

of or default under any obligation of the Lessor under any Superior Document, it being the intention hereof that Lessee shall comply with and observe each and all of such covenants, conditions and provisions of the Superior Document or any future superior document affecting the Demised Premises so that they will at all times be in good standing and there will not be any default on the part of the Lessor thereunder.

I. Upon Lessor's request, to the extent such statements are prepared by or for Lessee, within 120 calendar days after the end of each of its fiscal years, or such shorter time as the Superior Documents may require, Lessee shall furnish to Lessor full and complete financial statements of the operations of the Demised Premises and nursing home operated thereon for such annual fiscal period which shall be prepared by a Certified Public Accountant, and which shall contain a balance sheet and detailed income and expense statement (collectively called "*Financial Statements*") as of the end of the fiscal year. In addition, without request, Lessee shall, within Fourteen (14) calendar days following filing, furnish Lessor with a copy of its federal income tax return for the preceding year. Each such statement shall be certified as being true, accurate, correct and complete by an officer or general partner or manager of Lessee.

J. Upon Lessor's request not more frequently than semi-annually unless the Superior Documents requires more frequently, within Forty-Five (45) calendar days, or such shorter time as the Superior Document may require, after each second calendar quarter, Lessee shall furnish to Lessor copies of all Financial Statements for the preceding Two (2) calendar quarters, to the extent such Financial Statements are prepared by or for Lessee.

K. Notwithstanding anything to the contrary contained elsewhere herein, Lessee agrees at its own cost and expense to provide Lessor such financial information in such formats, at such time periods and certified by such persons as the Superior Interest Holders and/or any of them may require Lessor to provide it. Any such financial statement(s) or other information required by the terms of any Superior Document shall be furnished to Lessor not later than ten (10) business days prior to the due date for Lessor to furnish the same to such Superior Interest Holder.

L. At all times, Lessee shall keep and maintain true, accurate, correct and complete records and books of account of the operations of Lessee in the Demised Premises and records and books of account of the entire business operations of Lessee in accordance with generally accepted accounting principles. Upon request by Lessor, Lessee shall make available for inspection by Lessor, its designee and/or a Superior Interest Holder, during reasonable business hours, the said records and books of account covering the entire business operations of Lessee on the Demised Premises.

M. Lessee represents and acknowledges that: (i) Lessor has specifically relied on each and every one of the promises, covenants, agreements, representations, warranties, indemnities, guaranties, duties and obligations of Lessee set forth herein; (ii) that Lessee's promises, covenants, agreements, representations, warranties, indemnities and guaranties were knowingly made by Lessee to induce Lessor to enter into this Lease; (iii) that notwithstanding any due diligence on Lessor's part, Lessor's reliance was/is reasonable; (iv) that Lessee's promises, covenants, agreements, representations, warranties, indemnities, guaranties, duties and obligations are material; and (v) that but for the promises, covenants, agreements, representations, warranties, indemnities, guaranties, duties and obligations of Lessee Lessor would not have entered into this Lease. Lessee further represents that any due diligence of Lessor notwithstanding, no statement of fact made by or on behalf of Lessee in this Lease and/or in any exhibit and/or schedule hereto and/or any document, instrument and/or certificate delivered to Lessor pursuant hereto and/or in accordance and/or connection herewith contains any untrue statement of a material fact or omits to state any material fact necessary to make statements contained herein or therein not misleading.

16. **LESSOR'S REPRESENTATIONS.** Lessor represents and warrants to Lessee:

A. Owner is an Illinois land trust duly organized and validly existing and in good standing under the laws of the State of Illinois.

B. Lessor is an Illinois limited liability company duly organized and validly existing and in good standing under the laws of the State of Illinois.

C. Lessor has full right and power to enter into, or perform its obligations under this Lease and has taken all requisite action to authorize the execution, delivery and performance of this Lease and has the full power and authority to lease the Premises. This Lease and all other agreements contemplated to be executed and delivered by Lessor have been duly authorized by all necessary corporate action. The execution and delivery of this Lease by Lessor is legally binding upon Lessor and no approval or consent of any person other than Lessor is necessary in connection with the performance by Lessor of its obligations hereunder or, if necessary, all consents shall be obtained by Lessor at his sole cost and expense and delivered to Lessee at or prior to Closing. All other agreements, certificates and instruments contemplated by this Lease to be executed and delivered by Lessor have been or will be, at or prior to the Commencement Date, duly executed and delivered by Lessor and constitute legal, valid and binding obligations of Lessor enforceable in accordance with their terms against Lessor. Neither the execution or delivery of this Lease nor the consummation of the transactions contemplated by Lessor will: (i) conflict with or constitute a violation or termination of any provision of any contracts and other agreements to which Lessor is a party or by which it is bound or to which its properties or assets are subject; (ii) conflict with or violate the organizational documents of Lessor; or (iii) violate any law, regulation, judgment, rule, order, decree or any other restriction of any kind or character applicable to Lessor or any of its properties or assets.

D. On the Commencement Date, Lessor will deliver to Lessee: (i) all security deposits, if any; (ii) all payments in advance for services to be rendered after that date; and (iii) all trust fund records and all deposits of patients' trust funds in the possession of the Lessor which were received by Lessor on behalf of and for the personal use of patients who are in the nursing home operated on the Demised Premises together with a list of the patients and the amount thereof to which each of said patients is entitled. Lessor and Lessee shall comply with the provisions of 210 ILCS 45/2-201(12). Lessee will give or return such deposits to the patients from time to time when and as requested by such patients. Lessee hereby indemnifies Lessor from all claims and loss arising out of or in connection with such funds or the delivery thereof to Lessee arising after the Commencement Date. Lessor hereby indemnifies Lessee from all claims and losses arising out of or in connection with any disbursements of such funds on behalf of any patients prior to the Commencement Date. To the best of Lessor's actual knowledge (not including knowledge of its agents) it does not possess, hold or retain any security deposit from any Public Aid or Public Aid pending resident of the Facility.

17.1 LESSOR'S ACCOUNTS PAYABLE AND EMPLOYEE MATTERS. Lessor will pay when due (or defend against) all bills, obligations, indebtedness or other liability due, accrued or incurred arising in its operation and/or maintenance of the Demised Premises or the Facility through the Commencement Date, if any, to the extent they would be so paid by Lessor in the normal course of its business but for this Lease. All of the suppliers' and merchants' accounts payable for goods or services to be delivered or furnished after the Commencement Date shall be the obligation of and shall be paid by Lessee. In consideration for Lessee's assuming Lessor's liability for Lessor's Vacation, Holiday and Sick Pay Obligations, as defined in subparagraph 17.1(A) hereof, if any, Lessor will deliver to Lessee at the Commencement Date sufficient inventory and supplies, including but not limited to food, foodstuffs and medical supplies, to comply with the rules and regulations of the IDPH, which inventory and supplies shall be at no cost to Lessee.

A. As of the Closing Date, Lessee shall rehire and retain for not less than One Hundred Twenty (120) days no less than Sixty-Seven (67%) percent of the employees of the Facility (subject to Sixty-Seven (67%) percent of the employees accepting Lessee's offer of employment) who, as of the Closing Date: (i) work at the Facility and have been employed on average for Twenty (20) hours or more per week at the Facility; (ii) have worked at least Six (6) of the last immediately preceding Twelve (12) months at the Facility; and (iii) provide services solely to the Facility; or (iv) are on approved leave of absence (including, without limitation, maternity, disability, medical and non-medical leave); which offer shall be on substantially the same terms and conditions, including, without limitation, job responsibility, compensation and benefit terms and conditions. In calculating the average weekly hours worked for an employee, the period of time used shall be the shorter of the actual time the employee has been employed or the most recent Ninety (90) days. Such employees whose employment is continued shall be referred to as the "**Hired Employees.**" As of the Closing Date, all such employees, together with all hourly employees, if any, who, immediately prior to the Closing, were on layoff status from the Lessor from their employment at the Facility, shall be deemed to be the employees of Lessee and no longer to be the employees of Lessor. Notwithstanding the foregoing, except as set forth in subparagraph 17.1 (C) hereof, Lessee shall not have any liability or obligation under any benefit plan, if any, currently maintained by the Lessor for its employees; further provided, however, Lessee expressly acknowledges that

Lessee shall assume on behalf of Lessor and also pay when and as due, all accrued vacation, holiday, bonus, sick pay and severance obligations, including but not limited to all FICA, withholding, unemployment, workmen's compensation and/or other payroll and/or other taxes of any and every nature whatsoever related to and/or associated with any and/or all of the aforesaid vacation, holiday, bonus, sick and/or severance pay and which the employer is obligated to pay and/or withhold, owed (whether directly, or by assumption) by Lessor to employees of the nursing home as of the Closing Date (hereinafter all of the aforesaid are collectively called "**Lessor's Vacation, Holiday and Sick Pay Obligations**") that would otherwise be Lessor's liability, that may arise as a result of offers of employment to any employees of the Facility, who, from and after the Closing Date, shall become employees of the Lessee, and Lessee will indemnify, defend, save, protect, and hold harmless Lessor from and against all Claims, loss, cost or expense (including reasonable attorneys fees) which Lessor may incur by reason of the foregoing. Lessor shall at Lease closing deliver to Lessee a complete, true, accurate and correct list of all Lessor's Vacation, Holiday and Sick Pay Obligations, and all other employee records ("**Employee Records**"), including but not limited to employee applications, W-4's, I-9's and disciplinary reports. Notwithstanding that Lessee agrees to comply with paragraph 17.1(A), it will retain all employees in a new employee relationship on a probationary status for no less than 120 days with no obligation to retain these employees beyond the probationary term if in Lessee's sole judgment the employees are not suitable for Lessee's operation of the Facility. Lessor or any of its affiliates shall have the right to employ or offer to employ any employee or former employee whom Lessee terminates and/or who declines to continue employment with Lessee. Lessor does not hereby make any representation, warranty or guaranty as to the number of employees of the Facility who will agree to continued employment with Lessee, and Lessor shall have no liability with respect thereto whatsoever.

B. Lessee and Lessor acknowledge and agree that the provisions of subparagraph 17.1(A) hereof are designed solely to ensure that Lessor is not required to give notice to the employees of the Facility of the "closure" thereof under the Worker Adjustment and Retraining Notification Act (the "**WARN Act**") or under any applicable state law. Lessee agrees to indemnify, save, protect, defend and hold harmless Lessor from and against any and all Claims that Lessor may incur under the WARN Act and/or any comparable state law in the event of a violation by Lessee of its obligations under this Section, provided, however, that nothing herein shall be construed as imposing on Lessee any obligation to indemnify Lessor from any liability Lessor may incur under the WARN Act as a result of acts or omissions of Lessor prior to the Closing Date, including without limitation any liability that may result from the aggregation of acts of Lessor prior to the Closing Date and the acts of Lessee after the Closing Date, it being understood and agreed that Lessee shall only be liable for its own acts and/or omissions after the Closing Date. Nothing in subparagraph 17.1(A) shall, however, create any rights in favor of any person not a party hereto, including the employees of the Facility, or constitute an employment agreement or condition of employment for any employee of Lessor or any affiliate of Lessor.

C. It is the intention of the Lessee following the Closing Date to continue to conduct the business of the Facility at the present locations and otherwise substantially as it is currently being conducted. In the event that any of the Persons who are deemed to become employees of the Lessee pursuant to paragraph 17.1(A) should at any time thereafter become entitled to severance pay, notice pay and/or accrued but unused vacation or sick pay for any reason for the period following the Closing Date, Lessee shall be obligated to make such payments and shall indemnify Lessor for any and all costs or expenses incurred by Lessor in conjunction herewith.

D. As of the Closing Date, Lessee will take such action as may be necessary or appropriate to provide all employees health and welfare benefit plan coverage that is substantially similar to the coverage provided by Lessor as of the Closing Date and will provide such benefits so that Lessor will not be required by law to provide any benefits of any nature whatsoever to any of its former employees pursuant to Section 601, *et seq.* of the Employees' Retirement Income Security Act of 1974 ("**ERISA**") and Section 4980B of the Internal Revenue Code of 1988, as amended, ("**COBRA**"). As of the Closing Date, all active employees of Lessor: (i) who participate as of the Closing Date in group health insurance coverage sponsored by Lessor and (ii) who remain employees of Lessee after the Closing Date, shall be eligible for participation in Lessee's group health plan (as defined for purposes of Internal Revenue Code Section 4980B) in accordance with the terms and conditions of such plan and, subject to the requirements and restrictions of such group health plan which are beyond the control of Lessee, all such employees shall be covered without a waiting period and without regard to any pre-existing condition unless: (a) they are under a waiting period with Lessor as of the Closing Date, in which case they shall be required to complete their waiting period while under Lessee's group health plan; or (b) they were subject to a pre-existing condition exclusion while under Lessor's group health plan,

in which case they shall be subject to the same exclusion while in Lessee's group health plan, which exclusion shall, if applicable, be subject to the same time limitation while in Lessee's employ as was applicable thereto while said employees were in Lessor's employ, with the time limit calculated from the date the same commenced while in Lessor's employ. Lessor and Lessee acknowledge and agree that it is the intent of this provision that Lessor shall not be required to provide continued health coverage under ERISA or Section 4980B of the Internal Revenue Code to any of such employees of Lessee who are retained as of the Closing Date or to any qualified beneficiary (as defined for purposes of Section 4980B of the Internal Revenue Code) with respect to any such employees.

E. On the Closing Date, Lessee shall assume all liability (including, without limitation, all administrative functions) for any then existing and future worker's compensation obligations relating to all: (i) pending Claims, (ii) Claims made subsequent to the Closing Date in respect of incidents or conditions which occurred prior to the Closing Date by any present or former employee of Lessor in connection with their employment at the Facility; and (iii) Claims made subsequent to the Closing Date based on incidents or conditions arising subsequent to the Closing Date.

F. Lessor shall not have any obligation or liability subsequent to the Closing Date with respect to any plan providing benefits to present or former employees of the Facility.

17.2 LESSOR'S ACCOUNTS RECEIVABLE. The accounts receivable accrued, whether or not billed, at the time of the Commencement Date, shall be the property of and belong to the Lessor (hereinafter referred to as "*Lessor's Accounts Receivable*"). Lessee hereby agrees to send billing statements for Lessor's Accounts Receivable together with its own regular billing statements (but in no event less than once per month for a period of Six (6) months). Payments received by Lessee which are allocated to particular receivable and time period shall be applied in payment of the particular receivable and time period to which such payments are so allocated. Payments received by Lessee from patients owing money for services rendered by Lessor and Lessee, and which are not allocated to a particular time period shall be applied One-Half (½) to the payment of Lessor's Accounts Receivable for that particular patient and One-Half (½) to the payment of Lessee's account receivable for that particular patient. No later than the Fifteenth (15th) day following the end of the preceding month Lessee will give to Lessor a detailed accounting of payments received with respect to Lessor's Accounts Receivable. Lessee shall deliver to Lessor in kind, and within Four (4) business days after receipt, any checks which represent payment of only Lessor's Accounts Receivable. With respect to checks which include payment of both Lessor's Accounts Receivable and Lessee's accounts receivable, the portion attributable to Lessor's Accounts Receivable shall be paid to Lessor within Fifteen (15) calendar days after receipt of such amount by Lessee. Subject to the foregoing provisions, terms and conditions of this paragraph 17.2, Lessee agrees to reasonably cooperate with Lessor and Lessor's pursuit of any collection of its Accounts Receivable; provided, however, that Lessor hereby indemnifies and holds harmless Lessee from and against any and/or all costs, expenses and/or Rents, including but not limited to, attorneys' fees, Lessee may suffer and/or incur and referring to, relating to, arising out of and/or connected with Lessee's cooperation and Lessor's collection of its Accounts Receivable and agrees to reimburse Lessee therefor within Ten (10) business days of the date of Lessee's written demand on Lessor.

17.3 DEPOSITS AND TRUST FUNDS. On the Commencement Date, Lessor will deliver to Lessee: (i) all security deposits, if any; (ii) all payments in advance for services to be rendered after that date; and (iii) all trust fund records and all deposits of patients' trust funds in the possession of the Lessor which were received by Lessor on behalf of and for the personal use of patients who are in the nursing home operated on the Demised Premises together with a list of the patients and the amount thereof to which each of said patients is entitled. Lessor and Lessee shall comply with the provisions of 210 ILCS 45/2-201(12). Lessee will give or return such deposits to the patients from time to time when and as requested by such patients. Lessee hereby indemnifies Lessor from all claims and loss arising out of or in connection with such funds or the delivery thereof to Lessee arising after the Commencement Date. Lessor hereby indemnifies Lessee from all claims and losses arising out of or in connection with any disbursements of such funds on behalf of any patients prior to the Commencement Date. To the best of Lessor's actual knowledge (not including knowledge of its agents) it does not possess, hold or retain any security deposit from any Public Aid or Public Aid pending resident of the Facility.

17.4 PARTIES' DUTY UPON RECEIPT OF PAYMENTS. If any party receives a payment from the IDHFS for care of residents in the nursing home:

Medicaid and/or Medicare receivables received by it and otherwise then due and owing to Lessee until such time as Lessor has received full credit for the amount of said Recoupment, and in the event Lessee's receivables are insufficient to cover the amount of the Recoupment the balance remaining shall be additional damages owing from Lessee to Lessor for which Lessee hereby absolutely, unconditionally and irrevocably indemnifies, saves, protects, defends and holds harmless Lessor.

18.2 LESSOR'S INDEMNIFICATION. Lessor agrees to indemnify, defend, protect, save and hold harmless Lessee, its past, present and future managers, members, employees and agents, their heirs, executors, administrators, successors and assigns, from and against any and all Claims of any nature whatsoever which Lessee may suffer as a result of the material inaccuracy and/or breach of any representation and/or warranty of Lessor herein or given pursuant hereto or any Default by Lessor in the performance of any of its respective covenants, commitments or conditions under this Lease, or for any liability which may arise from the operation of the Property before the Commencement Date or possession date, if earlier, including but not limited to for injury to or death of person or loss of or damage to property, occurring on the Demised Premises or any adjoining sidewalks, streets or ways, or in any manner growing out of or connected with the use and occupation of the Demised Premises or the condition thereof, or the use of any existing or future sewer system, or the use of any adjoining sidewalks, streets or ways arising during the Terms of this Lease, and Lessor further agrees to pay any reasonable attorneys' fees and expenses incident to the defense by Lessee of any such Claims, the cause of which arose prior to the Commencement Date. Any and all Claims arising under the Medicaid and/or Medicare programs for period prior to the Commencement Date shall be the sole obligation of Lessor and shall, subject to Lessor's right to contest the same so long as Lessee may remain in the respective program and no sum is Recouped from Lessee during the period of such contest, be paid by Lessor and Lessee shall not be liable therefor. In the event that Medicaid and/or Medicare Recoups any and/or all sums (over)paid to Lessor for any period prior to the Commencement Date and said Recoupment is deducted from any payment paid or to be paid to Lessee and encompassing in whole and/or in part any period subsequent to the Commencement Date and Lessor fails or refuses to reimburse Lessee the amount of said Recoupment within Thirty (30) calendar days of Lessee's demand for the same, then Lessee shall be entitled to deduct the amount of said Recoupment from any and all Fixed Monthly Rent then due and owing or to become due and owing to Lessor in the future until such time as Lessee has received full credit for the amount of said Recoupment; provided, however, that in all events Lessee shall pay to Lessor as Rent in each month during which it is setting off the Recoupment amount a sum equal to the greater of the amount of any Prime Lease base rent, installment purchase price or any monthly Mortgage installment payment of principal and interest, and taxes and reserves Lessor must pay under any Superior Document in said month. There is expressly excluded from Lessor's indemnity hereunder any Claim or proceeding which is based upon any of the following: (i) the physical condition of the Demised Premises or Personal Property or any part thereof existing prior to the Commencement Date (excluding, however, accrued third party claims for personal injury); or (ii) any form of relief which is not fully satisfied by payment of money. Notwithstanding anything in the preceding sentence to the contrary, Lessor also agrees to indemnify and hold Lessee harmless from and against any Claim or liability arising under any environmental law which Claim or liability is based on acts, omissions and/or conditions occurring prior to the Commencement Date.

18.3 BED TAX. Lessor and Lessee hereby covenant, promise and agree, each to the other, that as between the parties Lessor shall be responsible for and shall pay promptly, before any penalty of any nature whatsoever attaches thereto, that portion of the State Provider Assessment Fee or [bed] tax (hereinafter "**Assessment**"), if any, due as a result of operations of the nursing home which is allocable to its operation prior to the Commencement Date, and Lessee shall pay promptly, before any penalty of any nature whatsoever attaches thereto, that portion which is allocable to its operations for the period of time after the Commencement Date, but, in the event of a termination of this Lease for any reason other than the exercise of the Option to Purchase, if any, Lessee shall not be liable for any Assessment for any period after the date of said termination of this Lease. In the event of any refund, reimbursement or other repayment (hereinafter collectively "**Repayment**") of any nature whatsoever from the State of Illinois of any portion of the State Assessment Fee or tax, that portion of said Repayment allocable to the period prior to the Commencement Date and which is received by Lessee shall be paid by Lessee to Lessor not later than Ten (10) calendar days after Lessee's receipt of said Repayment. Each party hereto indemnifies, defends, protects, saves and holds harmless the other party hereto from and against any and all Claims of the State of Illinois to recover, reclaim, recoup, recapture, withhold and/or set-off against sums owed to the other party any alleged underpayment of the Assessment by the said party during any period the said party was in possession of the Facility. Notwithstanding anything to the contrary contained elsewhere herein, no provision, term, condition, promise, agreement, covenant, duty and/or obligation of any party hereto shall be deemed,

interpreted and/or construed to be for the benefit of, and/or enforceable by, any third party, including but not limited to the State of Illinois, to this Lease.

18.4 INDEMNITIES CUMULATIVE; SURVIVAL. Notwithstanding anything to the contrary contained elsewhere herein, each and every indemnity set forth in this Lease, no matter where they are set forth herein, shall be cumulative and not mutually exclusive and shall be in addition to and not in lieu, place, stead, replacement and/or substitution of any other indemnity(ies) and/or remedy(ies) set forth elsewhere herein. Except as otherwise specifically set forth elsewhere herein, if at all, notwithstanding anything general to the contrary contained elsewhere herein, all Lessee's indemnities, no matter where they are set forth herein, shall absolutely, unconditionally and irrevocably survive the voluntary and/or involuntary Termination of this Lease for any and every reason whatsoever, including but not limited to the completion and execution of any Lease and Option Cancellation and Indemnity Agreement, for a period of 72 months following the Termination Date.

18.5 PROCEDURE. In the event any Claim ("*Indemnitee's Claim*") is made against and/or received by any Indemnitee, Indemnitee shall notify Indemnitor in writing within Twenty-One (21) calendar days of Indemnitee's receipt of written notice of said Indemnitee's Claim; provided, however, that Indemnitee's failure to timely notify Indemnitor of Indemnitee's receipt of an Indemnitee's Claim shall not impair, void, vitiate and/or invalidate Indemnitor's Indemnity hereunder nor release Indemnitor from the same, which duty, obligation and Indemnity shall remain valid, binding, enforceable and in full force and effect so long as Indemnitee's delay in notifying Indemnitor does not, solely by itself, directly and materially prejudice Indemnitor's right and/or ability to defend the Indemnified Claim, and, in said event, shall only be a defense for the specific Claim so prejudiced by Indemnitee's delay in notification and not for any other Claim. Upon their receipt of any and/or all Indemnitee's Claim(s) Indemnitor shall, in its discretion, diligently and vigorously defend, compromise and/or settle said Indemnitee's Claim at Indemnitor's sole and exclusive cost and expense and shall promptly provide Indemnitee written evidence thereof within Fourteen (14) calendar days of the final, unappealable resolution of said Indemnitee's Claim. Any and all final resolutions of an Indemnified Claim, other than by judgment, shall include a complete, general and unconditional release, waiver and satisfaction of any and all Claims claimant/plaintiff has and/or may have against any and/or all Indemnitees. Prior to the final, unappealable resolution of said Indemnitee's Claim, upon the receipt of the written request of Indemnitee, Indemnitor shall within Fourteen (14) calendar days provide Indemnitee a true, correct, accurate and complete written status report regarding the then current status of said Indemnitee's Claim and Indemnitor's efforts to resolve the same. In the event that Indemnitor fails or refuses: (i) to defend, compromise and/or settle the Indemnitee's Claim; and/or (ii) to diligently pursue the same to its conclusion, and/or to obtain a full, complete and unconditional general release, waiver and satisfaction of any and all Claims claimant/plaintiff has against any and/or all Indemnitees; and/or (iii) to timely report to Indemnitee, as aforesaid, the status of its efforts to reach a final resolution of any Indemnitee's Claim; and/or (iv) to indemnify, save, protect, defend and/or hold harmless Indemnitee from and/or against the Indemnitee's Claim; and/or (v) to timely pay Indemnitee and/or any claimant/plaintiff any sum due and owing hereunder; then on Seven (7) calendar days prior written notice to Indemnitors during which time Indemnitor may cure any alleged default hereunder, Indemnitor's failure to timely cure shall immediately, automatically and without further notice of any nature whatsoever be an Event of Default hereunder. Upon the occurrence of an Event of Default hereunder, Indemnitee may, but shall not be obligated to, immediately and without notice to Indemnitor (except such notice as may be required by law or rule of Court) intervene in and defend, settle, compromise and/or pay said Indemnitee's Claim at Indemnitor's sole and exclusive cost and expense, including but not limited to attorneys' fees. Thereafter, not later than Seven (7) calendar days after the date of written demand for the same (unless the original Event of Default was for the failure or refusal to pay Indemnitee and/or any claimant/plaintiff any sum due them, in which event no additional notice shall be necessary) Indemnitor shall reimburse Indemnitee all said Indemnitee's Claims and the reasonable costs, expenses and attorneys' fees incurred by Indemnitee to defend, settle, compromise and/or pay said Indemnitee's Claims, plus interest on any and all funds actually expended by Indemnitee to pay, settle, compromise and/or defend said Indemnified Claim at the annual rate equal to the Default Rate from the date of each and every said expenditure through and including the date of full and final reimbursement by Indemnitor. Notwithstanding anything to the contrary contained elsewhere herein, prior to Indemnitor's Event of Default under this Paragraph 18.5 Indemnitee may, at its option and at its own expense, but need not, participate in the defense of any Indemnified Claim; provided, however, Indemnitee shall not unreasonably interfere with and/or unduly delay Indemnitors' defense, compromise and/or settlement of the same so long as Indemnitor completely complies with and is in full accordance with all of the terms, provisions and conditions hereof, including specifically but not limited to those which provide for a general release of Indemnitee.

- (A) For any period prior to the Commencement Date such payment shall be promptly paid to Lessor;
- (B) For any period during the Term, such account shall be promptly paid to Lessee.

17.5 **INDEMNITY.** If and to the extent Lessee uses Lessor's IDHFS provider number for reimbursement of resident care at the facility Lessee agrees to indemnify, save, protect, defend and hold harmless Lessor from and against any and all loss, Claim or charges by the IDHFS for reimbursement for care for any period from and after the Commencement Date.

18.1 **LESSEE'S INDEMNIFICATION.** Lessee absolutely, unconditionally and irrevocably agrees to protect, indemnify, save, defend and hold harmless Lessor, its past, present and future managers, members, employees and agents, their heirs, executors, administrators, successors and assigns, from and against any and all tort, contract, common law and/or statutory actions, causes, causes of action, claims, damages, including but not limited to actual, compensatory, consequential, treble and/or punitive damages, debts, demands, injuries, lawsuits, suits (whether the foregoing are threatened or initiated), liabilities, liens, mechanics' and/or workmen's liens, encumbrances, financing statements, security agreements, security interests, losses, monies, sums, sums of money, interest, fines, CMP's (including but not limited to those commencing at any during the Term hereof and extending without interruption beyond the Term hereof), penalties, taxes, pro-rations, recaptures, recoveries, recoupments, repayments, set-offs, withholdings, accounts, bills, invoices, statements, bonds, reckonings, specialties, controversies, breaches, defaults, acts, omissions, specific performance and other injunctive relief, agreements, covenants, promises, representations, warranties, guaranties, indemnities, duties, obligations, variances, trespasses, fees, costs, expenses, judgments, attachments, garnishments, levies and/or executions, of any and every nature whatsoever, whether general and/or special, ordinary and/or extraordinary, direct and/or indirect, known and/or unknown, suspected and/or unsuspected, foreseen and/or unforeseen, whether liquidated, fixed and/or contingent, including but not limited to any and all rights of subrogation, contribution and/or indemnification, whether in law and/or in equity, judicial and/or administrative, including but not limited to attorneys fees, including specifically but not limited to attorneys' fees in any enforcement and/or collection action and/or in preparation therefor whether or not resulting in any litigation and/or in any bankruptcy (including but not limited to any proceeding to modify, lift, vacate, and/or dissolve any automatic stay) and/or appellate proceedings (hereinafter and hereinafter all of the aforesaid are collectively referred to as "Claims") which Lessor may suffer or incur as a result of the material inaccuracy of any representation and/or the breach of any term, provision, condition, duty, obligation, promise, agreement, covenant, representation and/or warranty of Lessee herein or given pursuant hereto or any Default by Lessee in the performance of any of its respective promises, agreements, covenants, commitments, warranties, representations, indemnities, guaranties, duties, obligations and/or terms, provisions and/or conditions under this Lease, or for any liability or Claim which may arise from the operation of the Property after the Commencement Date or possession date, if earlier, including but not limited to for employee benefits and/or injury to or death of persons or loss of or damage to property, occurring on the Demised Premises or any adjoining sidewalks, streets or ways, or in any manner growing out of or connected with the use and occupation of the Demised Premises or the condition thereof, or the use of any existing or future sewer system, or the use of any adjoining sidewalks, streets or ways arising during the Terms of this Lease, and Lessee further agrees to pay any reasonable attorneys' fees and expenses incident to the defense by Lessor of any such Claims. In addition, Lessee also, without limitation, specifically agrees in addition to absolutely, unconditionally and irrevocably save, defend, protect, indemnify and hold Lessor harmless from and against all Claims or liabilities arising under any Hazardous Material Law which Claim or liability is based on acts, omissions or conditions occurring after the Commencement Date. Furthermore, any and all Claims arising under the Medicaid and/or Medicare programs for periods after the Commencement Date shall be the sole obligation of Lessee and shall be paid by Lessee and Lessor shall not be liable therefor, and Lessee hereby indemnifies, defends, protects, saves and holds harmless Lessor from and against the same. In the event that after a termination of this Lease and/or Lessee's right to possession of the Demised Premises without terminating this Lease Medicare and/or Medicaid sets-off, recoups, recovers, recaptures and/or withholds (hereinafter "**Recoupment**") any and/or all sums, including but not limited to C-13 advances, (over)paid to Lessee for any period after the Commencement Date and prior to the date (hereinafter "**Surrender Date**") of Lessee's delivery of possession of the Demised Premises to Lessor and said Recoupment is deducted from any payment paid or to be paid to Lessor and/or subsequent lessee and encompassing in whole and/or in part any period prior to the Commencement Date and/or subsequent to the Surrender Date and Lessee fails or refuses to reimburse Lessor the amount of said Recoupment within Seven (7) calendar days of Lessor's demand for the same, then Lessor shall be entitled to deduct the amount of said Recoupment from any and all subsequent

Notwithstanding anything to the contrary contained elsewhere herein, neither the right to indemnity, nor the right of termination, nor the right to sue for damages, nor the right to injunctive relief nor any other right or remedy available to either party hereunder shall be exclusive of any other right or remedy given hereunder or now or hereafter existing at law or in equity, nor shall the pursuit of any particular right or remedy be deemed an election thereof, or be deemed, interpreted or construed to bar, prevent or preclude the simultaneous, contemporaneous, consecutive and/or successive exercise of any other remedy available hereunder or in law or equity.

19. **NON-LIABILITY OF LESSOR.** Notwithstanding anything to the contrary contained elsewhere herein, except only as provided by unwaivable and/or unmodifiable Illinois statute, Lessor shall not be liable to Lessee, and/or any of his employees, agents, independent contractors and/or invitees, for any damages of any and every nature whatsoever, including specifically but not limited to by failure of Lessor to keep the Property in repair, including but not limited to any and/or all damage done or occasioned by or from snow and/or ice, plumbing, gas, water, sprinkler, if any, steam or other pipes or sewerage, or the bursting, leaking or running of any pipes, tank or plumbing fixtures, and/or the interruption of any utility service. Lessee hereby acknowledges and agrees that it is solely and exclusively responsible for the maintenance and repair of the Property and hereby **WAIVES AND RELEASES** any and all Claims it might otherwise have against Lessor directly and/or indirectly referring to, relating to, pertaining to, stemming from, arising out of and/or connected therewith, and indemnifies, saves, defends, protects and holds harmless Lessor from and against all of the same.

20. **NOTICES.** All Notices hereunder shall be in writing, and shall be either: (a) personally delivered to the parties; (b) mailed to the parties by certified mail, return receipt requested, postage prepaid; or (c) sent by nationally recognized overnight delivery service, priority next business day delivery, billed to sender; at the address following their signatures to this Agreement with copies to their respective attorneys as set forth following their signatures. Notices which are personally delivered shall be deemed received on the date of delivery, notices sent by overnight delivery service shall be deemed received the next business day and notices sent by mail shall be deemed received on the Third (3rd) day after mailing (unless, in the case of overnight delivery or mail, proof of delivery shows earlier receipt or refusal in which case said date of receipt or refusal shall be deemed the date of receipt) except in each and every case if the day of receipt would be a Saturday, Sunday, national or Jewish holiday, the next business day shall be deemed the day of receipt; further provided, however, that the inability to deliver a notice due to the wrong address and/or the fact that an office was closed at the time of delivery shall not be deemed, interpreted and/or construed as the refusal of a delivery unless the party to whom said Notice was directed failed or refused to timely notify the other party hereto of a change in said party's address for Notice. Addresses for Notice may be changed by Notice to the other party given in accordance herewith. Each party hereto promises, covenants and agrees to promptly advise the other party hereto from time to time of any and all changes in said party's address for Notice not later than Ten (10) calendar days after an actual change in said party's address for Notice.

21. **COPIES.** Whenever, if at all, this Agreement provides for either party to deliver to the other party hereto a copy of any notice, report, certificate, document and/or instrument of any nature whatsoever, it shall be deemed, interpreted and construed to mean that the copy to be provided shall in all events and circumstances of any and every nature whatsoever be a legible, true, accurate, correct and complete copy of the original of said notice, report, certificate, document and/or instrument and so certified by the party required to provide said copy. No original nor any copy shall contain any untrue statement of a material fact, or omit to state any material fact necessary to make the statements contained therein not misleading.

22. **MODIFICATION.** This Agreement may not be amended, modified, changed or altered except in writing signed by the party against whom enforcement is sought.

23. **ENTIRE AGREEMENT.** Neither party hereto has made any promise, covenant, agreement, representation, warranty, indemnity or guaranty and/or assumed and/or undertaken any duty and/or obligation concerning the subject matter hereof except those expressly set forth in this Agreement. This Agreement contains the entire agreement between the parties concerning the subject matter hereof, and supersedes all prior negotiations and agreements between them concerning the subject matter hereof all of which are hereby merged herein.

24. **SEVERANCE.** In the event any term, provision and/or condition of this Agreement shall be declared invalid, null, void, non-binding and/or unenforceable it shall not affect the validity of any other term, provision and/or condition hereof, all of which shall remain valid, binding and legally enforceable.

25. **GOVERNING LAW.** This Agreement shall be governed and interpreted in accordance with the laws of the State of Illinois.

26. **SURVIVABILITY OF REPRESENTATIONS.** Notwithstanding anything to the contrary contained elsewhere herein, unless expressly and specifically set forth otherwise elsewhere herein, all of the representations, warranties, promises, covenants, guaranties and indemnities of Lessee contained in this Agreement shall be absolute, unconditional and irrevocable and shall survive the termination of this Agreement and the delivery and surrender of possession and control of the Property to Lessor for a period of One (1) year.

27. **BINDING NATURE.** This Agreement and the respective party's duties, obligations, promises, agreements, covenants, representations, warranties, indemnities, guarantees, rights and privileges hereunder shall be binding upon, and inure to the benefit of, each respective party's successors and assigns.

28. **CONSTRUCTION.** Each party to this Agreement has been ably represented by legal counsel of its own choosing and the terms, provisions and conditions hereof have been thoroughly negotiated by the parties hereto and reviewed by said counsel, and, therefore, this Agreement shall be deemed to have been drafted jointly by the parties hereto, and, the legal rule of contract construction and/or interpretation that any ambiguity in the terms, conditions and provisions of a document and/or instrument are construed and/or interpreted against the drafter thereof shall not apply to this Agreement and/or its construction and/or interpretation.

29. **SUBORDINATION AND ATTORNMENT.** This Lease is automatically subordinate to any and all mortgages which now or may hereafter affect the Property and to all extensions, amendments, renewals, modifications, consolidations, replacements, executions and/or re-financings thereof, provided, however that any such extensions, amendments, renewals, modifications, consolidations and/or re-financings do not require monthly payments thereon of principal and interest in excess of 95% of the monthly Rent payment required hereunder at the time it is executed. Lessee shall execute and deliver upon demand such amendments, and/or further instruments subordinating this Lease to any such liens or encumbrances, as shall be desired by Lessor and Lessor agrees to deliver to Lessee all documents pertaining to such Mortgage within Ten (10) calendar days of receipt by Lessee; provided, however, that such documents shall not affect any of the provisions of this Lease relating to the amount of the Fixed Monthly Rental, the purposes for which the Demised Premises may be used, the size and/or location of the Demised Premises, the duration and/or commencement date of the Lease Term, nor modify any representations, covenants or warranties, if any, made by Lessor. Lessee shall within Ten (10) calendar days of demand execute and deliver to Lessor an estoppel letter stating that the Lease is in full force and effect, that there are not any defaults thereunder by Lessor or Lessee or describing said alleged defaults and all steps being taken to cure the same, and that no Rent has been prepaid more than One (1) month in advance. In the event of any (re)financing Lessor shall use its reasonable best efforts to obtain from its lender on behalf of Lessee a customary non-disturbance and attornment agreement, but Lessor's failure to obtain such an agreement shall not be a Default by Lessor hereunder or bar, prevent or preclude it from entering into any mortgage against the Demised Premises which otherwise complies with the terms and conditions of this paragraph 29. Lessee covenants and agrees that, if by reason of a default upon the part of the Lessor herein in the performance of any of the terms and conditions of any Superior Document, and the estate of the Lessor thereunder is terminated by summary dispossession proceedings or otherwise, upon written request Lessee will promptly attorn to and recognize the Superior Interest Holder under the Superior Document as the Lessor under this Lease. Lessee covenants and agrees to execute and deliver, at any time and from time to time, upon the request of Lessor, the Superior Interest Holder or other appropriate party, any instrument which may be necessary or appropriate to evidence such attornment.

30. **TIME IS OF THE ESSENCE.** Time is of the essence of this Agreement and each and every term, condition, provision, representation, warranty, guaranty, indemnity, duty and obligation contained herein.

31. **MISCELLANEOUS.** *If, but only if, required by law, it shall in all events be a condition precedent of both Lessor's and Lessee's obligations hereunder, respectively, that the HFPB first grant its permission, approval*


and consent to the transaction contemplated herein and issue an exemption to Lessee from the requirement of obtaining a CON, or that it grant and/or issue said CON, if required by law. In the event that HFPB fails and/or refuses to grant its consent and/or approval to this transaction, this Lease shall terminate in accordance with the terms and conditions hereof, and thereafter this Lease shall be invalid, non-binding, unenforceable, and null and void, ab initio and the parties agree to take all steps necessary, if any, to unwind this transaction, and thereafter, except for any surviving indemnities, neither party hereto shall any further duty, obligation and/or liability hereunder to the other party hereto all of which shall be null, void, invalid, non-binding and unenforceable.

32. **COUNTERPARTS.** This Agreement may be executed in several counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. In addition, this Agreement may contain more than one counterpart of the signature page and this Agreement may be executed by affixing of the signatures of each of the parties to one or more of such counterpart signature pages; all of such counterpart signature pages shall be read as though one, and they shall have the same force and effect as though all of the signers had signed a single signature page. The parties hereto expressly acknowledge that this Agreement may be transmitted by facsimile machine for execution and that a facsimile copy and/or any photocopy of a facsimile copy of the signature of any party shall be a valid, binding and enforceable signature of said party as if it were an original signature of said party; and it shall not be a defense to the enforcement of any party's covenants hereunder that the other party hereto does not possess an original signature of the party against whom enforcement of this Agreement is sought.

IN WITNESS WHEREOF, the parties hereto state that they have read and understand this Agreement, and that they have knowingly, intelligently, voluntarily, freely, without force, coercion or duress or the threat thereof, and without undue influence and with advice of counsel of their own choosing and a full understanding of the meaning and consequences hereof and the intent to be legally and validly bound by the same and that the same be fully enforceable against each of them in accordance with its terms executed this Agreement this 15th day of October, 2007 for the purposes set forth herein.


LESSOR:

MCALLISTER PROPERTIES, LLC,
an Illinois Limited Liability Company

By: 
an authorized Manager

LESSEE:

MCALLISTER NURSING & REHAB,
LLC, an Illinois Limited Liability Company

By: 
an authorized Manager

Address for Notices:

MCALLISTER PROPERTIES, LLC,
9777 Greenwood
Niles, IL 60714

MCALLISTER NURSING & REHAB, LLC,
9777 Greenwood
Niles, IL 60714

Copy to:

Lawrence Y. Schwartz
8170 N. McCormick Blvd, Ste 219
Skokie, IL 60076
Fax #: (847) 679-2011

Lawrence Y. Schwartz
8170 N. McCormick Blvd., Ste 219
Skokie, IL 60676
Fax #: (847) 679-2011

ATTACHMENT-41 FINANCIAL VIABILITY RATIOS

MCALLISTER PROPERTY, LLC
HISTORICAL AND FORECASTED VIABILITY RATIOS WORKSHEET
LTC FACILITY OWNER

	2008	2009	2010	2015
<u>CURRENT RATIO</u>				
1. CURRENT ASSETS	\$1,241,315	\$1,311,309	\$1,690,975	\$360,325
2. CURRENT LIABILITIES	\$1,181,555	\$592,044	\$536,199	\$600,647
3. CURRENT RATIO (LINE 1 DIVIDED BY LINE 2)	1.05	2.21	3.15	0.60
<u>NET MARGIN PERCENTAGE</u>				
4. NET INCOME OR (LOSS)	-\$190,711	-\$278,291	\$8,597	-\$513,024
5. NET OPERATING REVENUE	\$245,240	\$352,846	\$515,610	\$2,318,741
6. NET MARGIN PERCENTAGE (LINE 4 DIVIDED BY LINE 5)	-77.77%	-78.87%	1.67%	-22.13%
<u>DEBT SERVICE COVERAGE RATIO</u>				
7. NET INCOME(LOSS)+DEPR+ INTEREST+AMORTIZATION	\$242,708	\$349,314	\$513,170	\$2,006,741
8. PRINCIPAL + INTEREST	\$249,996	\$213,984	\$205,116	\$1,994,741
9. DEBT SERVICE COVERAGE RATIO (LINE 7 DIVIDED BY LINE 8)	0.97	1.63	2.50	1.01
<u>DEBT CAPITALIZATION RATIO</u>				
10. LONG TERM DEBT	\$4,600,000	\$4,600,000	\$4,600,000	\$26,262,526
11. LONG TERM DEBT + EQUITY	\$4,409,289	\$4,739,674	\$4,748,271	\$26,857,137
12. DEBT CAPITALIZATION RATIO (LINE 10 DIVIDED BY LINE 11)	104%	97%	97%	98%
<u>DAYS CASH</u>				
13. CASH AND INVESTMENTS	\$1,241,315	\$1,311,309	\$1,540,975	\$210,325
14. OPER EXPENSE LESS DEPR/365	\$683.00	\$700.00	\$673.00	\$5,739
15. DAYS CASH ON HAND(LINE13/LI	1817	1873	2290	37
<u>CUSHION RATIO</u>				
16. CASH AND INVESTMENTS	\$1,241,315	\$1,311,309	\$1,540,975	\$210,325
17. MAX ANNUAL DEBT SER	\$249,996	\$213,984	\$205,116	\$1,994,741
18. CUSHION (LINE 16/LINE 17)	4.97	6.13	7.51	0.11

MCELLISTER NURSING & REHAB, LLC
HISTORICAL AND FORECASTED VIABILITY RATIOS WORKSHEET
200 BED LONG-TERM CARE FACILITY OPERATOR

	2008	2009	2010	2015
<u>CURRENT RATIO</u>				
1. CURRENT ASSETS	\$1,790,953	\$1,919,599	\$1,828,802	\$6,390,983
2. CURRENT LIABILITIES	\$1,927,182	\$2,073,318	\$1,790,580	\$2,032,998
3. CURRENT RATIO (LINE 1 DIVIDED BY LINE 2)	0.93	0.93	1.02	3.14
<u>NET MARGIN PERCENTAGE</u>				
4. NET INCOME OR (LOSS)	\$97,248	\$153,603	\$409,401	\$1,288,384
5. NET OPERATING REVENUE	\$4,696,449	\$4,997,798	\$5,826,839	\$12,820,625
6. NET MARGIN PERCENTAGE (LINE 4 DIVIDED BY LINE 5)	2.07%	3.07%	7.03%	10.05%
<u>DEBT SERVICE COVERAGE RATIO</u>				
NET INCOME(LOSS)+DEPR+				
7. INTEREST+AMORTIZATION	\$186,080	\$264,472	\$518,073	\$1,471,884
8. PRINCIPAL + INTEREST	\$34,436	\$160,032	\$86,114	\$120,000
9. DEBT SERVICE COVERAGE RATIO (LINE 7 DIVIDED BY LINE 8)	5.4	1.7	6.0	12.3
<u>DEBT CAPITALIZATION RATIO</u>				
10. LONG TERM DEBT	\$0	\$0	\$52,717	\$0
11. LONG TERM DEBT + EQUITY	\$104,474	\$124,760	\$528,793	\$4,785,056
12. DEBT CAPITALIZATION RATIO (LINE 10 DIVIDED BY LINE 11)	0.00%	0.00%	9.97%	0.00%
<u>DAYS CASH</u>				
13. CASH AND INVESTMENTS	\$33,516	\$52,746	\$23,917	\$4,586,098
14. OPER EXPENSE LESS DEPR/365	\$12,490	\$13,188	\$14,712	\$31,421
15. DAYS CASH ON HAND(LINE13/LI	2.7	4.0	1.6	146.0
<u>CUSHION RATIO</u>				
16. CASH AND INVESTMENTS	\$33,516	\$52,746	\$23,917	\$4,586,098
17. MAX ANNUAL DEBT SER	\$34,436	#REF!	\$86,114	\$120,000
18. CUSHION (LINE 16/LINE 17)	1.0	#REF!	0.3	38.2

COMBINED McALLISTER ENTITIES
HISTORICAL AND FORECASTED VIABILITY RATIOS WORKSHEET
200 BED LONG-TERM CARE FACILITY-OWNER AND OPERATOR

	2008	2009	2010	2015
<u>CURRENT RATIO</u>				
1. CURRENT ASSETS	\$3,032,268	\$3,230,908	\$3,519,777	\$6,400,375
2. CURRENT LIABILITIES	\$3,108,737	\$2,665,362	\$2,326,779	\$2,282,712
3. CURRENT RATIO (LINE 1 DIVIDED BY LINE 2)	0.98	1.21	1.51	2.80
<u>NET MARGIN PERCENTAGE</u>				
4. NET INCOME OR (LOSS)	-\$93,463	-\$124,688	\$417,998	\$775,360
5. NET OPERATING REVENUE	\$4,716,682	\$5,027,565	\$5,836,565	\$12,820,625
6. NET MARGIN PERCENTAGE (LINE 4 DIVIDED BY LINE 5)	-1.98%	-2.48%	7.16%	6.05%
<u>DEBT SERVICE COVERAGE RATIO</u>				
NET INCOME(LOSS)+DEPR+				
7. INTEREST+AMORTIZATION	\$428,785	\$613,786	\$1,031,243	\$3,478,625
8. PRINCIPAL + INTEREST	\$284,432	\$374,016	\$291,230	\$1,902,566
9. DEBT SERVICE COVERAGE RATIO (LINE 7 DIVIDED BY LINE 8)	1.5	1.6	3.5	1.8
<u>DEBT CAPITALIZATION RATIO</u>				
10. LONG TERM DEBT	\$4,600,000	\$4,600,000	\$4,652,717	\$26,262,526
11. LONG TERM DEBT + EQUITY	\$4,513,763	\$4,864,434	\$5,277,064	\$31,426,358
12. DEBT CAPITALIZATION RATIO (LINE 10 DIVIDED BY LINE 11)	102%	95%	88%	84%
<u>DAYS CASH</u>				
13. CASH AND INVESTMENTS	\$1,274,831	\$1,364,055	\$1,564,892	\$4,796,423
14. OPER EXPENSE LESS DEPR/365	\$13,173	\$13,888	\$15,385	\$30,807
15. DAYS CASH ON HAND(LINE13/L	97	98	102	156
<u>CUSHION RATIO</u>				
16. CASH AND INVESTMENTS	\$1,274,831	\$1,364,055	\$1,564,892	\$4,796,423
17. MAX ANNUAL DEBT SER	\$284,432	\$374,016	\$291,230	\$1,902,566
18. CUSHION (LINE 16/LINE 17)	4.5	3.6	5.4	2.5

MC ALLISTER PROPERTY, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2010

Krupnick Bokor Kagda & Brooks, Ltd.
Certified Public Accountants
3750 W Devon Ave
Lincolnwood, IL 60712

INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

McAllister Property, LLC
18300 S. Lavergne Avenue
Tinley Park, IL 60477

To The Members,

We have compiled the accompanying statement of assets, liabilities, and member's equity-income tax basis of McAllister Property, LLC (a partnership) as of December 31, 2010, and the related statement of revenues and expenses-income tax basis for the year then ended. We have not audited or reviewed the accompanying financial statements and, accordingly, do not express an opinion or provide any assurance about whether the financial statements are in accordance with the income tax basis of accounting.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the income tax basis of accounting and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the compilation in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form of financial statements without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial statements.

Management has elected to omit substantially all of the disclosures ordinarily included in financial statements prepared in accordance with the income tax basis of accounting. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's assets, liabilities, equity, revenues, and expenses. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Respectfully submitted,

Krupnick, Bokor, Kagda & Brooks, Ltd.
Certified Public Accountants

April 1, 2011

MC ALLISTER PROPERTY, LLC
STATEMENT OF ASSETS, LIABILITIES AND EQUITY-INCOME TAX BASIS
DECEMBER 31, 2010

ASSETS

CURRENT ASSETS:

CASH AND CASH EQUIVALENTS	\$ 1,540,975	
LOANS & EXCHANGES	150,000	
TOTAL CURRENT ASSETS		\$ 1,690,975

PROPERTY AND EQUIPMENT:

LAND	726,776	
BUILDING	2,907,102	
IMPROVEMENTS	102,302	
EQUIPMENT	650,000	
FURNISHINGS	92,443	
TOTAL COST	4,478,623	
LESS: ACCUMULATED DEPRECIATION	(823,704)	
NET PROPERTY & EQUIPMENT		3,654,919

OTHER ASSETS:

DEFERRED LOAN COSTS	44,103	
LESS: AMORTIZATION	(40,428)	
GOODWILL	350,000	
LESS: AMORTIZATION	(64,166)	
TOTAL OTHER ASSET		289,509

TOTAL ASSETS		\$ 5,635,403
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LIABILITIES AND MEMBERS' EQUITY

CURRENT LIABILITIES:

ACCRUED INTEREST	\$ 16,128	
ACCRUED EXPENSES	6,750	
DUE TO OPERATIONS	350,933	
NOTE PAYABLE- 1ST EQUITY # 816245	513,321	
TOTAL CURRENT LIABILITIES		\$ 887,132

LONG-TERM DEBT:

MORTGAGE PAYABLE	4,600,000	
TOTAL LONG-TERM DEBT		4,600,000

MEMBERS' EQUITY

MEMBERS' CAPITAL-BEGINNING	139,674	
NET INCOME FOR THE PERIOD	8,597	
TOTAL MEMBERS' EQUITY		148,271

TOTAL LIABILITIES AND MEMBERS' EQUITY		\$ 5,635,403
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See Accountants' Compilation Report

MC ALLISTER PROPERTY, LLC
STATEMENT OF REVENUES AND EXPENSES-INCOME TAX BASIS

	<u>YEAR ENDED</u>	
	<u>DECEMBER 31, 2010</u>	
	<u>AMOUNT</u>	<u>PCT</u>
REVENUES		
RENTAL INCOME	\$ 505,884	98.1
INTEREST INCOME	9,726	1.9
TOTAL REVENUES	515,610	100.0
OPERATING EXPENSES:		
AMORTIZATION- LOAN COSTS	14,701	2.9
AMORTIZATION- GOODWILL	23,333	4.5
BANK CHARGES	6	-
DEPRECIATION	261,423	50.7
INTEREST-MORTGAGE	174,896	33.9
INTEREST- FIRST EQUITY BANK #816245	30,220	5.9
LICENSES & PERMITS	1,684	0.3
PROFESSIONAL FEES	750	0.1
TOTAL EXPENSES	507,013	98.3
NET INCOME (LOSS)	\$ 8,597	1.7

See Accountants' Compilation Report

MC ALLISTER PROPERTY, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2009

Krupnick Bokor Kagda & Brooks, Ltd.
Certified Public Accountants
3750 W Devon Ave
Lincolnwood, IL 60712

McAllister Property, LLC

Niles, IL 60626-1418

To The Members:

We have compiled the accompanying balance sheet of McAllister Property, LLC (a limited liability company) as of December 31, 2009, and the related statement of income for the year then ended, and the accompanying supplementary information, which is presented only for supplementary analysis purposes, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of financial statements and supplementary schedules information that is the representation of management. We have not audited or reviewed the accompanying financial statements and supplementary schedules and, accordingly, do not express an opinion or any other form of assurance on them.

Management has elected to omit substantially all of the disclosures and the statement of cash flows required by generally accepted accounting principles. If the omitted disclosures and statement of cash flows were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements and supplementary schedules are not designed for those who are not informed about such matters.

The accompanying financial statements do not include a provision of liability for federal income taxes because the members are taxed individually on their share of earnings.

April 12, 2010

MC ALLISTER PROPERTY, LLC
STATEMENT OF ASSETS, LIABILITIES AND EQUITY-INCOME TAX BASIS
DECEMBER 31, 2009

ASSETS

CURRENT ASSETS:

CASH AND CASH EQUIVALENTS	\$ 1,311,309	
TOTAL CURRENT ASSETS		\$ 1,311,309

PROPERTY AND EQUIPMENT:

LAND	726,776	
BUILDING	2,907,102	
IMPROVEMENTS	92,105	
EQUIPMENT	650,000	
FURNISHINGS	82,104	
TOTAL COST	4,458,087	
LESS: ACCUMULATED DEPRECIATION	(562,281)	
NET PROPERTY & EQUIPMENT		3,895,806

OTHER ASSETS:

DEFERRED LOAN COSTS	44,103	
LESS: AMORTIZATION	(25,727)	
GOODWILL	350,000	
LESS: AMORTIZATION	(40,833)	
TOTAL OTHER ASSEST		327,543

TOTAL ASSETS		\$ 5,534,658
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LIABILITIES AND MEMBERS' EQUITY

CURRENT LIABILITIES:

ACCRUED INTEREST	\$ 18,226	
ACCRUED EXPENSES	29,497	
DUE TO OPERATIONS	202,940	
NOTE PAYABLE- 1ST EQUITY # 816245	546,321	
TOTAL CURRENT LIABILITIES		\$ 794,984

LONG-TERM DEBT:

MORTGAGE PAYABLE	4,600,000	
TOTAL LONG-TERM DEBT		4,600,000

MEMBERS' EQUITY

MEMBER'S CAPITAL-BEGINNING	(190,711)	
MEMBER'S CAPITAL CONTRIBUTED	608,676	
NET LOSS FOR THE PERIOD	(278,291)	
TOTAL MEMBERS' EQUITY		139,674

TOTAL LIABILITIES AND MEMBERS' EQUITY		\$ 5,534,658
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See Accountants' Compilation Report

MC ALLISTER PROPERTY, LLC
STATEMENT OF REVENUES AND EXPENSES-INCOME TAX BASIS

	<u>YEAR ENDED</u>	
	<u>DECEMBER 31, 2009</u>	
	<u>AMOUNT</u>	<u>PCT</u>
REVENUES		
RENTAL INCOME	\$ 322,875	91.5
INTEREST INCOME	29,971	8.5
TOTAL REVENUES	352,846	100.0
 OPERATING EXPENSES:		
AMORTIZATION- LOAN COSTS	14,701	4.2
AMORTIZATION- GOODWILL	23,333	6.8
BANK CHARGES	32	-
DEPRECIATION	375,587	108.4
INTEREST-MORTGAGE	180,781	51.2
INTEREST- FIRST EQUITY BANK #816245	33,223	9.4
PROFESSIONAL FEES	3,500	1.0
TOTAL EXPENSES	631,137	178.9
 NET INCOME (LOSS)	 \$ (278,291)	 (78.9)

See Accountants' Compilation Report

MC ALLISTER PROPERTY, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2008

MC ALLISTER PROPERTY, LLC
STATEMENT OF ASSETS, LIABILITIES AND EQUITY-INCOME TAX BASIS
DECEMBER 31, 2008

ASSETS

CURRENT ASSETS:

CASH AND CASH EQUIVALENTS	\$ 1,241,315	
TOTAL CURRENT ASSETS		\$ 1,241,315

PROPERTY AND EQUIPMENT:

LAND	726,776	
BUILDING	2,907,102	
EQUIPMENT	650,000	
TOTAL COST	4,283,878	
LESS: ACCUMULATED DEPRECIATION	(186,694)	
NET PROPERTY & EQUIPMENT		<u>4,097,184</u>

OTHER ASSETS:

DEFERRED LOAN COSTS	44,103	
LESS: AMORTIZATION	(11,026)	
GOODWILL	350,000	
LESS: AMORTIZATION	(17,500)	
TOTAL OTHER ASSET		<u>365,577</u>

TOTAL ASSETS

\$ 5,704,076

LIABILITIES AND MEMBERS' EQUITY

CURRENT LIABILITIES:

ACCRUED INTEREST	\$ 14,397	
ACCRUED EXPENSES	2,500	
DUE TO OPERATIONS	113,232	
DUE TO MEMBERS	582,337	
NOTE PAYABLE- 1ST EQUITY # 816245	582,321	
TOTAL CURRENT LIABILITIES		\$ 1,294,787

LONG-TERM DEBT:

MORTGAGE PAYABLE	4,600,000	
TOTAL LONG-TERM DEBT		4,600,000

MEMBERS' EQUITY

NET LOSS FOR THE PERIOD	(190,711)	
TOTAL MEMBERS' EQUITY		<u>(190,711)</u>

TOTAL LIABILITIES AND
MEMBERS' EQUITY

\$ 5,704,076

See Accountants' Compilation Report

MC ALLISTER PROPERTY, LLC
STATEMENT OF REVENUES AND EXPENSES-INCOME TAX BASIS

	<u>YEAR ENDED</u>	
	<u>DECEMBER 31, 2008</u>	
	<u>AMOUNT</u>	<u>PCT</u>
REVENUES		
RENTAL INCOME	\$ 225,007	91.7
INTEREST INCOME	20,233	8.3
TOTAL REVENUES	245,240	100.0
OPERATING EXPENSES:		
AMORTIZATION- LOAN COSTS	11,026	4.5
AMORTIZATION- GOODWILL	17,500	7.1
DEPRECIATION	186,694	76.1
INTEREST-MORTGAGE	187,702	76.5
INTEREST- FIRST EQUITY BANK #816245	30,494	12.4
OFFICE EXPENSES	35	-
PROFESSIONAL FEES	2,500	1.0
TOTAL EXPENSES	435,951	177.8
NET INCOME (LOSS)	\$ (190,711)	(77.8)

See Accountants' Compilation Report

McAllister Property, LLC

**PROJECTED
YR 2**

Rent Income	1,800,000
Interest Income	
Income	
Operating exp	
G &A	2,500
Capital charges	2,008,372
Other (inc)Exp	
Total Exp	<u>2,010,872</u>
Net Inc	(210,872)
Depn	713,866
Interest	1,271,173
Amort	23,333
Mgt Fees	
Rent	
R/E/Tx	
Capital charges	2,008,372

Krupnick Bokor Kagda & Brooks, Ltd.
Certified Public Accountants
3750 W Devon Ave
Lincolnwood, IL 60712

INDEPENDENT ACCOUNTANT'S COMPILATION REPORT

McAllister Nursing & Rehab, LLC
18300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

To The Members,

We have compiled the accompanying balance sheet of McAllister Nursing & Rehab, LLC as of December 31, 2010, and the related statement of income for the year then ended and the accompanying supplementary schedules which are presented only for supplementary analysis purposes. We have not audited or reviewed the accompanying financial statements and supplementary schedules and, accordingly, do not express an opinion or provide any assurance about whether the financial statements and supplementary schedules are in accordance with accounting principles generally accepted in the United States of America.

Management is responsible for the preparation and fair presentation of the financial statements and supplementary schedules in accordance with accounting principles generally accepted in the United States of America and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements and supplementary schedules.

Our responsibility is to conduct the compilation in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form of financial statements and supplementary schedules without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial statements and supplementary schedules.

Management has elected to omit substantially all of the disclosures and the statement of cash flows required by accounting principles generally accepted in the United States of America. If the omitted disclosures and statement of cash flows were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

Accounting principles generally accepted in the United States of America require the primary beneficiary of a variable interest entity to consolidate the variable interest entity in its financial statements. Management has informed us that the Company's financial statements do not include the accounts of variable interest entities in which the Company holds a variable interest and is the primary beneficiary. The effect of this departure from accounting principles generally accepted in the United States of America on the financial position, results of operations, and cash flows have not been determined.

Respectfully submitted,

Krupnick, Bokor, Kagda & Brooks, Ltd.
Certified Public Accountants

April 1, 2011

McALLISTER NURSING & REHAB, LLC
18300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

TABLE OF CONTENTS

BALANCE SHEET	EXHIBIT "A"
STATEMENT OF INCOME & EXPENSE	EXHIBIT "B"
SCHEDULE OF INCOME	SCHEDULE "B-1"
SCHEDULE OF OPERATING EXPENSES	SCHEDULE "B-2"
SCHEDULE OF ADMINISTRATIVE EXPENSES	SCHEDULE "B-3"
SCHEDULE OF OTHER INCOME (EXPENSE)	SCHEDULE "B-4"
SCHEDULE OF CAPITAL CHARGES	SCHEDULE "B-5"
SCHEDULE OF SALARIES	SCHEDULE "B-6"

McALLISTER NURSING & REHAB, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2010

McALLISTER NURSING & SENIOR, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2010

ASSETS

CURRENT ASSETS

CASH AND CASH EQUIVALENTS	\$ 23,917	
ACCOUNTS RECEIVABLE - PATIENTS	428,646	
LESS: ALLOWANCE FOR BAD DEBTS	(35,000)	
DUE FROM AFFILIATES	1,191,130	
PREPAID EXPENSES	<u>220,109</u>	
TOTAL CURRENT ASSETS		\$ 1,828,802

PROPERTY AND EQUIPMENT:

LEASEHOLD IMPROVEMENTS	4,517	
FURNITURE & EQUIPMENT	130,408	
COMPUTER SOFTWARE	41,960	
VEHICLES	<u>72,755</u>	
TOTAL COST	249,640	
LESS: ACCUMULATED DEPRECIATION	<u>(160,588)</u>	
NET PROPERTY & EQUIPMENT		89,052

OTHER ASSETS

DEVELOPMENTAL COSTS	28,086	
DUE FROM McALLISTER PROPERTIES	350,933	
SECURITY DEPOSITS	<u>22,500</u>	
TOTAL OTHER ASSET		<u>401,519</u>
TOTAL ASSETS		<u>\$ 2,319,373</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHAB, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2010

LIABILITIES AND EQUITY

CURRENT LIABILITIES

ACCOUNTS PAYABLE-TRADE	\$ 628,381	
ACCOUNTS PAYABLE-INSURANCE	200,021	
ACCRUALS:		
OPERATING EXPENSES	\$ 5,711	
PAYROLL	126,650	
REAL ESTATE TAXES	317,527	
LICENSE FEE	15,318	
SALES TAX	<u>1,342</u>	
		466,548
PAYROLL TAXES PAYABLE		35,269
UNION DUES PAYABLE		4,990
NOTE PAYABLE-FIRST MERIT		440,055
EMPLOYEE WAGE ASSIGNMENTS		2,590
PATIENT PERSONAL FUNDS		<u>12,726</u>
TOTAL CURRENT LIABILITIES		\$ 1,790,580

LONG-TERM DEBT:

NOTE PAYABLE- INFINITI FINANCIAL SERVICES	<u>52,717</u>	
TOTAL LONG-TERM DEBT		52,717

EQUITY

MEMBERS CAPITAL	123,493	
WITHDRAWALS	(56,818)	
NET INCOME FOR THE PERIOD	<u>409,401</u>	
TOTAL EQUITY		<u>476,076</u>
TOTAL LIABILITIES AND EQUITY		<u>\$ 2,319,373</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHAB. LLC
STATEMENT OF INCOME AND EXPENSE

	FOR THE YEAR ENDED <u>DEC. 31, 2010</u>	<u>PCT</u>	PER PATIENT <u>DAY</u>
INCOME			
ROUTINE SERVICES	\$ 5,826,839	100.0	\$ 165.733
OPERATING EXPENSES			
NURSING COSTS	2,064,221	35.4	58.713
EMPLOYEE WELFARE COSTS	417,027	7.2	11.862
HOUSEKEEPING & PLANT COSTS	362,985	6.2	10.324
LAUNDRY & LINEN COSTS	100,466	1.7	2.858
DIETARY COSTS	<u>407,962</u>	<u>7.0</u>	<u>11.604</u>
TOTAL OPERATING EXPENSES	<u>3,352,661</u>	<u>57.5</u>	<u>95.360</u>
INCOME BEFORE GENERAL AND ADMINISTRATIVE EXPENSES	2,474,178	42.5	70.373
GENERAL & ADMINISTRATIVE	<u>947,808</u>	<u>16.3</u>	<u>26.959</u>
INCOME BEFORE CAPITAL CHARGES	1,526,370	26.2	43.415
CAPITAL CHARGES	<u>1,087,265</u>	<u>18.7</u>	<u>30.925</u>
NET INCOME BEFORE OTHER INCOME	439,105	7.5	12.489
OTHER INCOME (EXPENSE)	<u>(29,704)</u>	<u>(0.5)</u>	<u>(0.845)</u>
NET INCOME (LOSS)	<u>\$ 409,401</u>	<u>7.0</u>	<u>\$ 11.645</u>

See Accountants' Compilation Report

Krupnick Bokor Kagda & Brooks, Ltd.

Certified Public Accountants

3750 W Devon Ave

Lincolnwood, IL 60712

McAllister Nursing & Rehab, LLC
18300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

To The Members:

We have compiled the accompanying balance sheet of McAllister Nursing & Rehab, LLC (a limited liability company) as of December 31, 2009, and the related statement of income for the year then ended, and the accompanying supplementary information contained in Schedules B-1 through B-6, which is presented only for supplementary analysis purposes, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of financial statements and supplementary schedules information that is the representation of management. We have not audited or reviewed the accompanying financial statements and supplementary schedules and, accordingly, do not express an opinion or any other form of assurance on them.

Management has elected to omit substantially all of the disclosures and the statement of cash flows required by generally accepted accounting principles. If the omitted disclosures and statement of cash flows were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements and supplementary schedules are not designed for those who are not informed about such matters.

The Company has elected not to consolidate its financial statements with those of other variable interest entities. The effect from the departure from generally accepted accounting principles on financial position and results of operations has not been determined.

The accompanying financial statements do not include a provision of liability for federal income taxes because the members are taxed individually on their share of earnings.

April 12, 2010

McALLISTER NURSING & REHAB, LLC
16300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

TABLE OF CONTENTS

BALANCE SHEET	EXHIBIT "A"
STATEMENT OF INCOME & EXPENSE	EXHIBIT "B"
SCHEDULE OF INCOME	SCHEDULE "B-1"
SCHEDULE OF OPERATING EXPENSES	SCHEDULE "B-2"
SCHEDULE OF ADMINISTRATIVE EXPENSES	SCHEDULE "B-3"
SCHEDULE OF OTHER INCOME (EXPENSE)	SCHEDULE "B-4"
SCHEDULE OF CAPITAL CHARGES	SCHEDULE "B-5"
SCHEDULE OF SALARIES	SCHEDULE "B-6"

McALLISTER NURSING & REHAB, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2009

McALLISTER NURSING & REHAB, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2009

ASSETS

CURRENT ASSETS

CASH AND CASH EQUIVALENTS	\$ 52,746	
ACCOUNTS RECEIVABLE - PATIENTS	908,122	
LESS: ALLOWANCE FOR BAD DEBTS	(22,500)	
DUE FROM AFFILIATES	768,338	
DUE FROM PRIOR OWNER	20,835	
PREPAID EXPENSES	<u>196,058</u>	
TOTAL CURRENT ASSETS		\$ 1,919,599

PROPERTY AND EQUIPMENT:

LEASEHOLD IMPROVEMENTS	4,517	
FURNITURE & EQUIPMENT	97,835	
COMPUTER SOFTWARE	41,960	
VEHICLES	<u>8,500</u>	
TOTAL COST	152,612	
LESS: ACCUMULATED DEPRECIATION	<u>(99,573)</u>	
NET PROPERTY & EQUIPMENT		53,039

OTHER ASSETS

DUE FROM McALLISTER PROPERTIES	202,940	
SECURITY DEPOSITS	<u>22,500</u>	
TOTAL OTHER ASSEST		<u>225,440</u>
 TOTAL ASSETS		 <u>\$ 2,198,078</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHABILITATION, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2009

LIABILITIES AND EQUITY

CURRENT LIABILITIES

ACCOUNTS PAYABLE-TRADE	\$	902,980	
ACCOUNTS PAYABLE-INSURANCE		172,043	
DUE TO DPA		8,867	
ACCRUALS:			
OPERATING EXPENSES	\$	1,753	
PAYROLL		112,140	
MANAGEMENT FEES		50,000	
REAL ESTATE TAXES		247,500	
LICENSE FEE		15,318	
SALES TAX		<u>1,343</u>	
			428,054
PAYROLL TAXES PAYABLE		22,489	
NOTE PAYABLE- FIRST BANK		531,229	
DUE TO PILAY PLAIN		6,535	
PATIENT PERSONAL FUNDS		<u>3,341</u>	
TOTAL CURRENT LIABILITIES			\$ 2,073,318

EQUITY

MEMBERS CAPITAL	103,787	
NET INCOME FOR THE PERIOD	<u>20,973</u>	
TOTAL EQUITY		<u>124,760</u>
TOTAL LIABILITIES AND EQUITY		<u>\$ 2,198,078</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHAB, LLC
STATEMENT OF INCOME AND EXPENSE

	FOR THE YEAR ENDED DEC. 31, 2009	PCT	PER PATIENT DAY
INCOME			
ROUTINE SERVICES	\$ 4,997,798	100.0	\$ 160.799
OPERATING EXPENSES			
NURSING COSTS	1,957,745	39.2	62.988
EMPLOYEE WELFARE COSTS	388,218	7.8	12.491
HOUSEKEEPING & PLANT COSTS	364,511	7.3	11.728
LAUNDRY & LINEN COSTS	117,712	2.4	3.787
DIETARY COSTS	394,291	7.9	12.686
TOTAL OPERATING EXPENSES	<u>3,222,477</u>	<u>64.5</u>	<u>103.680</u>
INCOME BEFORE GENERAL AND ADMINISTRATIVE EXPENSES	1,775,321	35.5	57.119
GENERAL & ADMINISTRATIVE	<u>863,940</u>	<u>17.3</u>	<u>27.796</u>
INCOME BEFORE CAPITAL CHARGES	911,381	18.2	29.323
CAPITAL CHARGES	<u>886,374</u>	<u>17.7</u>	<u>28.518</u>
NET INCOME BEFORE OTHER INCOME	25,007	0.5	0.805
OTHER INCOME (EXPENSE)	<u>(4,034)</u>	<u>(0.1)</u>	<u>(0.130)</u>
NET INCOME (LOSS)	<u>\$ 20,973</u>	<u>0.4</u>	<u>\$ 0.675</u>

See Accountants' Compilation Report

Krupnick Bokor Kagda & Brooks, Ltd.
Certified Public Accountants
3750 W Devon Ave
Lincolnwood, IL 60712

McAllister Nursing & Rehab, LLC
18300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

To The Members:

We have compiled the accompanying balance sheet of McAllister Nursing & Rehab, LLC (a limited liability company) as of December 31, 2008, and the related statement of income for the year then ended, and the accompanying supplementary information contained in Schedules B-1 through B-6, which is presented only for supplementary analysis purposes, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of financial statements and supplementary schedules information that is the representation of management. We have not audited or reviewed the accompanying financial statements and supplementary schedules and, accordingly, do not express an opinion or any other form of assurance on them.

Management has elected to omit substantially all of the disclosures and the statement of cash flows required by generally accepted accounting principles. If the omitted disclosures and statement of cash flows were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, these financial statements and supplementary schedules are not designed for those who are not informed about such matters.

The Company has elected not to consolidate its financial statements with those of other variable interest entities. The effect from the departure from generally accepted accounting principles on financial position and results of operations has not been determined.

The accompanying financial statements do not include a provision of liability for federal income taxes because the members are taxed individually on their share of earnings.

June 30, 2009

McALLISTER NURSING & REHAB, LLC
18300 SOUTH LAVERGNE AVE
TINLEY PARK, IL 60477

TABLE OF CONTENTS

BALANCE SHEET	EXHIBIT "A"
STATEMENT OF INCOME & EXPENSE	EXHIBIT "B"
SCHEDULE OF INCOME	SCHEDULE "B-1"
SCHEDULE OF OPERATING EXPENSES	SCHEDULE "B-2"
SCHEDULE OF ADMINISTRATIVE EXPENSES	SCHEDULE "B-3"
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SCHEDULE OF CAPITAL CHARGES	SCHEDULE "B-5"
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McALLISTER NURSING & REHAB, LLC

FINANCIAL STATEMENTS

DECEMBER 31, 2008

McALLISTER NURSING & REHAB, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2008

ASSETS

CURRENT ASSETS

CASH AND CASH EQUIVALENTS	\$ 33,516	
ACCOUNTS RECEIVABLE - PATIENTS	1,374,426	
LESS: ALLOWANCE FOR BAD DEBTS	(22,500)	
DUE FROM AFFILIATES	58,008	
DUE FROM PRIOR OWNER	27,707	
DUE FR INNOVATIVE	112,792	
PREPAID EXPENSES	<u>207,004</u>	
TOTAL CURRENT ASSETS		\$ 1,790,953

PROPERTY AND EQUIPMENT:

LEASEHOLD IMPROVEMENTS	4,517	
FURNITURE & EQUIPMENT	68,459	
COMPUTER SOFTWARE	41,960	
DEPOSIT ON FIXED ASSET	<u>45,000</u>	
TOTAL COST	159,936	
LESS: ACCUMULATED DEPRECIATION	<u>(54,965)</u>	
NET PROPERTY & EQUIPMENT		104,971

OTHER ASSETS

DUE FROM McALLISTER PROPERTIES	113,232	
SECURITY DEPOSITS	<u>22,500</u>	
TOTAL OTHER ASSET		<u>135,732</u>
TOTAL ASSETS		<u>\$ 2,031,656</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHAB, LLC
BALANCE SHEET
AS OF DECEMBER 31, 2008

LIABILITIES AND EQUITY

CURRENT LIABILITIES

ACCOUNTS PAYABLE-TRADE	\$	820,788	
ACCOUNTS PAYABLE-INSURANCE		154,808	
ACCRUALS:			
OPERATING EXPENSES	\$	2,278	
PAYROLL		108,766	
REAL ESTATE TAXES		<u>175,000</u>	
			286,044
PAYROLL TAXES PAYABLE			33,858
NOTE PAYABLE- FIRST BANK			625,000
PATIENT PERSONAL FUNDS			<u>6,684</u>
TOTAL CURRENT LIABILITIES			\$ 1,927,182

EQUITY

MEMBERS CAPITAL		7,321	
NET INCOME FOR THE PERIOD		<u>97,153</u>	
TOTAL EQUITY			<u>104,474</u>
 TOTAL LIABILITIES AND EQUITY			 \$ <u>2,031,656</u>

See Accountants' Compilation Report

McALLISTER NURSING & REHAB, LLC
STATEMENT OF INCOME AND EXPENSE

	TWELVE MONTHS ENDED DEC. 31, 2008	PCT	PER PATIENT DAY
INCOME			
ROUTINE SERVICES	\$ 4,696,449	100.0	\$ 152.168
OPERATING EXPENSES			
NURSING COSTS	2,093,685	44.6	67.836
EMPLOYEE WELFARE COSTS	368,064	7.8	11.925
HOUSEKEEPING & PLANT COSTS	424,302	9.0	13.747
LAUNDRY & LINEN COSTS	123,628	2.6	4.006
DIETARY COSTS	404,617	8.6	13.110
TOTAL OPERATING EXPENSES	<u>3,414,296</u>	<u>72.7</u>	<u>110.624</u>
INCOME BEFORE GENERAL AND ADMINISTRATIVE EXPENSES	1,282,153	27.3	41.542
GENERAL & ADMINISTRATIVE	<u>596,275</u>	<u>12.7</u>	<u>19.319</u>
INCOME BEFORE CAPITAL CHARGES	685,878	14.6	22.223
CAPITAL CHARGES	<u>566,130</u>	<u>12.1</u>	<u>18.343</u>
NET INCOME BEFORE OTHER INCOME	119,748	2.5	3.880
OTHER INCOME (EXPENSE)	<u>(22,500)</u>	<u>(0.5)</u>	<u>(0.729)</u>
NET INCOME BEFORE INCOME TAXES	97,248	2.1	3.151
INCOME TAXES	<u>95</u>		<u>0.003</u>
NET INCOME (LOSS)	\$ <u>97,153</u>	<u>2.1</u>	\$ <u>3.148</u>

See Accountants' Compilation Report

McAllister Nursing & Rehab, LLC

	PROJECTED	
	YR 2	FPD
Income	12,820,625	189.865
Census	67,525	
% to capacity	93%	
Operating Expenses		
Payroll Costs	4,308,000	63.799
Employee Welfare	816,000	12.084
Housekeeping & Plant	655,200	9.703
Laundry & Linen Costs	196,800	2.914
Dietary Costs	396,000	5.864
Nursing Costs	918,000	13.595
Total Operating Expenses	7,290,000	107.960
Rent	1,800,000	26.657
Real Estate Taxes	312,000	4.621
Interest Expense/Bank Charges	120,000	1.777
Depreciation	50,000	0.740
Amortization	13,500	0.200
Total Capital Expenses	2,295,500	33.995
Administrative Costs	1,740,000	25.768
Total Expenses	11,325,500	167.723
Net Income	1,495,125	22.142

MALLISTER PROPERTY, LLC
 FORECASTED BALANCE SHEET
 200 BED LONG-TERM CARE FACILITY OWNER

2015

ASSETS

CURRENT ASSETS:

CASH	\$210,325
LOAN AND EXCHANGES	\$150,000

TOTAL CURRENT ASSETS	\$360,325
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PROPERTY AND EQUIPMENT:

LAND AND LAND IMPROVEMENTS	\$3,513,496
BUILDING AND BUILDING IMPROVEMENTS	\$23,585,883
EQUIPMENT AND FURNISHINGS	\$1,091,000
LESS ACCUM DEPRECIATION	-\$1,308,755

NET PROPERTY AND EQUIPMENT	\$26,881,624
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OTHER ASSETS:

GOODWILL	\$350,000
LESS AMORTIZATION	-\$134,165
TOTAL OTHER ASSETS	\$215,835

TOTAL ASSETS	\$27,457,784
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LIABILITIES AND EQUITY

CURRENT LIABILITIES:

OTHER ACCRUED EXPENSES	\$22,878
DUE TO OPERATING ENTITY	\$350,933
CURRENT PORTION OF MORTGAGE	\$226,836
TOTAL CURRENT LIABILITIES	\$600,647

LONG-TERM DEBT:

MORTGAGE PAYABLE	\$26,262,526
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TOTAL NON-CURRENT LIABILITIES:	\$26,262,526
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TOTAL LIABILITIES	\$26,863,173
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EQUITY:

MEMBERS BEGINNING EQUITY	\$1,107,635
OPERATING PROFIT OR LOSS	-\$513,024
TOTAL EQUITY	\$594,611

TOTAL LIABILITIES AND EQUITY	\$27,457,784
	\$0

MCALESTER NURSING & REHAB, LLC
 FORECASTED BALANCE SHEET
 200 BED LONG-TERM CARE FACILITY OPERATOR

2015

ASSETS

CURRENT ASSETS:

CASH	\$4,586,098
ACCOUNTS RECEIVABLE	\$393,646
PREPAID EXPENSES	\$220,109
DUE FROM AFFILIATES	\$1,191,130
TOTAL CURRENT ASSETS	\$6,390,983

NON-CURRENT ASSETS

DEVELOPMENTAL COSTS	\$14,586
DUE FROM REALTY	\$350,933
SECURITY DEPOSITS	\$22,500
TOTAL NON-CURRENT ASSETS	\$388,019

PROPERTY AND EQUIPMENT

LEASEHOLD IMPROVEMENTS	\$4,517
FURNITURE & EQUIPMENT	\$245,123
LESS ACCUMULATED DEPRECIATION	-\$210,588
NET PROPERTY & EQUIPMENT	\$39,052

TOTAL ASSETS	\$6,818,054
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LIABILITIES AND EQUITY

CURRENT LIABILITIES:

ACCOUNTS PAYABLE	\$828,402
PAYROLL AND PAYROLL TAXES PAYABLE	\$169,499
ACCRUED EXPENSES	\$22,371
RESIDENT FUNDS PAYABLE	\$12,726
WORKING LINE OF CREDIT	\$1,000,000
TOTAL CURRENT LIABILITIES	\$2,032,998

LONG-TERM DEBT	\$0
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TOTAL LIABILITIES	\$2,032,998
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EQUITY:

MEMBERS' BEGINNING EQUITY	\$3,496,672
OPERATING PROFIT OR LOSS	\$1,288,384
TOTAL EQUITY	\$4,785,056

TOTAL LIABILITIES AND EQUITY	\$6,818,054
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0

COMBINED MCALLISTER ENTITIES
 FORECASTED BALANCE SHEET
 200 BED LONG-TERM CARE FACILITY-OWNER AND OPERATOR

2015

ASSETS

CURRENT ASSETS:

CASH	\$4,796,423
ACCOUNTS RECEIVABLE	\$543,646
PREPAID EXPENSES	\$220,109
DUE FROM AFFILIATES	\$840,197
TOTAL CURRENT ASSETS	\$6,400,375

OTHER ASSETS:

DEVELOPMENTAL COSTS	\$14,586
DUE FROM REALTY	\$350,933
SECURITY DEPOSITS	\$22,500
TOTAL OTHER ASSETS	\$388,019

PROPERTY AND EQUIPMENT:

LAND AND LAND IMPROVEMENTS	\$3,513,496
BUILDING AND BUILDING IMPROVEMENTS	\$23,590,400
EQUIPMENT AND FURNISHINGS	\$1,336,123
LESS ACCUM DEPRECIATION	-\$1,519,343
NET PROPERTY & EQUIPMENT	\$26,920,676

TOTAL ASSETS

\$33,709,070

LIABILITIES AND EQUITY

CURRENT LIABILITIES:

ACCOUNTS PAYABLE	\$828,402
PAYROLL AND PAYROLL TAXES PAYABLE	\$169,499
ACCRUED EXPENSES	\$45,249
CURRENT PORTION OF LONG TERM	\$226,836
RESIDENT FUNDS PAYABLE	\$12,726
WORKING LINE OF CREDIT	\$1,000,000
TOTAL CURRENT LIABILITIES	\$2,282,712

LONG-TERM DEBT:

MORTGAGE PAYABLE	\$26,262,526
TOTAL LONG-TERM DEBT	\$26,262,526

TOTAL LIABILITIES

\$28,545,238
 \$28,545,238

EQUITY:

MEMBERS' BEGINNING EQUITY	\$4,388,472
OPERATING PROFIT OR LOSS	\$775,360
TOTAL EQUITY	\$5,163,832

TOTAL LIABILITIES AND EQUITY

\$33,709,070

\$0

MCALLISTER PROPERTY, LLC
FORECASTED INCOME STATEMENT
200 BED LONG-TERM CARE FACILITY OWNER

	2015
RENT	\$2,318,741
<u>OPERATING COSTS AND EXPENSES</u>	
DEPRECIATION	\$713,866
INTEREST EXPENSE	\$1,782,566
AMORTIZATION OF CAPITAL FIN. CHGS.	\$23,333
REAL ESTATE TAXES	<u>\$312,000</u>
TOTAL OPERATING COSTS	\$2,831,765
<u>NET INCOME OR (LOSS)</u>	-\$513,024

MCALLISTER NURSING & REHAB, LLC
FORECASTED INCOME STATEMENT
200 BED LONG-TERM CARE FACILITY OPERATOR

2015

<u>INCOME</u>	\$12,820,625
<u>OPERATING COSTS AND EXPENSES</u>	
PAYROLL COSTS	\$4,308,000
EMPLOYEE WELFARE	\$816,000
HOUSEKEEPING AND PLANT COSTS	\$655,200
LAUNDRY AND LINEN COSTS	\$196,800
DIETARY COSTS	\$396,000
NURSING COSTS	\$918,000
 TOTAL OPERATING COSTS	 \$7,290,000
 <u>NET OPERATING INCOME</u>	 \$5,530,625
<u>CAPITAL EXPENSES</u>	
DEPRECIATION	\$50,000
INTEREST EXPENSE	\$120,000
RENT	\$2,318,741
REAL ESTATE TAXES	\$0
AMORTIZATION	\$13,500
 TOTAL CAPITAL EXPENSES	 \$2,502,241
 <u>AMINISTRATIVE COSTS.</u>	 \$1,740,000
 <u>NET INCOME OR (LOSS)</u>	 \$1,288,384

COMBINED MCALLISTER ENTITIES
 FORECASTED INCOME STATEMENT
 200 BED LONG-TERM CARE FACILITY-OWNER AND OPERATOR

	2015
<u>INCOME</u>	\$12,820,625
<u>OPERATING COSTS AND EXPENSES</u>	
PAYROLL COSTS	\$4,308,000
EMPLOYEE WELFARE	\$816,000
HOUSEKEEPING AND PLANT COSTS	\$655,200
LAUNDRY AND LINEN COSTS	\$196,800
DIETARY COSTS	\$396,000
NURSING COSTS	\$918,000
TOTAL OPERATING COSTS	\$7,290,000
<u>NET OPERATING INCOME</u>	\$5,530,625
<u>CAPITAL EXPENSES</u>	
DEPRECIATION	\$763,866
INTEREST EXPENSE	\$1,902,566
RENT	\$0
REAL ESTATE TAXES	\$312,000
AMORTIZATION	\$36,833
TOTAL CAPITAL EXPENSES	\$3,015,265
<u>AMINISTRATIVE COSTS.</u>	\$1,740,000
<u>NET INCOME OR (LOSS)</u>	<u>\$775,360</u>

ATTACHMENT-42 FINANCING ARRANGEMENTS

B. Criterion 1120.310(b), Conditions of Debt Financing

Read the criterion and provide a notarized statement signed by two authorized representatives of the applicant entity (in the case of a corporation, one must be a member of the board of directors) that attests to the following as applicable:

1. The selected form of debt financing the project will be at the lowest net cost available or if a more costly form of financing is selected, that form is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional debt, term (years) financing costs, and other factors;
2. All or part of the project involves the leasing of equipment or facilities and the expenses incurred with such leasing are less costly than constructing a new facility or purchasing new equipment.

[Handwritten Signature]
Board Member or Officer

[Handwritten Signature]
Board Member or Officer

Notarization:
Subscribed and sworn to me
this 5 day of JULY

[Handwritten Signature]
Signature of Notary

Seal



Notarization:
Subscribed and sworn before me
this 5 day of JULY 2011

[Handwritten Signature]
Signature of Notary

Seal



ATTACHMENT 75

ATTACHMENT-42 OPERATING AND CAPITAL COSTS

Projected Operating Cost

Salaries	\$4,308,000
Supplies	\$2,166,000
Welfare and Benefits	<u>\$816,000</u>
Total Direct Cost	\$7,290,000

Year of Target Utilization		2014
Patient Days Per Year	67,525	
Resultant Costs Per Patient Day		\$107.96

Projected Capital Costs

Total Annual Capital Costs	\$2,295,500	
Year of Target Utilization		2014
Patient Days Per Year	67,525	
Capital Cost Per Patient Day		\$33.99