

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0025056 Facility Name: Oakton Pavillion Address: 1660 Oakton Pavillion Des Plaines 60018 County: Cook Telephone Number: (847) 299-5588 Fax #: (847) 493-6525 HFS ID Number: Date of Initial License for Current Owners: 01/02/1980 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Sanford B. Alper Telephone Number: (847) 580-4100 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Jay Lewkowicz (Title) Paid Preparer (Signed) (Print Name and Title) Sanford B. Alper Principal (Firm Name & Address) Kessler, Orlean, Silver & Company, P.C. 1101 Lake Cook Road Suite C, Deerfield Illinois 60015 (Telephone) (847) 580-4100 Fax #: (847) 580-4199 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
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Facility Name & ID Number Oakton Pavillion

0025056 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

294

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	294	294	107,310	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
294	TOTALS	294	107,310	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	29,442	18,919	7,027	55,388	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,442	18,919	7,027	55,388	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.61%

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)

Home Meals

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

☐

NO

☒

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

YES

☐

NO

☒

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

Date started

01/20/1980

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

YES

☒

Date

01/20/1980

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

294

and days of care provided

5,799

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/2011

Fiscal Year:

12/31/2011

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	424,401	47,941		472,342		472,342		472,342			1
2	Food Purchase		412,638		412,638	(64,386)	348,252	(5,806)	342,446			2
3	Housekeeping	163,236	70,749		233,985		233,985		233,985			3
4	Laundry	161,681	16,309		177,990		177,990		177,990			4
5	Heat and Other Utilities			230,326	230,326		230,326		230,326			5
6	Maintenance	136,503	163,618		300,121		300,121		300,121			6
7	Other (specify):* See Attached Sch			42,786	42,786		42,786		42,786			7
8	TOTAL General Services	885,821	711,255	273,112	1,870,188	(64,386)	1,805,802	(5,806)	1,799,996			8
	B. Health Care and Programs											
9	Medical Director			35,004	35,004		35,004		35,004			9
10	Nursing and Medical Records	2,364,079	496,523	19,689	2,880,291		2,880,291		2,880,291			10
10a	Therapy	169,762		332,553	502,315		502,315		502,315			10a
11	Activities	179,471	40,033		219,504		219,504		219,504			11
12	Social Services	69,627			69,627		69,627		69,627			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,782,939	536,556	387,246	3,706,741		3,706,741		3,706,741			16
	C. General Administration											
17	Administrative	381,352		1,476,798	1,858,150		1,858,150	(1,271,798)	586,352			17
18	Directors Fees											18
19	Professional Services			182,363	182,363		182,363	11,849	194,212			19
20	Dues, Fees, Subscriptions & Promotions			55,856	55,856		55,856	(44,623)	11,233			20
21	Clerical & General Office Expenses	349,445		141,157	490,602		490,602	(1,658)	488,944			21
22	Employee Benefits & Payroll Taxes			584,945	584,945	64,386	649,331	(13,656)	635,675			22
23	Inservice Training & Education											23
24	Travel and Seminar			550	550		550		550			24
25	Other Admin. Staff Transportation			3,421	3,421		3,421	(1,013)	2,408			25
26	Insurance-Prop.Liab.Malpractice			178,045	178,045		178,045		178,045			26
27	Other (specify):* Loss on Disp of Equip							22,917	22,917			27
28	TOTAL General Administration	730,797		2,623,135	3,353,932	64,386	3,418,318	(1,297,982)	2,120,336			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,399,557	1,247,811	3,283,493	8,930,861		8,930,861	(1,303,788)	7,627,073			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							264,534	264,534			30
31	Amortization of Pre-Op. & Org.							3,237	3,237			31
32	Interest							134,006	134,006			32
33	Real Estate Taxes			485,463	485,463		485,463		485,463			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			20,983	20,983		20,983		20,983			35
36	Other (specify):*											36
37	TOTAL Ownership			1,946,446	1,946,446		1,946,446	(1,038,223)	908,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,965	160,965		160,965		160,965			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			160,965	160,965		160,965		160,965			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,399,557	1,247,811	5,390,904	11,038,272		11,038,272	(2,342,011)	8,696,261			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(122,632)	30		9
10	Interest and Other Investment Income	(854)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,806)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,013)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,450)	21		20
21	Owner or Key-Man Insurance	(13,656)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(32,746)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(44,623)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (228,780)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,113,231)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,113,231)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,342,011)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,440,000	Oakton Terrace	100.00%	\$	\$ (1,440,000)	1
2	V	32	Interest Income	732	Oakton Terrace	100.00%		(732)	2
3	V	21	Other Income	49	Oakton Terrace	100.00%		(49)	3
4	V	17	Consulting Fees		Oakton Terrace	100.00%	205,000	205,000	4
5	V	30	Depreciation		Oakton Terrace	100.00%	387,166	387,166	5
6	V	31	Amortization		Oakton Terrace	100.00%	3,237	3,237	6
7	V	19	Accounting and Legal Fees		Oakton Terrace	100.00%	8,899	8,899	7
8	V	32	Mortgage Interest		Oakton Terrace	100.00%	134,738	134,738	8
9	V	21	Miscellaneous Financial Exp		Oakton Terrace	100.00%	630	630	9
10	V	21	Penalties		Oakton Terrace	100.00%	1,280	1,280	10
11	V	27	Loss on Disposal of Equipment		Oakton Terrace	100.00%	22,917	22,917	11
12	V	21	Provision of Income Tax		Oakton Terrace	100.00%	10,701	10,701	12
13	V	17	Management Fee Income	1,476,798	FMH Management Company	100.00%		(1,476,798)	13
14	Total			\$ 2,917,579			\$ 774,568	\$ * (2,143,011)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Accounting and Legal Fees	\$	FMH Management Company	100.00%	\$ 2,950	\$ 2,950	15
16	V	21	Miscellaneous Financial Exp		FMH Management Company	100.00%	570	570	16
17	V	21	Penalties		FMH Management Company	100.00%	2,561	2,561	17
18	V	32	Interest Expense		FMH Management Company	100.00%	854	854	18
19	V	21	Taxes - Other		FMH Management Company	100.00%	800	800	19
20	V	21	Income Tax Expense		FMH Management Company	100.00%	22,045	22,045	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 29,780	\$ * 29,780	39

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jay Lewkowitz	Administrator	Administrative	9.375%	N/A	40	90.00	Salary	\$ 138,808	17-1	1
2	Fred Weiss	General Partner	Administrative	24.420%	N/A	10	20.00	Mng Fees	75,000	17-7	2
3	Jay Lewkowitz	Administrator	Administrative	See Above	N/A			Mng Fees	130,000	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 343,808		13

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Private Bank		X	Building Mortgage	\$13,314.00	06/01/08	\$ 2,600,000	\$ 2,322,192	06/27/13	LIBR+1.75	\$ 134,738	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$13,314.00		\$ 2,600,000	\$ 2,322,192			\$ 134,738	9	
	B. Non-Facility Related*												
10	Oakton Terrace	X									(732)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (732)	14	
15	TOTALS (line 9+line14)						\$ 2,600,000	\$ 2,322,192			\$ 134,006	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	615,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	400,463	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(214,537)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	700,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	485,463	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	521,183	8	
		2007	551,210	9	
		2008	419,713	10	
		2009	596,839	11	
		2010	400,463	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakton Pavillion COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0025056
CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper
TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>09-29-106-006-000</u>	<u>Oakton Pavillion</u>	\$ <u>400,463.00</u>	\$ <u>400,463.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>400,463.00</u>	\$ <u>400,463.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

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

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	74,998	1975	\$ 200,000	1
2					2
3	TOTALS	74,998		\$ 200,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	294		1980	1980	\$ 4,171,968	\$ 61,056	40	\$ 104,229	\$ 43,173	\$ 3,996,193
5										
6										
7										
8										
	Improvement Type**									
9	Audit Adjustment		1981		955		20			955
10	Audit Adjustment		1983		30,266		20			30,266
11	Doors		1985		1,500		10			1,500
12	Sidewalk		1985		350		20			350
13	Audit Adjustment		1985		9,122		20			9,122
14	Decorating		1985		6,905		10			6,905
15	Hot Water Heater		1987		12,788		10			12,788
16	Light Fixtures		1987		11,288		10			11,288
17	Antena Hook Up		1988		4,905		10			4,905
18	A/C Compressor		1988		8,000		10			8,000
19	Sod / Environment Center		1989		7,282		10			7,282
20	Doors / Carpet		1990		3,609		10			3,609
21	Boiler Shell		1991		1,760		10			1,760
22	Roof		1991		40,000		20			40,000
23	Improvements		1991		4,590		10			4,590
24	Fire Dapers & Doors		2001		148,267	3,802	39	3,802		39,920
25	Sliding Door		2001		10,498		39	269	269	2,825
26	White Way Sign		2001		2,082	54	39	54		558
27	Remodeling Garden Level		2001		208,312	5,341	39	5,341		56,085
28	Smoke Detector		2003		4,320		10	432	432	3,888
29	Pump		2003		14,118		10	1,412	1,412	12,708
30	Electircal Circuits		2004		6,811	175	39	175		1,400
31	Elevator Modernization		2004		24,393	625	39	625		5,000
32	Shed		2004		3,566	79	7	509	430	4,072
33	Plumbing Improvements		2004		44,749	1,148	39	1,148		9,181
34	Elevator Modernization		2005		86,956	2,230	39	2,230		15,606
35	Pantry Reovation		2005		8,155	209	39	209		1,463
36	Asphalt Work		2005		22,835	1,349	15	2,169	820	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakton Pavillion

0025056

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Electrical Improvements	2005	\$ 1,730	\$ 44	39	\$ 44	\$	\$ 308	37
38	Outside Lights	2006	2,816	72	39	72		432	38
39	Plumbing Improvements	2006	3,100	79	39	79		475	39
40	Roof Replacement	2006	131,130	3,362	39	3,362		20,172	40
41	Masonry Renovation	2006	12,415	319	39	319		1,909	41
42	Steel Window Lintel Replacement	2006	48,850	1,252	39	1,252		7,517	42
43	Steel Window Lintel Replacement	2006	4,100	105	39	105		631	43
44	Tuckpointing and Brick Replacement	2006	25,000	641	39	641		3,846	44
45	Elevator Power Unit	2006	9,959	255	39	255		1,530	45
46	Roof Exhaust Fan	2006	2,080	54	39	54		319	46
47	Roof Drains	2006	10,850	278	39	278		1,668	47
48	Sewage Pump	2007	3,905	101	39	101		501	48
49	Chilled Water Coils	2007	29,744	763	39	763		3,814	49
50	Fire Alarm System	2007	10,625	272	39	272		1,360	50
51	Cooling Tower Monitor	2007	2,560	66	39	66		330	51
52	1st Floor Remodeling - Contracted - Total	2009	15,000	385	39	385		1,155	52
53	Rebuild Water Pump	2009	4,580	117	39	117		352	53
54	Kitchen Plumbing Renovation	2009	9,578	245	39	245		737	54
55	Boiler	2009	15,700	403	39	403		1,208	55
56	Boiler Vale	2009	4,995	128	39	128		384	56
57	Tub Room Renovation	2010	9,300	239	39	239		378	57
58	Ejector Pump	2010	7,500	192	39	192		304	58
59	Cement Ramps	2010	4,544	117	39	117		175	59
60	Flagpole	2010	2,093	54	39	54		85	60
61	Awnings	2010	7,997	205	39	205		342	61
62	Recirculating Water Pump	2010	2,750	70	39	70		88	62
63	HVAC Circulating Pump	2010	10,735	275	39	275		390	63
64	Temperature Control Valve	2010	6,200	159	39	159		238	64
65	Laundry Room Ejector Pump	2010	18,787	482	39	482		522	65
66	Corridor AHU Pump	2011	11,090	261	39	261		261	66
67	Cooler Tower	2011	53,306	1,139	39	1,139		1,139	67
68	Fence	2011	3,979	51	39	51		51	68
69	4th Floor Renovation	2011	380,155	8,123	39	8,123		8,123	69
70	TOTAL (lines 4 thru 69)		\$ 5,767,503	\$ 96,376		\$ 142,912	\$ 46,536	\$ 4,352,963	70

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

Facility Name & ID Number Oakton Pavillion

0025056

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 5,767,503	\$ 96,376		\$ 142,912	\$ 46,536	\$ 4,352,963	1
2 3rd Floor Renovation	2011	380,155	6,498	39	6,498		6,498	2
3 2nd Floor Renovation	2011	380,155	4,061	39	4,061		4,061	3
4 Sidewalk	2011	5,690	73	39	73		73	4
5 Voltage Regulator	2011	2,700	35	39	35		35	5
6 1st Floor Renovation	2011	380,155	1,625	39	1,625		1,625	6
7 Concrete Patio	2011	2,970	25	39	25		25	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,919,328	\$ 108,693		\$ 155,229	\$ 46,536	\$ 4,365,280	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 782,551	\$ 38,737	\$ 78,255	\$ 39,518	10	\$ 624,403	71
72	Current Year Purchases	236,886	236,886	23,689	(213,197)	10	23,689	72
73	Fully Depreciated Assets	575,688				10	575,688	73
74								74
75	TOTALS	\$ 1,595,125	\$ 275,623	\$ 101,944	\$ (173,679)		\$ 1,223,780	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Patients	1992 Ford Van	1992	\$ 27,300	\$	\$	\$	5	\$ 27,300	76
77	Administrative	2009 Accura	2009	36,806	2,850	7,361	4,511	5	11,745	77
78	Administrative	2005 Ford E350	2005	49,451				5	49,451	78
79										79
80	TOTALS			\$ 113,557	\$ 2,850	\$ 7,361	\$ 4,511		\$ 88,496	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,828,010	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 387,166	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,534	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (122,632)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,677,556	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1980	294		\$ 1,440,000			3
4	Additions							4
5								5
6								6
7	TOTAL		294		\$ 1,440,000			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 20,983
- Description: Copier Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 01/01/2011

Ending 12/31/2011

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$ 151,557		\$	\$		\$ 151,557	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs	4,607					4,607	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs	132,833					132,833	4
5	Physician Care		visits							5
6	Dental Care	10a-3	visits	4,800					4,800	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Fall-Risk Mng</u>			7,200					7,200	12
13	Other (specify): <u></u>			31,556					31,556	13
14	TOTAL			\$ 332,553		\$	\$		\$ 332,553	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	970,909	1
2	Cash-Patient Deposits	24,598	24,598	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,721,267	3,721,267	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,228,728	2,116,148	8
9	Other(specify): <u>See Attached Schedule</u>	421,535	426,948	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,396,128	\$ 7,259,870	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		4,171,968	14
15	Leasehold Improvements, at Historical Cost		2,223,429	15
16	Equipment, at Historical Cost		2,232,613	16
17	Accumulated Depreciation (book methods)		(5,635,473)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Loan Costs</u>		4,575	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 3,197,112	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,396,128	\$ 10,456,982	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 153,963	\$ 153,963	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,598	24,598	28
29	Short-Term Notes Payable		87,198	29
30	Accrued Salaries Payable	80,874	80,874	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	700,000	700,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		32,289	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	7,468,518	1,654,164	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,427,953	\$ 2,733,086	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,234,994	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,234,994	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,427,953	\$ 4,968,080	46
47	TOTAL EQUITY(page 18, line 24)	\$ 968,175	\$ 5,488,902	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,396,128	\$ 10,456,982	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,157,034	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,157,034	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,188,859)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,188,859)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 968,175	24 *

* This must agree with page 17, line 47.

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

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,458,519	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,458,519	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,976,759	6
7	Oxygen	3,358	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,980,117	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,645	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	22,397	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,042	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	383,735	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 383,735	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,849,413	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,870,188	31
32	Health Care	3,706,741	32
33	General Administration	3,353,932	33
	B. Capital Expense		
34	Ownership	1,946,446	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	160,965	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,038,272	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,188,859)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,188,859)	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,360	1,360	\$ 55,577	\$ 40.87	1
2	Assistant Director of Nursing	1,136	1,490	44,998	30.20	2
3	Registered Nurses	26,212	29,379	738,278	25.13	3
4	Licensed Practical Nurses	19,793	20,319	452,517	22.27	4
5	CNAs & Orderlies	95,363	101,587	1,054,740	10.38	5
6	CNA Trainees					6
7	Licensed Therapist	3,438	3,470	169,762	48.92	7
8	Rehab/Therapy Aides	1,498	1,498	17,969	12.00	8
9	Activity Director	960	1,098	16,511	15.04	9
10	Activity Assistants	14,131	15,043	162,960	10.83	10
11	Social Service Workers	3,117	3,317	69,627	20.99	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,328	56,278	24.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,652	37,778	368,123	9.74	15
16	Dishwashers					16
17	Maintenance Workers	8,241	9,106	136,503	14.99	17
18	Housekeepers	16,054	17,948	163,236	9.09	18
19	Laundry	15,469	16,994	161,681	9.51	19
20	Administrator	2,080	2,080	138,808	66.73	20
21	Assistant Administrator	4,160	4,400	242,544	55.12	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,349	21,016	349,445	16.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	270,093	290,211	\$ 4,399,557 *	\$ 15.16	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	35,004	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,229	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 44,233		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 9,110	10-3	50
51	Licensed Practical Nurses		1,350	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 10,460		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Jay Lewkowitz	Administrator	9.375	\$ 138,808	Workers' Compensation Insurance	\$ 59,665	IDPH License Fee	\$	
Maureen Krah	Assistant Admin	0.00	162,847	Unemployment Compensation Insurance	63,683	Advertising: Employee Recruitment		
Judy Aliferis	Assistant Admin	0.00	79,697	FICA Taxes	337,874	Health Care Worker Background Check		
				Employee Health Insurance	74,744	(Indicate # of checks performed 65)	650	
				Employee Meals	64,386	Patient Background Checks 10	100	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	44,623	
				Employee Welfare	35,323	Dues & Subscriptions	7,282	
TOTAL (agree to Schedule V, line 17, col. 1)						Licenses & Fees	3,201	
(List each licensed administrator separately.)			\$ 381,352					
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees			\$ 1,476,798			Yellow page advertising	(44,623)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,476,798	TOTAL (agree to Schedule V, line 22, col.8)		\$ 635,675	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,233
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Kessler, Orlean, Silver & Co.	Accounting		\$ 34,564					
Richard Peelo	Accounting		4,500					
Arnstein Arnstein & Lehr LLP	Legal		2,500					
Aronberg Goldgehn	Legal		1,652				In-State Travel	
Dowd, Dowd & Mertes, Ltd	Legal		5,572					
Fisk, Kart, Katz and Regal Ltd	Legal		84,483					
Polsinelli Shughart	Legal		7,614					
Werman Law, P.C.	Legal		34,839				Seminar Expense	550
American Profit Recovery	Collection Agency		2,325					
Legat Architects	Life Safety Code Consult		4,314					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 182,363				TOTAL	\$ 550

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,818 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 160,965
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 64,386 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? N/A
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees