

		FOR BHF USE					

LL1

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

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: 0051862

Facility Name: OAKRIDGE HEALTHCARE CTR

Address: 323 OAKRIDGE AVE HILLSIDE 60162
Number City Zip Code

County: COOK

Telephone Number: (708) 547-6595 Fax # (708) 547-1971

HFS ID Number:

Date of Initial License for Current Owners: 01/01/12

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "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 BOKOR Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) ELI ATKIN
(Title) ADMINISTRATOR

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)
(Print Name and Title) SANFORD BOKOR
PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number OAKRIDGE HEALTHCARE CTR# 0051862 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	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	<u>58</u>	Skilled (SNF)	<u>58</u>	<u>21,228</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>15</u>	Intermediate (ICF)	<u>15</u>	<u>5,490</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,718	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	<u>9,884</u>	<u>2,246</u>	<u>3,269</u>	<u>15,399</u>	8
9	SNF/PED					9
10	ICF	<u>4,477</u>	<u>1,458</u>	<u>1,368</u>	<u>7,303</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,361	3,704	4,637	22,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.97%

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?

YESG. 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 1 / 01 / 12

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

YES ☒Date 1/1/12NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 17 and days of care provided 3,269Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	157,755	11,539	5,067	174,361		174,361		174,361		1
2	Food Purchase		145,803		145,803	(20,203)	125,600		125,600		2
3	Housekeeping		8,394		8,394		8,394		8,394		3
4	Laundry		14,057	55,000	69,057		69,057		69,057		4
5	Heat and Other Utilities			74,655	74,655		74,655		74,655		5
6	Maintenance	40,648	10,553	95,363	146,564		146,564		146,564		6
7	Other (specify):*			9,371	9,371		9,371		9,371		7
8	TOTAL General Services	198,403	190,346	239,456	628,205	(20,203)	608,002		608,002		8
	B. Health Care and Programs										
9	Medical Director			8,760	8,760		8,760		8,760		9
10	Nursing and Medical Records	1,344,077	114,403	5,710	1,464,190		1,464,190		1,464,190		10
10a	Therapy										10a
11	Activities	81,276	4,357		85,633		85,633		85,633		11
12	Social Services			3,135	3,135		3,135		3,135		12
13	CNA Training										13
14	Program Transportation			2,763	2,763		2,763		2,763		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,425,353	118,760	20,368	1,564,481		1,564,481		1,564,481		16
	C. General Administration										
17	Administrative	57,982			57,982		57,982		57,982		17
18	Directors Fees										18
19	Professional Services			38,851	38,851		38,851		38,851		19
20	Dues, Fees, Subscriptions & Promotions			12,922	12,922		12,922	(5,573)	7,349		20
21	Clerical & General Office Expenses	82,033	16,793	19,021	117,847		117,847	(100)	117,747		21
22	Employee Benefits & Payroll Taxes			341,154	341,154	20,203	361,357		361,357		22
23	Inservice Training & Education			1,760	1,760		1,760		1,760		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			19,745	19,745		19,745	(19,745)			25
26	Insurance-Prop.Liab.Malpractice			81,860	81,860		81,860		81,860		26
27	Other (specify):*			36,000	36,000		36,000	(36,000)			27
28	TOTAL General Administration	140,015	16,793	551,313	708,121	20,203	728,324	(61,418)	666,906		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,763,771	325,899	811,137	2,900,807		2,900,807	(61,418)	2,839,389		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,067
	REPAIRS & MAINTENANCE		0
			0
			5,067
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
	CONTRACTED LAUNDRY SERVICE		55,000
5	HEAT & OTHER UTILITIES		
	GAS HEAT		19,443
	ELECTRICITY		29,273
	WATER		23,976
	CABLE TV - LOBBY		1,963
			0
			74,655
6	MAINTENANCE		
	GROUNDS MAINTENANCE		80
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		6,991
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,178
	FIRE SERVICE		3,614
	CONTRACTED BUILDING MAINT		82,500
			0
			0
			0
			95,363
7	OTHER		
	SCAVENGER		8,437
	SECURITY SERVICE		934
			0
			0
			9,371
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,760

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	1,270
	UTILIZATION REVIEW FEES	XVIII B -2	0
	PHYSICIANS	XVIII B -2	0
	PSYCHIATRIC	XVIII B -2	0
	NURSING	XVIII B 38-2	1,589
	DENTAL SERVICE		2,745
	DENTAL		106
			5,710
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		2,250
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	885
	SOCIAL WORKER	XVIII B 45-2	0
			3,135
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		2,763
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	0
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	14,425
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	24,426
			0
			38,851
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,573
	EMPLOYEE WANT ADS	XIX F	375
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	941
	LICENSES & PERMITS	XIX F	5,783
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	250
	PATIENT BACKGROUND CHECKS	XIX F	0
			12,922
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		7,588
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		1,000
	PENALTIES / OVERDRAFT CHARGES	VI 18	100
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		10,333
	MESSENGER SERVICE		0
			0
			19,021

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	134,677
	UNEMPLOYMENT COMPENSATION	XIX D	105,039
	WORKERS COMPENSATION INSURANC	XIX D	52,301
	HOSPITALIZATION INSURANCE	XIX D	47,706
	EMPLOYEE BENEFITS - OTHER	XIX D	1,221
	EMPLOYEE PHYSICAL EXAMS	XIX D	210
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			341,154
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		1,760
			1,760
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		19,745
			19,745
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		81,860
			81,860
27	OTHER		
	BAD DEBTS	VI 24	36,000
			36,000

GRAND TOTAL COLUMN 3 OTHER

811,137

OAKRIDGE HEALTHCARE CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	145,803	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	145,803	
TOTAL PATIENT CENSUS	22,702	
TIMES 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	68,106	
ADD # EMPLOYEE MEALS/DAY	30	
TIMES # DAYS	<u>366</u>	
TOTAL EMPLOYEE MEALS	10,980	
PATIENT MEALS	68,106	
ADD EMPLOYEE MEALS	<u>10,980</u>	
TOTAL MEALS/YEAR	79,086	
NET FOOD	145,803	
DIVIDE TOTAL MEALS/YEAR	<u>79,086</u>	
COST PER MEAL	1.84	
TIMES EMPLOYEE MEALS	<u>10,980</u>	
EMPLOYEE MEAL RECLASSIFICATION	<u><u>20,203</u></u>	

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			26,875	26,875		26,875	33,102	59,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,312	6,312		6,312	184,221	190,533			32
33	Real Estate Taxes			148,100	148,100		148,100		148,100			33
34	Rent-Facility & Grounds			252,000	252,000		252,000	(252,000)				34
35	Rent-Equipment & Vehicles			13,328	13,328		13,328		13,328			35
36	Other (specify):*											36
37	TOTAL Ownership			446,615	446,615		446,615	(34,677)	411,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,906	4,112	69,018		69,018		69,018			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,327	169,327		169,327		169,327			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,906	173,439	238,345		238,345		238,345			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,763,771	390,805	1,431,191	3,585,767		3,585,767	(96,095)	3,489,672			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(37,049)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(996)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(100)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	27		24
25	Fund Raising, Advertising and Promotional	(5,573)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(19,745)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,463)		\$	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)	3,368		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,368		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,095)		37

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

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

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

STATE OF ILLINOIS
OAKRIDGE HEALTHCARE CTR

Page 5A

Report Period Beginning: ID# 0051862
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NON ALLOWABLE TRAVEL	\$ (19,745)	25	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	(19,745)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKRIDGE HEALTHCARE CTR # 0051862 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,573)	0	0	0	0	0	0	0	0	0	0	(5,573)	20
21	Clerical & General Office Expenses	(100)	0	0	0	0	0	0	0	0	0	0	(100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(19,745)	0	0	0	0	0	0	0	0	0	0	(19,745)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(36,000)	0	0	0	0	0	0	0	0	0	0	(36,000)	27
28	TOTAL General Administration	(61,418)	0	0	0	0	0	0	0	0	0	0	(61,418)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(61,418)	0	0	0	0	0	0	0	0	0	0	(61,418)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(37,049)	70,151	0	0	0	0	0	0	0	0	0	33,102	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(996)	185,217	0	0	0	0	0	0	0	0	0	184,221	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(252,000)	0	0	0	0	0	0	0	0	0	(252,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(38,045)	3,368	0	0	0	0	0	0	0	0	0	(34,677)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(99,463)	3,368	0	0	0	0	0	0	0	0	0	(96,095)	45

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
ELISHA ATKIN	50	MCALLISTER NURSING AND REHAB LLC	TINLEY PARK	OAKRIDGE	HILLSIDE	REALTY
Yael Atkin	50			NURSING AND		
				REHAB PROP, LLC		
					TINLEY PARK	REALTY
				MCALLISTER		
				PROPERTY,LLC		

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

X YES NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 252,000	OAKRIDGE NURSING AND REHAB PROPERTIES, LLC		\$	(252,000)	1
2	V	30	DEPRECIATION				70,151	70,151	2
3	V	32	INTEREST				185,217	185,217	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 252,000			\$ 255,368	\$ * 3,368	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CTR # 0051862 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 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	TZVI ATKIN	ASSIST ADMIN				40		SALARY	\$ 18,206	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,206		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 OAKRIDGE HEALTHCARE CTR # 0051862 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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	RELATED PARTY						\$					\$	1		
2													2		
3	INTERNATIONAL BANK		X	MORTGAGE				2,272,500		1/8/13	0.0525	129,708	3		
4	MICHAEL ACERRA		X	2ND MORTGAGE				750,000				56,109	4		
5	BANK LEUMI		X	MORTGAGE	\$20,425.40	12/27/12		3,000,000	3,000,000				5		
	Working Capital														
6	BANK LEUMI			LINE OF CREDIT	INT ONLY				220,000			2,599	6		
7				INSURANCE								2,717	7		
8													8		
9	TOTAL Facility Related				\$20,425.40		\$	6,022,500	\$	3,220,000			\$	191,133	9
	B. Non-Facility Related*														
10				BED TAX								996	10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	996	14	
15	TOTALS (line 9+line14)						\$	6,022,500	\$	3,220,000			\$	192,129	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	N/A	Line #	36
------------	--	-----------	------------	---------------	-----------

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

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

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 2011 report.	\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3. Under or (over) accrual (line 2 minus line 1).	\$			3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	148,100		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.	\$	148,100		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007		8	
	2008		9	
	2009		10	
	2010		11	
	2011	148,100	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.				

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

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKRIDGE HEALTHCARE CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051862

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

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

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	15-17-413-052-0000	NURSING HOME	\$ 76,956.89	\$ 76,956.89
2.	15-17-413-067-0000	NURSING HOME	\$ 71,143.14	\$ 71,143.14
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 148,100.03	\$ 148,100.03

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

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?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2009	\$ 225,000	1
2					2
3	TOTALS			\$ 225,000	3

HFS 3745 (N-4-99)

IL478-2471

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	73		2009		\$ 1,295,561	\$ 47,111	27.5	\$ 47,111	\$	\$ 47,111
5										
6										
7										
8										
	Improvement Type**									
9	vinyl plank flooring for two dining rooms and hallways			2012	16,959	18	27.5	18		18
10	ROOF			2012	4,950	5	27.5	5		5
11	draperies,cornices>window treatments in resident rooms,									
12	and in the public area			2012	18,857	9,766	7	1,345	(8,421)	1,345
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,336,327	\$56,900		\$48,479	\$(8,421)	\$48,479	70

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	29,969	17,086	1,498	(15,588)	10 YRS	1,498	72
73	Fully Depreciated Assets							73
74	REL PARTY		23,040	10,000	(13,040)	10 YRS	10,000	74
75	TOTALS	\$ 29,969	\$ 40,126	\$ 11,498	\$ (28,628)		\$ 11,498	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,591,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,026	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,977	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (37,049)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 59,977	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:				\$252,000			3
4	Additions							4
5								5
6								6
7	TOTAL				\$252,000			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: \$11,190
- Description:SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18				2,138	18
19					19
20					20
21	TOTAL		\$	2,138	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

12345678										
	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	39-3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				58,758		58,758	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RADIOLOGY,LABORATORY Other (specify): SUPPLIES					4,112	6,148		4,112 6,148	13
14	TOTAL			\$		\$ 4,112	\$ 64,906		\$ 69,018	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	\$ 361,713	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (33,415))	1,301,274		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	300		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,663,287	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	21,909		15
16	Equipment, at Historical Cost	48,826		16
17	Accumulated Depreciation (book methods)	(26,875)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSIT	9,710		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 53,570	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,716,857	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 403,013	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	220,000		29
30	Accrued Salaries Payable	30,540		30
31	Accrued Taxes Payable (excluding real estate taxes)	81,411		31
32	Accrued Real Estate Taxes(Sch.IX-B)	148,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Prior Owner, HC Dekor	114,295		36
37	Due To Oakridge Properties	549,875		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,547,234	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,547,234	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 169,623	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,716,857	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	289,623	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	(120,000)	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)	\$ 169,623	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)	\$ 169,623	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
 Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,853,334	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,853,334	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	757	12
13	Barber and Beauty Care	852	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,609	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	SETTLEMENT WITH PRIOR OWNERS	20,447	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,447	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,875,390	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	628,205	31
32	Health Care	1,564,481	32
33	General Administration	708,121	33
	B. Capital Expense		
34	Ownership	446,615	34
	C. Ancillary Expense		
35	Special Cost Centers	69,018	35
36	Provider Participation Fee	169,327	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,585,767	40
41	Income before Income Taxes (line 30 minus line 40)**	289,623	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 289,623	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,102,096	44
45	Private Pay - Net Inpatient Revenue	571,040	45
46	Medicare - Net Inpatient Revenue	766,072	46
47	Other-(specify) VETERAN	130,767	47
48	Other-(specify) INSURANCE	283,359	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,853,334	49

**TAX RETURN PREPARED ON CASH BASIS

* This must agree with page 4, line 45, column 4.
 ** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** 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	2,018	2,091	\$ 74,560	\$ 35.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,328	6,633	201,091	30.32	3
4	Licensed Practical Nurses	13,201	13,766	363,188	26.38	4
5	CNAs & Orderlies	51,536	53,407	556,972	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,852	2,050	30,783	15.02	9
10	Activity Assistants	3,362	3,482	50,493	14.50	10
11	Social Service Workers					11
12	Dietician	201	204	4,745	23.26	12
13	Food Service Supervisor					13
14	Head Cook	822	822	10,115	12.31	14
15	Cook Helpers/Assistants	12,280	12,898	142,895	11.08	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,105	40,648	19.31	17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	2,966	3,012	57,982	19.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,567	4,808	82,033	17.06	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)	2,854	2,913	148,266	50.90	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,980	108,191	\$ 1,763,771 *	\$ 16.30	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	M	\$ 5,067	1-3	35
36	Medical Director	O	8,760	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,589	10-3	38
39	Pharmacist Consultant	H	1,270	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	885	12-3	45
46	Other(specify) REHABILITATION	S	2,250	12-3	46
47	DENTAL		106	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,927		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number		OAKRIDGE HEALTHCARE CTR		STATE OF ILLINOIS		# 0051862		Report Period Beginning:		01/01/2012		Page 21		Ending: 12/31/2012			
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount			
ELISHA ATKIN		ADMINISTRATOR		50		\$ 0		Workers' Compensation Insurance		\$ 52,301		IDPH License Fee		\$			
WILLIAM BOKOR		ASST ADMIN				39,776		Unemployment Compensation Insurance		105,039		Advertising: Employee Recruitment		375			
TZVI ATKIN		ASST ADMIN				18,206		FICA Taxes		134,677		Health Care Worker Background Check		250			
								Employee Health Insurance		47,706		(Indicate # of checks performed)					
								Employee Meals		20,203		Patient Background Checks		0			
								Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		0			
								EMPLOYEE BENEFITS - OTHER		1,221		MARKETING/ADV/PROMO		5,573			
								EMPLOYEE PHYSICAL EXAMS		210		LICENSES/DUES/SUBSCRIPTIONS		6,724			
								PENSION/PROFIT SHARING PLANS		0		MGMT CO ALLOC					
TOTAL (agree to Schedule V, line 17, col. 1)								CHICAGO HEAD TAX		0		TRUST/FRANCHISE/CONTRIB/ETC		0			
(List each licensed administrator separately.)						\$ 57,982		INSURANCE - EXECUTIVE LIFE		0		Less: Public Relations Expense		(0)			
B. Administrative - Other												Non-allowable advertising				(5,573)	
Description						Amount						Yellow page advertising		(0)			
						\$ 0		INSURANCE - EXECUTIVE LIFE VI 21		0							
												TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,349			
								TOTAL (agree to Schedule V, line 22, col.8)		\$ 361,357							
TOTAL (agree to Schedule V, line 17, col. 3)												G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees													
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount			
				\$						\$		Out-of-State Travel		\$			
												In-State Travel					
														0			
												Seminar Expense					
														0			
												Entertainment Expense		()			
SEE SCHEDULE ATTACHED				38,851								(agree to Sch. V, line 24, col. 8)					
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				\$		TOTAL		\$			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 38,851													
* Attach copy of IMRF notifications																	
**See instructions.																	

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

NO
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YR
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$ _____ Line _____

10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (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 _____
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 169,327
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

- (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?
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.

NO
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
\$ _____
Has any meal income been offset against related costs?
Indicate the amount. \$ _____

20,203
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

c.

What percent of all travel expense relates to transportation of nurses and patients?

5%

d.

Have vehicle usage logs been maintained?

NO

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO

h.

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?
Firm Name: _____

NO
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

YES