FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0025056

Facility Name: Oakton Pavillion

Address: 1660 Oakton Place (Number) | Des Plaines (City) | 60018 (Zip Code)

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jay Lewkowitz
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) Sanford B. Alper, Principal
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C., 1101 Lake Cook Road, Suite C, 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**

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,637	18,485	1,127	54,249	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,637	18,485	1,127	54,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.55%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/20/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/20/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 294 and days of care provided 5,748

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	457,242	47,388	13,214	517,844	(70,467)	447,377		447,377			1
2	Food Purchase		390,921		390,921		390,921	(15,630)	375,291			2
3	Housekeeping	252,693	43,089		295,782		295,782		295,782			3
4	Laundry	155,864	32,427		188,291		188,291		188,291			4
5	Heat and Other Utilities			249,901	249,901		249,901		249,901			5
6	Maintenance	133,898	135,979		269,877		269,877		269,877			6
7	Other (specify):* See Attached Sch			38,220	38,220		38,220		38,220			7
8	TOTAL General Services	999,697	649,804	301,335	1,950,836	(70,467)	1,880,369	(15,630)	1,864,739			8
	B. Health Care and Programs											
9	Medical Director			40,970	40,970		40,970		40,970			9
10	Nursing and Medical Records	2,799,624	500,527	29,157	3,329,308		3,329,308		3,329,308			10
10a	Therapy	17,321		669,639	686,960		686,960		686,960			10a
11	Activities	210,204	46,718		256,922		256,922		256,922			11
12	Social Services	62,142			62,142		62,142		62,142			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,089,291	547,245	739,766	4,376,302		4,376,302		4,376,302			16
	C. General Administration											
17	Administrative	221,069		1,649,323	1,870,392		1,870,392	(1,494,323)	376,069			17
18	Directors Fees											18
19	Professional Services			71,678	71,678		71,678	11,568	83,246			19
20	Dues, Fees, Subscriptions & Promotions			53,212	53,212		53,212	(41,984)	11,228			20
21	Clerical & General Office Expenses	361,110		116,310	477,420		477,420	(6,418)	471,002			21
22	Employee Benefits & Payroll Taxes			678,845	678,845	70,467	749,312	(13,288)	736,024			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,709	3,709		3,709	(1,287)	2,422			25
26	Insurance-Prop.Liab.Malpractice			125,491	125,491		125,491		125,491			26
27	Other (specify):*											27
28	TOTAL General Administration	582,179		2,698,568	3,280,747	70,467	3,351,214	(1,545,732)	1,805,482			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,671,167	1,197,049	3,739,669	9,607,885		9,607,885	(1,561,362)	8,046,523			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakton Pavillion #0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							222,921	222,921			30
31	Amortization of Pre-Op. & Org.							3,237	3,237			31
32	Interest							122,609	122,609			32
33	Real Estate Taxes			809,319	809,319		809,319		809,319			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			18,878	18,878		18,878		18,878			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,268,197	2,268,197		2,268,197	(1,091,233)	1,176,964			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)**	4,671,167	1,197,049	6,168,831	12,037,047		12,037,047	(2,652,595)	9,384,452			45

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	(24,164)	30		9
10	Interest and Other Investment Income	(13,506)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15,630)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,287)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,140)	21		20
21	Owner or Key-Man Insurance	(13,288)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,653)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(27,723)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(41,984)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (146,375)		$	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)	(2,506,220)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,506,220)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,652,595)		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

Oakton Pavillion

ID# 0025056

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,630)	0	0	0	0	0	0	0	0	0	0	(15,630)	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	(15,630)	0	0	0	0	0	0	0	0	0	0	(15,630)	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	(1,494,323)	0	0	0	0	0	0	0	0	0	(1,494,323)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,568	0	0	0	0	0	0	0	0	0	11,568	19
20	Fees, Subscriptions & Promotions	(41,984)	0	0	0	0	0	0	0	0	0	0	(41,984)	20
21	Clerical & General Office Expenses	(8,793)	2,375	0	0	0	0	0	0	0	0	0	(6,418)	21
22	Employee Benefits & Payroll Taxes	(13,288)	0	0	0	0	0	0	0	0	0	0	(13,288)	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	(1,287)	0	0	0	0	0	0	0	0	0	0	(1,287)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(65,352)	(1,480,380)	0	0	0	0	0	0	0	0	0	(1,545,732)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,982)	(1,480,380)	0	0	0	0	0	0	0	0	0	(1,561,362)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakton Pavillion # 0025056 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,164)	247,085	0	0	0	0	0	0	0	0	0	222,921	30
31	Amortization of Pre-Op. & Org.	0	3,237	0	0	0	0	0	0	0	0	0	3,237	31
32	Interest	(13,506)	136,115	0	0	0	0	0	0	0	0	0	122,609	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,440,000)	0	0	0	0	0	0	0	0	0	(1,440,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(27,723)	27,723	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(65,393)	(1,025,840)	0	0	0	0	0	0	0	0	0	(1,091,233)	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)**	(146,375)	(2,506,220)	0	0	0	0	0	0	0	0	0	(2,652,595)	45

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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. [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	$ 1,440,000	Oakton Terrace	100.00%	$	$ (1,440,000)	1
2	V	32	Interest Income	2,696	Oakton Terrace	100.00%		(2,696)	2
3	V	17	Consulting Fees		Oakton Terrace	100.00%	155,000	155,000	3
4	V	30	Depreciation		Oakton Terrace	100.00%	247,085	247,085	4
5	V	31	Amortization		Oakton Terrace	100.00%	3,237	3,237	5
6	V	19	Accounting Fees		Oakton Terrace	100.00%	8,910	8,910	6
7	V	32	Mortgage Interest		Oakton Terrace	100.00%	138,811	138,811	7
8	V	21	Miscellaneous Expenses		Oakton Terrace	100.00%	2,200	2,200	8
9	V	36	Income Tax Expense		Oakton Terrace	100.00%	11,191	11,191	9
10	V	17	Rental Income	1,649,323	FMH Management Company	100.00%		(1,649,323)	10
11	V	19	Accounting Fees		FMH Management Company	100.00%	2,658	2,658	11
12	V	21	Miscellaneous Expenses		FMH Management Company	100.00%	175	175	12
13	V	36	Income Tax Expense		FMH Management Company	100.00%	16,532	16,532	13
14	Total			$ 3,092,019			$ 585,799	$ * (2,506,220)	14

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jay Lewkowitz	Administrator	Administrative	9.375%	N/A	40	90.00	Salary	$ 125,000	17-1	1
2	Fred Weiss	General Partner	Administrative	24.42	N/A	10	20.00	Mng Fees	25,000	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	$ 280,000		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: 01/01/2010 Ending: 2/31/2010

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 2,405,603	06/27/13	LIBR+1.75	$ 138,811	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	$ 2,405,603			$ 138,811	9
	B. Non-Facility Related*											
10	Oakton Terrace	X									(2,696)	10
11	Interest Income										(13,506)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,202)	14
15	TOTALS (line 9+line14)						$ 2,600,000	$ 2,405,603			$ 122,609	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.)**

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 433,000	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.)		$ 596,839	2
3. Under or (over) accrual (line 2 minus line 1).		$ 163,839	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 615,000	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.)		$ 30,480	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.		$ 809,319	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	510,277	8
	2006	521,183	9
	2007	551,210	10
	2008	419,713	11
	2009	596,839	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-29-106-006-000	Oakton Pavillion	$ 596,838.70	$ 596,838.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 596,838.70	$ 596,838.70

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,000 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 4

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	294		1980	1980	$ 4,171,968	$ 61,056	40	$ 104,229	$ 43,173	$ 3,891,964	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Audit Adjustment			1981	955		20			955	9
10	Audit Adjustment			1983	30,266		20			30,266	10
11	Doors			1985	1,500		10			1,500	11
12	Sidewalk			1985	350		20			350	12
13	Audit Adjustment			1985	9,122		20			9,122	13
14	Decorating			1985	6,905		10			6,905	14
15	Hot Water Heater			1987	12,788		10			12,788	15
16	Light Fixtures			1987	11,288		10			11,288	16
17	Antena Hook Up			1988	4,905		10			4,905	17
18	A/C Compressor			1988	8,000		10			8,000	18
19	Sod / Environment Center			1989	7,282		10			7,282	19
20	Doors / Carpet			1990	3,609		10			3,609	20
21	Boiler Shell			1991	1,760		10			1,760	21
22	Roof			1991	40,000		20	2,000	2,000	40,000	22
23	Improvements			1991	4,590		10			4,590	23
24	Fire Dapers & Doors			2001	148,267	3,801	39	3,801		36,118	24
25	Sliding Door			2001	10,498		39	269	269	2,556	25
26	White Way Sign			2001	2,082	53	39	53		504	26
27	Remodeling Garden Level			2001	208,312	5,341	39	5,341		50,744	27
28	Smoke Detector			2003	4,320	135	10	432	297	3,456	28
29	Pump			2003	14,118	315	10	1,412	1,097	11,296	29
30	Electircal Circuits			2004	6,811	175	39	175		1,225	30
31	Elevator Modernization			2004	24,393	625	39	625		4,375	31
32	Shed			2004	3,566	159	7	509	350	3,563	32
33	Plumbing Improvements			2004	44,749	1,147	39	1,147		8,033	33
34	Elevator Modernization			2005	86,956	2,230	39	2,230		13,376	34
35	Pantry Reovation			2005	8,155	209	39	209		1,254	35
36	Asphalt Work			2005	22,835	1,423	15	2,169	746	12,367	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Electrical Improvements	2005	$ 1,730	$ 44	39	$ 44	$	$ 264	37
38	Outside Lights	2006	2,816	72	39	72		360	38
39	Plumbing Improvements	2006	3,100	80	39	80		396	39
40	Roof Replacement	2006	131,130	3,362	39	3,362		16,810	40
41	Masonary Renovation	2006	12,415	318	39	318		1,590	41
42	Steel Window Lintel Replacement	2006	48,850	1,253	39	1,253		6,265	42
43	Steel Window Lintel Replacement	2006	4,100	106	39	106		526	43
44	Tuckpointing and Brick Replacement	2006	25,000	641	39	641		3,205	44
45	Elevator Power Unit	2006	9,959	255	39	255		1,275	45
46	Roof Exhaust Fan	2006	2,080	53	39	53		265	46
47	Roof Drains	2006	10,850	278	39	278		1,390	47
48	Sewage Pump	2007	3,905	100	39	100		400	48
49	Chilled Water Coils	2007	29,744	762	39	762		3,051	49
50	Fire Alarm System	2007	10,625	272	39	272		1,088	50
51	Cooling Tower Monitor	2007	2,560	66	39	66		264	51
52	1st Floor Remodeling - Contracted - Total	2009	15,000	385	39	385		770	52
53	Rebuild Water Pump	2009	4,580	118	39	118		235	53
54	Kitchen Plumbing Renovation	2009	9,578	246	39	246		492	54
55	Boiler	2009	15,700	402	39	402		805	55
56	Boiler Vale	2009	4,995	128	39	128		256	56
57	Tub Room Renovation	2010	9,300	139	39	139		139	57
58	Ejector Pump	2010	7,500	112	39	112		112	58
59	Cement Ramps	2010	4,544	58	39	58		58	59
60	Flagpole	2010	2,093	31	39	31		31	60
61	Awnings	2010	7,997	137	39	137		137	61
62	Recirculating Water Pump	2010	2,750	18	39	18		18	62
63	HVAC Circulating Pump	2010	10,735	115	39	115		115	63
64	Temperature Control Valve	2010	6,200	79	39	79		79	64
65	Laundry Room Ejector Pump	2010	18,787	40	39	40		40	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,318,973	$ 86,339		$ 134,271	$ 47,932	$ 4,224,587	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 536,403	$ 12,286	$ 52,493	$ 40,207	10	$ 522,074	71
72	Current Year Purchases	246,148	140,811	24,074	(116,738)	10	24,074	72
73	Fully Depreciated Assets	606,345				10	606,345	73
74								74
75	TOTALS	$ 1,388,896	$ 153,097	$ 76,567	$ (76,531)		$ 1,152,493	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Patients	1992 Ford Van	1992	$ 27,300	$	$	$	5	$ 27,300	76
77	Administrative	2009 Accura	2009	36,806	4,800	2,192	(2,608)	5	4,384	77
78	Administrative	2005 Ford E350	2005	49,451	2,848	9,891	7,043	5	49,451	78
79										79
80	TOTALS			$ 113,557	$ 7,648	$ 12,083	$ 4,435		$ 81,135	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)	$ 7,021,426	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 247,084	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 222,921	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,164)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,458,215	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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

10. Effective dates of current rental agreement:
Beginning 01/01/2010
Ending 12/31/2010

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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 [X] NO Terms: *

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 18,878 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

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 175,969		$	$		$ 175,969	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs	487,589					487,589	4
5	Physician Care		visits							5
6	Dental Care	10a-3	visits	5,600					5,600	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):									12
13	Other (specify):									13
14	TOTAL			$ 669,158		$	$		$ 669,158	14

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

Facility Name & ID Number Oakton Pavillion **#** 0025056 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,530,834	$ 2,161,617	1
2	Cash-Patient Deposits	17,853	17,853	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,565,771	2,565,771	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)	4,366,399	1,968,760	8
9	Other(specify): See Attached Schedule	43,609	789,642	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,524,466	$ 7,503,643	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		1,147,005	15
16	Equipment, at Historical Cost		1,502,452	16
17	Accumulated Depreciation (book methods)		(5,256,050)	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 (spe Loan Costs		7,812	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 1,773,187	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,524,466	$ 9,276,830	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 167,784	$ 168,034	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,853	17,853	28
29	Short-Term Notes Payable		88,410	29
30	Accrued Salaries Payable	74,899	74,899	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	615,000	615,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		27,881	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	5,491,896	527,569	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,367,432	$ 1,519,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,317,193	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)**	$	$ 2,317,193	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,367,432	$ 3,836,839	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,157,034	$ 5,439,991	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,524,466	$ 9,276,830	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,171,467	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,171,468	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,014,434)	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)**	$ (1,014,434)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,157,034	24 *

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

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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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,472,677	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,472,677	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	994,386	6
7	Oxygen	4,645	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 999,031	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	6,249	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	20,785	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,034	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,506	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,506	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	510,365	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 510,365	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,022,613	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,950,836	31
32	Health Care	4,376,302	32
33	General Administration	3,280,747	33
	B. Capital Expense		
34	Ownership	2,268,197	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)***	$ 12,037,047	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,014,434)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,014,434)	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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 58,406	$ 28.08	1
2	Assistant Director of Nursing	2,080	2,080	65,474	31.48	2
3	Registered Nurses	39,737	43,708	1,073,262	24.56	3
4	Licensed Practical Nurses	11,120	11,376	253,537	22.29	4
5	CNAs & Orderlies	111,047	118,354	1,348,945	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,437	1,443	17,321	12.00	8
9	Activity Director	2,080	2,287	35,456	15.50	9
10	Activity Assistants	13,803	15,778	174,748	11.08	10
11	Social Service Workers	2,440	3,004	62,142	20.69	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,268	52,979	23.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,163	40,935	404,263	9.88	15
16	Dishwashers					16
17	Maintenance Workers	8,282	8,874	133,898	15.09	17
18	Housekeepers	23,064	25,474	252,693	9.92	18
19	Laundry	15,028	16,462	155,864	9.47	19
20	Administrator	2,080	2,085	125,000	59.95	20
21	Assistant Administrator	2,080	2,185	96,069	43.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,298	20,488	361,110	17.63	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)	295,899	318,881	$ 4,671,167 *	$ 14.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,214	1-3	35
36	Medical Director	Monthly	40,970	9-3	36
37	Medical Records Consultant	Monthly	3,160	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,428	10-3	39
40	Physical Therapy Consultant	Monthly	481	10a-3	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)		$ 64,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	65	$ 18,909	10-3	50
51	Licensed Practical Nurses	15	660	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	80	$ 19,569		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jay Lewkowitz	Administrator	9.375	$ 125,000
Maureen Krahl	Assistant Admin	0.000	96,069
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 221,069

B. Administrative - Other

Description	Amount
Management Fees	$ 1,649,323
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,649,323
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Olrean, Silver & Co.	Accounting	$ 33,080
Richard Peelo	Accounting	4,500
Innovative Therapy Partners	Publicate Consultant	5,600
Polsinelli Shughart	Publicate Consultant	8,943
Sheila Krahl	Publicate Consultant	1,750
Dowd, Dowd & Mertes, Ltd.	Legal	481
Sugar & Filsenthal LLP	Legal	1,300
Werman Law P.C.	Legal	16,024
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 71,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,620
Unemployment Compensation Insurance	55,058
FICA Taxes	337,788
Employee Health Insurance	175,156
Employee Meals	70,467
Illinois Municipal Retirement Fund (IMRF)*	
Employee Welfare	40,223
Officer Life Insurance	(13,288)
TOTAL (agree to Schedule V, line 22, col.8)	$ 736,024

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 75)	750
Patient Background Checks	
Advertising	41,984
Dues and Subscriptions	2,709
Licences and Permits	7,769
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(41,984)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,228

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **56,033** 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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **70,467** 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 fo
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 othe
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 ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees