FOR BHF USE

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

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

I. IDPH License ID Number: 0051144

Facility Name: Oak Lawn Nursing and Rehabilitation Center

Address: 9525 South Mayfield (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708) 636-7000 **Fax #** ( )

HFS ID Number: 273059928001

Date of Initial License for Current Owners: 9/1/10

Type of Ownership:

	VOLUNTARY,NON-PROFIT		X	PROPRIETARY			GOVERNMENTAL
	Charitable Corp.			Individual			State
	Trust			Partnership			County
				Corporation			Other
				"Sub-S" Corp.			
			X	Limited Liability Co.			
				Trust			
				Other			

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/11 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)	Moishe Gubin
	(Title)	Manager
Paid Preparer	(Signed)	See Accountants' Compilation Report (Date)
	(Print Name and Title)	Daniel S. Gaafar, Partner
	(Firm Name & Address)	Bradley Associates, 201 S. Capitol Ave, Ste 910, Indianapolis, IN 46225
	(Telephone)	(317) 237-5500 Fax # (317) 237-5503

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar
Telephone Number: (317) 237-5500
Email Address: dang@bradleycpa.com

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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 N/A

	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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,195	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	10,502	181	2,940	13,623	8
9	SNF/PED					9
10	ICF	15,033	260		15,293	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,535	441	2,940	28,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.40%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 9/1/2010

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 2,820

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number: Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclassification	Reclassified Total	Adjustments	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	183,519	18,997	15,000	217,516		217,516	(7,956)	209,560			1
2	Food Purchase		130,029		130,029		130,029	(258)	129,771			2
3	Housekeeping	126,301	23,104		149,405		149,405		149,405			3
4	Laundry	58,577	15,873		74,450		74,450		74,450			4
5	Heat and Other Utilities			135,600	135,600		135,600	299	135,899			5
6	Maintenance	39,706	23,895	30,428	94,029		94,029	378	94,407			6
7	Other (specify):*											7
8	**TOTAL General Services**	408,103	211,898	181,028	801,029		801,029	(7,537)	793,492			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,402,174	645,733	29,875	3,077,782		3,077,782	4,782	3,082,564			10
10a	Therapy			260,963	260,963		260,963		260,963			10a
11	Activities	83,551	6,991		90,542		90,542		90,542			11
12	Social Services	46,090		1,859	47,949		47,949		47,949			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			5,091	5,091		5,091		5,091			15
16	**TOTAL Health Care and Programs**	2,531,815	652,724	315,788	3,500,327		3,500,327	4,782	3,505,109			16
	C. General Administration											
17	Administrative	99,322			99,322		99,322		99,322			17
18	Directors Fees											18
19	Professional Services			198,352	198,352		198,352	(191,813)	6,539			19
20	Dues, Fees, Subscriptions & Promotions			4,174	4,174		4,174	250	4,424			20
21	Clerical & General Office Expenses	192,534	75,191	29,120	296,845		296,845	154,154	450,999			21
22	Employee Benefits & Payroll Taxes			535,442	535,442		535,442	(644)	534,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,521	3,521		3,521	(1,926)	1,595			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			179,351	179,351		179,351	4,686	184,037			26
27	Other (specify):*											27
28	**TOTAL General Administration**	291,856	75,191	949,960	1,317,007		1,317,007	(35,293)	1,281,714			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,231,774	939,813	1,446,776	5,618,363		5,618,363	(38,048)	5,580,315			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Oak Lawn Nursing and Rehabilitation Center #0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			77,745	77,745		77,745	172,981	250,726			30
31	Amortization of Pre-Op. & Org.							22,222	22,222			31
32	Interest			89,365	89,365		89,365	42,524	131,889			32
33	Real Estate Taxes							236,608	236,608			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(839,106)	120,894			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax							1,879	1,879			36
37	TOTAL Ownership			1,127,110	1,127,110		1,127,110	(362,892)	764,218			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			172,003	172,003		172,003		172,003			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,293	78,293		78,293		78,293			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			250,296	250,296		250,296		250,296			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,231,774	939,813	2,824,182	6,995,769		6,995,769	(400,940)	6,594,829			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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 Reference	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	(4,064)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	1		13
14	Non-Care Related Interest	(68,451)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,061)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,841)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (107,432)		$	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)	(293,508)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (293,508)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (400,940)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Oak Lawn Nursing and Rehabilitation Center

ID# 0051144

Report Period Beginning: 1/1/2011

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COMMUTING	$ (2,262)	24	1
2	MEDICAL RECORDS INCOME	(812)	10	2
3	JURY DUTY INCOME	(34)	21	3
4	PURCHASE DISCOUNTS	(4,490)	21	4
5	EMPLOYEE EXPENSE REFUND	(5,099)	22	5
6	FOOD REBATE	(102)	2	6
7	REFUND	(42)	21	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**	(12,841)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	(10)	(7,946)	0	0	0	0	0	0	0	0	0	(7,956)	1
2	Food Purchase	(102)	(156)	0	0	0	0	0	0	0	0	0	(258)	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	299	0	0	0	0	0	0	0	0	0	299	5
6	Maintenance	0	378	0	0	0	0	0	0	0	0	0	378	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(112)	(7,425)	0	0	0	0	0	0	0	0	0	(7,537)	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	(812)	5,594	0	0	0	0	0	0	0	0	0	4,782	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**	(812)	5,594	0	0	0	0	0	0	0	0	0	4,782	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	(191,813)	0	0	0	0	0	0	0	0	0	(191,813)	19
20	Fees, Subscriptions & Promotions	0	0	250	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(26,627)	139,906	40,875	0	0	0	0	0	0	0	0	154,154	21
22	Employee Benefits & Payroll Taxes	(5,099)	4,455	0	0	0	0	0	0	0	0	0	(644)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,262)	336	0	0	0	0	0	0	0	0	0	(1,926)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,686	0	0	0	0	0	0	0	0	0	4,686	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(33,988)	(42,430)	41,125	0	0	0	0	0	0	0	0	(35,293)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,912)	(44,261)	41,125	0	0	0	0	0	0	0	0	(38,048)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	(4,064)	0	177,045	0	0	0	0	0	0	0	0	172,981	30
31	Amortization of Pre-Op. & Org.	0	0	22,222	0	0	0	0	0	0	0	0	22,222	31
32	Interest	(68,456)	110,980	0	0	0	0	0	0	0	0	0	42,524	32
33	Real Estate Taxes	0	0	236,608	0	0	0	0	0	0	0	0	236,608	33
34	Rent-Facility & Grounds	0	9,267	(848,373)	0	0	0	0	0	0	0	0	(839,106)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	1,879	0	0	0	0	0	0	0	0	1,879	36
37	**TOTAL Ownership**	(72,520)	120,247	(410,619)	0	0	0	0	0	0	0	0	(362,892)	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)**	(107,432)	75,986	(369,494)	0	0	0	0	0	0	0	0	(400,940)	45

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

VII. RELATED PARTIES

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

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	$ 7,054	$ (7,946)	1
2	V	6	MAINTENANCE	200	INFINITY HEALTHCARE MANAGEMENT		578	378	2
3	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		30,794	5,594	3
4	V	21	OFFICE EXPENSE	9,147	INFINITY HEALTHCARE MANAGEMENT		149,053	139,906	4
5	V	5	UTILITIES	73	INFINITY HEALTHCARE MANAGEMENT		372	299	5
6	V	19	PROFESSIONAL SERVICES	192,000	INFINITY HEALTHCARE MANAGEMENT		187	(191,813)	6
7	V	22	EMPLOYEE BENEFITS	2,601	INFINITY HEALTHCARE MANAGEMENT		7,056	4,455	7
8	V	24	AUTO/TRAVEL EXPENSE	29	INFINITY HEALTHCARE MANAGEMENT		365	336	8
9	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		318	318	9
10	V	34	FACILITY/GROUNDS		INFINITY HEALTHCARE MANAGEMENT		9,267	9,267	10
11	V	2	FOOD	156	INFINITY HEALTHCARE MANAGEMENT			(156)	11
12	V	26	INSURANCE		OAK LAWN NURSING REALTY		4,368	4,368	12
13	V	32	INTEREST		OAK LAWN NURSING REALTY		110,980	110,980	13
14	Total			$ 244,406			$ 320,392	$ * 75,986	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	20	LICENSE	$	OAK LAWN NURSING REALTY		$ 250	$ 250	15
16	V	31	AMORTIZATION		OAK LAWN NURSING REALTY		22,222	22,222	16
17	V	21	BANK SERVICE CHARGE		OAK LAWN NURSING REALTY		39,875	39,875	17
18	V	30	DEPRECIATION		OAK LAWN NURSING REALTY		177,045	177,045	18
19	V	33	PROPERTY TAXES		OAK LAWN NURSING REALTY		236,608	236,608	19
20	V	36	REPLACEMENT TAX		OAK LAWN NURSING REALTY		1,879	1,879	20
21	V	34	RENT	960,000	OAK LAWN NURSING REALTY		111,627	(848,373)	21
22	V	21	RECONCILIATION DISCREPENCIES		OAK LAWN NURSING REALTY		1,000	1,000	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 960,000			$ 590,506	$ * (369,494)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Cente # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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								TOTAL	$		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS		OTHER RELATED BUSINESS ENTITIES		
NAME	OWNERSHIP %	NAME	CITY	TYPE OF BUSINESS
		INFINITY HEALTHCARE MANAGEMENT	HILLSIDE, IL	MANAGEMENT CO.
MOISHE GUBIN	30.000%			
MICHAEL BLISKO	30.000%			
A&F REALTY	20.000%			
ROSIE SCHWARTZ	20.000%			
	100.000%			

NOTE: INFINITY HEALTHCARE MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	CHASE		X	MORTGAGE	$17,754.00	5/12/11	$ 2,527,620	$ 2,434,746	9/30/12	3+LIBOR	$ 85,021	1
2	REGAL HOLDINGS		X	MORTGAGE	$3,411.39	5/13/11	682,277	453,552	9/13/13	6.0000	22,950	2
3												3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL	NONE	9/1/10	1,500,000	1,500,000	10/6/12	4.5000	89,365	6
7												7
8												8
9	TOTAL Facility Related				$21,165.39		$ 4,709,897	$ 4,388,298			$ 197,336	9
	B. Non-Facility Related*											
10	A&F REALTY, LLC	X		MORTGAGE	INTEREST ON	12/31/11	2,000,000	2,000,000	1/1/17	6.0000	67,274	10
11	STRAWBERRY PATCH	X		MORTGAGE	INTEREST ON	12/31/11	35,000	35,000	1/1/17	6.0000	1,177	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 2,035,000	$ 2,035,000			$ 68,451	14
15	TOTALS (line 9+line14)						$ 6,744,897	$ 6,423,298			$ 265,787	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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.

Line	Description	Amount	
1	1. Real Estate Tax accrual used on 2010 report.	$	1
2	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.)	$ 236,607	2
3	3. Under or (over) accrual (line 2 minus line 1).	$ 236,607	3
4	4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 1	4
5	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	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	7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 236,608	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2006		8
2007		9
2008		10
2009		11
2010	236,607	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Lawn Nursing and Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051144

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-08-201-007-0000	NURSING HOME	$ 236,606.92	$ 236,606.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 236,606.92	$ 236,606.92

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,070 B. General Construction Type: Exterior BRICK Frame ______ Number of Stories 3

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? [X] (a) Own the Equipment [X] (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).

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

1. Total Amount Incurred: 500,000
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 22,222
4. Dates Incurred: 9/1/10

Nature of Costs: ORGANIZATION 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		2010	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	143		2010	1960	$ 2,000,000	$ 34,188	39	$ 51,282	$ 17,094	$ 34,188	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Painting			9/15/2010	1,981	51	39	51		60	9
10	Drywall			8/27/2010	1,500	38	39	38		45	10
11	Roofing			9/21/2010	40,500	1,038	39	1,038		1,224	11
12	Signs			9/20/2010	3,102	80	39	80		94	12
13	Windows			9/20/2010	16,500	423	39	423		498	13
14	Walls, Wallpaper, Flooring, Doors			10/13/2010	88,500	2,269	39	2,269		2,674	14
15	Signs			9/20/2010	6,298	161	39	161		190	15
16	Windows			10/7/2010	50,630	1,298	39	1,298		1,530	16
17	Concrete and Asphalt for driveway			9/14/2010	38,000	974	39	974		1,148	17
18	Concrete and Asphalt for driveway			10/18/2010	17,490	448	39	448		528	18
19	Air conditioner			4/25/2011	753	19	39	14	(5)	23	19
20	Chair mats			4/28/2011	346	9	39	7	(2)	10	20
21	Fire alarm system			1/28/2011	16,210	416	39	416		490	21
22	Drywall			3/7/2011	1,696	44	39	36	(7)	51	22
23	Electrical Outlets			6/22/2011	3,200	82	39	48	(34)	97	23
24	Subpanel in 2nd floor med room			7/26/2011	3,500	90	39	45	(45)	106	24
25	remove & install new shingle roof			12/1/2010	20,490	525	39	525	(0)	619	25
26	Mirrors, Vanity Lights, Ceiling Painting			1/7/2011	45,280	1,161	39	1,161		1,368	26
27	Signage permit for mirros, vanitity, etc.			11/22/2010	450	12	39	12		14	27
28	Window permit for mirrors, vanity, etc.			11/22/2010	900	23	39	23		27	28
29	Air conditioner			1/16/2011	3,620	93	39	93		109	29
30	Tables and Chairs			12/14/2010	5,525	142	39	142		167	30
31	Mirrors, Vanity Lights, Ceiling Painting			12/16/2010	67,919	1,742	39	1,742	(0)	2,052	31
32	Aluminum and glass store front, wiring, sidewalk, sprinkler			12/16/2010	39,750	1,019	39	1,019		1,201	32
33	Sprinkler system			3/16/2011	9,500	244	39	203	(41)	287	33
34	Shower Door Frame			3/15/2011	550	14	39	12	(2)	17	34
35	Granite shelf			3/16/2011	300	8	39	6	(1)	9	35
36	Drywall soffit for sprinkler pipe enclosure			3/16/2011	650	17	39	14		20	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Profile cove base	3/16/2011	$ 1,350	$ 35	39	$ 29	$ (6)	$ 41	37
38	Laminate column covers	3/16/2011	945	24	39	20	(4)	29	38
39	Drywall for spinkler pipe enclosure	3/16/2011	500	13	39	11	(2)	15	39
40	Hallway & Shower room walls, tiles, wander board, lighting, grab b	1/7/2011	66,717	1,711	39	1,711		2,016	40
41	build new closet	1/17/2011	1,100	28	39	28		33	41
42	Plumbing for lobby bathroom	1/17/2011	1,600	41	39	41		48	42
43	Drywall and insulation for dining room & hallway	3/16/2011	5,344	137	39	114	(23)	161	43
44	Granite countertop and wood front	3/16/2011	8,500	218	39	182	(36)	257	44
45	Profile cove base	6/22/2011	1,350	35	39	20	(14)	41	45
46	Bathroom doors and frames	6/22/2011	1,200	31	39	18	(13)	36	46
47	Bathroom doors and frames	6/22/2011	1,200	31	39	18	(13)	36	47
48	Office walls, rewiring, lighting, doors	6/17/2011	3,900	100	39	58	(42)	118	48
49	Door and frame	6/17/2011	1,450	37	39	22	(15)	44	49
50	Bulletin boards	7/20/2011	1,256	32	39	16	(16)	38	50
51	Foundation, tiles, exit signs, lighting	8/12/2011	8,160	209	39	87	(122)	247	51
52	Shower room plumbing, drain, door, drywall	8/12/2011	2,050	53	39	22	(31)	62	52
53	Room repair for canopy, steel column, wood cover	8/12/2011	11,450	294	39	122	(171)	346	53
54	Elevator new valve (Maxton UC 4)	3/22/2011	3,650	94	39	78	(16)	110	54
55	Fire dampers and smoke detectors	3/24/2011	2,125	54	39	45	(9)	64	55
56	Fire dampers and smoke detectors	3/9/2011	2,125	54	39	45	(9)	64	56
57	Plumbing	4/4/2011	2,800	72	39	54	(18)	85	57
58	Lights	4/28/2011	3,165	81	39	61	(20)	96	58
59	Ejector pumps and control panel	5/22/2011	1,385	36	39	24	(12)	42	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,618,461	$ 50,046		$ 66,407	$ 16,364	$ 52,872	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	$ 49,342	$ 4,859	$ 9,412	$ 4,553		$ 31,961	71
72	Current Year Purchases	2,057,029	199,885	174,907	(24,978)		199,885	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,106,371	$ 204,744	$ 184,319	$ (20,425)		$ 231,846	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)	$ 4,824,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 254,790	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 250,726	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,064)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 284,718	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE

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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 72,555	$		$ 72,555	1
2	Licensed Speech and Language Development Therapist		hrs			101,475			101,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			86,933			86,933	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				162,760		162,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY & LAB						9,243		9,243	13
14	TOTAL			$		$ 260,963	$ 172,003		$ 432,966	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ (171,605)	$ (139,749)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,062,241	2,065,937	3
4	Supply Inventory (priced at)		899,000	4
5	Short-Term Investments			5
6	Prepaid Insurance	157,867	157,867	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,048,503	$ 2,983,055	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,000,000	14
15	Leasehold Improvements, at Historical Cost	618,461	618,461	15
16	Equipment, at Historical Cost	101,948	2,101,948	16
17	Accumulated Depreciation (book methods)	(103,250)	(280,295)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		500,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,222)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Security Deposit	128	128	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 617,287	$ 5,018,020	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,665,790	$ 8,001,075	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,836,719	$ 1,836,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,330	213,330	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKING CAPITAL NOTE	1,500,000	1,500,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,550,049	$ 3,550,049	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,923,298	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)**	$	$ 4,923,298	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,550,049	$ 8,473,347	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (884,259)	$ (472,272)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,665,790	$ 8,001,075	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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)	(361,847)	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) Beginning (not previously reported)	(522,412)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (884,259)	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)**	$ (884,259)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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	$ 6,355,940	1
2	Discounts and Allowances for all Levels	(403,147)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,952,793	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	543,991	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 543,991	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	163,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,514	19
20	Radiology and X-Ray	1,044	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 177,219	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	MISCELLANEOUS	(40,086)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (40,086)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,633,922	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	801,029	31
32	Health Care	3,500,327	32
33	General Administration	1,317,007	33
	B. Capital Expense		
34	Ownership	1,127,110	34
	C. Ancillary Expense		
35	Special Cost Centers	172,003	35
36	Provider Participation Fee	78,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,995,769	40
41	**Income before Income Taxes (line 30 minus line 40)****	(361,847)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (361,847)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,469	1,840	$ 74,582	$ 40.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,087	15,216	477,907	31.41	3
4	Licensed Practical Nurses	28,216	30,469	788,974	25.89	4
5	CNAs & Orderlies	50,395	54,862	566,921	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	18,852	20,537	465,493	22.67	8
9	Activity Director	6,627	7,330	83,551	11.40	9
10	Activity Assistants					10
11	Social Service Workers	2,126	2,318	46,090	19.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,151	17,576	183,519	10.44	15
16	Dishwashers					16
17	Maintenance Workers	1,970	2,090	39,706	19.00	17
18	Housekeepers	12,446	13,305	126,301	9.49	18
19	Laundry	5,884	6,319	58,577	9.27	19
20	Administrator	1,942	2,046	99,322	48.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,664	11,787	192,534	16.33	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	1,823	1,823	28,297	15.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,652	187,518	$ 3,231,774 *	$ 17.23	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	598	29,875	10-3	38
39	Pharmacist Consultant	102	5,091	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	53	1,859	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,182	$ 51,825		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIE DERZSY	ADMIN	0	$ 99,322
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 99,322

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
BRADLEY & ASSOCIATES	ACCOUNTING	$ 3,852
JOHNSON, GOLDBERG, BROWN	ACCOUNTING	2,500
INFINITY HEALTCHARE MGT	MANAGEMENT CO.	192,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 198,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,331
Unemployment Compensation Insurance	74,699
FICA Taxes	241,551
Employee Health Insurance	116,726
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
UNIFORMS	9,015
EMPLOYEE	33,580
PENSION	28,198
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,100

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	$ 1,314
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
COOK COUNTY COLLECTOR	248
SECRETARY OF STATE	250
FILING FEES	250
VILLAGE OF OAK LAWN	1,634
DAVID SCHECHTER	728
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,424

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE	1,061
AUTO ALLOWANCE	159
Seminar Expense	
SEMINAR	375
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,595

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oak Lawn Nursing and Rehabilitation Center # 0051144 Report Period Beginning: 1/1/2011 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Oak Lawn Nursing and Rehabilitation Center** **# 0051144** **Report Period Beginning: 1/1/2011** **Ending: 12/31/11**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,838** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **78,293**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **0**

d. Have vehicle usage logs been maintained? **N/A**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A**

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

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