FOR BHF USE

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

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

I. IDPH License ID Number: 0051144

Facility Name: Oak Lawn Respiratory & Rehab

Address: 9525 S Mayfield (Number) Oaklawn (City) 60453 (Zip Code)

County: Cook

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

HFS ID Number:

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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Alan Sorscher **Telephone Number:** (708)-449-1900
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 1/1/12 to 12/31/12 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) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 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	75	Skilled (SNF)	75	27,450	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,338	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	13,460	97	3,764	17,321	8
9	SNF/PED					9
10	ICF	12,424	90		12,514	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,884	187	3,764	29,835	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.00%

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 3,632

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: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	195,453	16,111	15,000	226,564		226,564	(7,559)	219,005			1
2	Food Purchase		136,628		136,628		136,628	(539)	136,089			2
3	Housekeeping	138,817	34,315		173,132		173,132		173,132			3
4	Laundry	67,135	14,920		82,055		82,055		82,055			4
5	Heat and Other Utilities			142,716	142,716		142,716	476	143,192			5
6	Maintenance	51,309	43,254	35,636	130,199		130,199	14	130,213			6
7	Other (specify):*											7
8	**TOTAL General Services**	452,714	245,228	193,352	891,294		891,294	(7,608)	883,686			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	2,644,517	969,138	30,803	3,644,458		3,644,458	4,148	3,648,606			10
10a	Therapy	65,931		299,344	365,275		365,275		365,275			10a
11	Activities		8,422		8,422		8,422		8,422			11
12	Social Services	39,145		1,505	40,650		40,650		40,650			12
13	CNA Training											13
14	Program Transportation			87	87		87		87			14
15	Other (specify):* Pharmacy Consultant			8,239	8,239		8,239		8,239			15
16	**TOTAL Health Care and Programs**	2,749,593	977,560	362,478	4,089,631		4,089,631	4,148	4,093,779			16
	C. General Administration											
17	Administrative	116,498			116,498		116,498		116,498			17
18	Directors Fees											18
19	Professional Services			214,276	214,276		214,276	(137,220)	77,056			19
20	Dues, Fees, Subscriptions & Promotions			12,396	12,396		12,396	250	12,646			20
21	Clerical & General Office Expenses	165,891	68,997	26,164	261,052		261,052	37,280	298,332			21
22	Employee Benefits & Payroll Taxes			576,356	576,356		576,356	51,431	627,787			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,710	1,710		1,710	195	1,905			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			174,518	174,518		174,518	5,590	180,108			26
27	Other (specify):*											27
28	**TOTAL General Administration**	282,389	68,997	1,005,420	1,356,806		1,356,806	(42,474)	1,314,332			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,484,696	1,291,785	1,561,250	6,337,731		6,337,731	(45,934)	6,291,797			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 Oak Lawn Respiratory & Rehab #0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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			66,828	66,828		66,828	188,785	255,613			30
31	Amortization of Pre-Op. & Org.							33,336	33,336			31
32	Interest			137,018	137,018		137,018	237,510	374,528			32
33	Real Estate Taxes							271,403	271,403			33
34	Rent-Facility & Grounds			1,206,098	1,206,098		1,206,098	(1,201,113)	4,985			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,409,944	1,409,944		1,409,944	(470,079)	939,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		266,012		266,012		266,012		266,012			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			360,499	360,499		360,499		360,499			42
43	Other (specify):* Bad Debt			300,000	300,000		300,000		300,000			43
44	TOTAL Special Cost Centers		266,012	660,499	926,511		926,511		926,511			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,484,696	1,557,797	3,631,693	8,674,186		8,674,186	(516,013)	8,158,173			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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	(148,345)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	(27,786)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,131)		$	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)	(339,882)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (339,882)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,013)		37

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

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

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

Oak Lawn Respiratory & Rehab

ID# 0051144

Report Period Beginning: 1/1/12

Ending: 12/31/12

	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 Oak Lawn Respiratory & Rehab # 0051144 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(7,559)	0	0	0	0	0	0	0	0	0	(7,559)	1
2	Food Purchase	0	(539)	0	0	0	0	0	0	0	0	0	(539)	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	476	0	0	0	0	0	0	0	0	0	476	5
6	Maintenance	0	14	0	0	0	0	0	0	0	0	0	14	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(7,608)	0	0	0	0	0	0	0	0	0	(7,608)	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	4,148	0	0	0	0	0	0	0	0	0	4,148	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	4,148	0	0	0	0	0	0	0	0	0	4,148	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	(191,209)	53,989	0	0	0	0	0	0	0	0	(137,220)	19
20	Fees, Subscriptions & Promotions	0	0	250	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(27,786)	32,337	32,729	0	0	0	0	0	0	0	0	37,280	21
22	Employee Benefits & Payroll Taxes	0	51,431	0	0	0	0	0	0	0	0	0	51,431	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	195	0	0	0	0	0	0	0	0	0	195	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	323	5,267	0	0	0	0	0	0	0	0	5,590	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,786)	(106,923)	92,235	0	0	0	0	0	0	0	0	(42,474)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,786)	(110,383)	92,235	0	0	0	0	0	0	0	0	(45,934)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Lawn Respiratory & Rehab **#** 0051144 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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	(148,345)	122	337,008	0	0	0	0	0	0	0	0	188,785	30
31	Amortization of Pre-Op. & Org.	0	0	33,336	0	0	0	0	0	0	0	0	33,336	31
32	Interest	0	0	237,510	0	0	0	0	0	0	0	0	237,510	32
33	Real Estate Taxes	0	0	271,403	0	0	0	0	0	0	0	0	271,403	33
34	Rent-Facility & Grounds	0	4,985	(1,206,098)	0	0	0	0	0	0	0	0	(1,201,113)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(148,345)	5,107	(326,841)	0	0	0	0	0	0	0	0	(470,079)	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)	(176,131)	(105,276)	(234,606)	0	0	0	0	0	0	0	0	(516,013)	45

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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
				Infinity Healthcare	Hillside, IL	Management Co.
Moishe Gubin	30					
Michael Blisko	30					
A&F Realty	20					
Rosie Schwartz	20					

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	1	DIETARY	$ 15,000	INFINITY HEALTHCARE MANAGEMENT	46.25%	$ 7,441	$ (7,559)	1
2	V	6	MAINTENANCE	2,988	INFINITY HEALTHCARE MANAGEMENT		3,002	14	2
3	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		29,348	4,148	3
4	V	21	OFFICE EXPENSE	34,484	INFINITY HEALTHCARE MANAGEMENT		66,821	32,337	4
5	V	19	PROFESSIONAL SERVICES	192,000	INFINITY HEALTHCARE MANAGEMENT		791	(191,209)	5
6	V	22	EMPLOYEE BENEFITS	4,370	INFINITY HEALTHCARE MANAGEMENT		55,801	51,431	6
7	V	2	FOOD	539	INFINITY HEALTHCARE MANAGEMENT			(539)	7
8	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		476	476	8
9	V	24	AUTO/TRAVEL		INFINITY HEALTHCARE MANAGEMENT		195	195	9
10	V	26	INSURANCE		INFINITY HEALTHCARE MANAGEMENT		323	323	10
11	V	34	FACILITY/GROUNDS		INFINITY HEALTHCARE MANAGEMENT		4,985	4,985	11
12	V	30	DEPRECIATION		INFINITY HEALTHCARE MANAGEMENT		122	122	12
13	V								13
14	Total			$ 274,581			$ 169,305	$ * (105,276)	14

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	19	Professional Services	$	Oak Lawn Nursing Realty		$ 53,989	$ 53,989	15
16	V	20	Dues & Fees		Oak Lawn Nursing Realty		250	250	16
17	V	21	Office Expense		Oak Lawn Nursing Realty		32,729	32,729	17
18	V	26	Insurance		Oak Lawn Nursing Realty		5,267	5,267	18
19	V	30	Depreciation		Oak Lawn Nursing Realty		337,008	337,008	19
20	V	31	Amortization		Oak Lawn Nursing Realty		33,336	33,336	20
21	V	32	Interest		Oak Lawn Nursing Realty		237,510	237,510	21
22	V	33	Property Taxes		Oak Lawn Nursing Realty		271,403	271,403	22
23	V	34	Rent	1,206,098	Oak Lawn Nursing Realty			(1,206,098)	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			$ 1,206,098			$ 971,492	$ * (234,606)	39

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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									$		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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CHASE		X	MORTGAGE	$17,754.00	5/12/11	$ 2,527,620	$	12/20/12	3+LIBOR	$ 77,866	1
2	REGAL HOLDINGS		X	MORTGAGE	$3,411.39	5/13/11	682,277		12/20/12	6.0000	21,018	2
3	BANK LEUMI		X	MORTGAGE		12/20/12	4,500,000	4,500,000	12/20/15	5.0000	138,626	3
4												4
5												5
	Working Capital											
6	BANK LEUMI		X	WORKING CAPITAL	NONE	9/1/10	1,500,000		8/31/12		25,787	6
7	Capital One		X	WORKING CAPITAL	NONE	8/31/12	10,000,000	1,910,231	8/31/15	Various	65,673	7
8	Infinity Funding	X		WORKING CAPITAL	NONE	various	various	1,325,000	various	various	45,558	8
9	TOTAL Facility Related				$21,165.39		$ 19,209,897	$ 7,735,231			$ 374,528	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,209,897	$ 7,735,231			$ 374,528	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.)**

**** 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 Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 1	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.)		$ 271,403	2
3. Under or (over) accrual (line 2 minus line 1).		$ 271,402	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 1	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 271,403	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008		9
2009		10
2010	236,607	11
2011	271,403	12

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

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Lawn Respiratory & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051144

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE (708)-449-1900 FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-08-201-007-000	NURSING HOME	$ 271,401.24	$ 271,401.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 271,401.24	$ 271,401.24

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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: 33,336 4. Dates Incurred: 9/1/10

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		2010	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 51,288	39	$ 51,282	$ (6)	$ 85,476	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Painting			9/15/2010	1,981	51	39	51		123	9
10	Drywall			8/27/2010	1,500	38	39	38		93	10
11	Roofing			9/21/2010	40,500	1,038	39	1,038		2,510	11
12	Signs			9/20/2010	3,102	80	39	80		192	12
13	Windows			9/20/2010	16,500	423	39	423		1,022	13
14	Walls, Wallpaper, Flooring, Doors			10/13/2010	88,500	2,269	39	2,269		5,484	14
15	Signs			9/20/2010	6,298	161	39	161		390	15
16	Windows			10/7/2010	50,630	1,298	39	1,298		3,139	16
17	Concrete and Asphalt for driveway			9/14/2010	38,000	974	39	974		2,355	17
18	Concrete and Asphalt for driveway			10/18/2010	17,490	448	39	448		1,083	18
19	Air conditioner			4/25/2011	753	19	39	19	(0)	39	19
20	Chair mats			4/28/2011	346	9	39	9	0	18	20
21	Fire alarm system			1/28/2011	16,210	416	39	416	(0)	831	21
22	Drywall			3/7/2011	1,696	44	39	43	(0)	87	22
23	Electrical Outlets			6/22/2011	3,200	82	39	82	0	164	23
24	Subpanel in 2nd floor med room			7/26/2011	3,500	90	39	90	0	180	24
25	remove & install new shingle roof			12/1/2010	20,490	525	39	525	(0)	1,051	25
26	Mirrors, Vanity Lights, Ceiling Painting			1/7/2011	45,280	1,161	39	1,161	(0)	2,322	26
27	Signage permit for mirros, vanitity, etc.			11/22/2010	450	12	39	12	(0)	23	27
28	Window permit for mirrors, vanity, etc.			11/22/2010	900	23	39	23	(0)	46	28
29	Air conditioner			1/16/2011	3,620	93	39	93	0	186	29
30	Tables and Chairs			12/14/2010	5,525	142	39	142	(0)	283	30
31	Mirrors, Vanity Lights, Ceiling Painting			12/16/2010	67,919	1,742	39	1,742	(0)	3,483	31
32	Aluminum and glass store front, wiring, sidewalk, sprinkler			12/16/2010	39,750	1,019	39	1,019	0	2,039	32
33	Sprinkler system			3/16/2011	9,500	244	39	244	(0)	487	33
34	Shower Door Frame			3/15/2011	550	14	39	14	0	28	34
35	Granite shelf			3/16/2011	300	8	39	8	0	15	35
36	Drywall soffit for sprinkler pipe enclosure			3/16/2011	650	17	39	17		33	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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 35	$ (0)	$ 69	37
38	Laminate column covers	3/16/2011	945	24	39	24	0	48	38
39	Drywall for spinkler pipe enclosure	3/16/2011	500	13	39	13	0	26	39
40	Hallway & Shower room walls, tiles, wander board, lighting, grab l	1/7/2011	66,717	1,711	39	1,711	0	3,422	40
41	build new closet	1/17/2011	1,100	28	39	28	(0)	56	41
42	Plumbing for lobby bathroom	1/17/2011	1,600	41	39	41	(0)	82	42
43	Drywall and insulation for dining room & hallway	3/16/2011	5,344	137	39	137	(0)	274	43
44	Granite countertop and wood front	3/16/2011	8,500	218	39	218	(0)	436	44
45	Profile cove base	6/22/2011	1,350	35	39	35	(0)	69	45
46	Bathroom doors and frames	6/22/2011	1,200	31	39	31	(0)	61	46
47	Bathroom doors and frames	6/22/2011	1,200	31	39	31	(0)	61	47
48	Office walls, rewiring, lighting, doors	6/17/2011	3,900	100	39	100		200	48
49	Door and frame	6/17/2011	1,450	37	39	37	(0)	74	49
50	Bulletin boards	7/20/2011	1,256	32	39	32	0	64	50
51	Foundation, tiles, exit signs, lighting	8/12/2011	8,160	209	39	209	0	419	51
52	Shower room plumbing, drain, door, drywall	8/12/2011	2,050	53	39	53	0	105	52
53	Room repair for canopy, steel column, wood cover	8/12/2011	11,450	294	39	294	(0)	587	53
54	Elevator new valve (Maxton UC 4)	3/22/2011	3,650	94	39	94	(0)	187	54
55	Fire dampers and smoke detectors	3/24/2011	2,125	54	39	54	(0)	109	55
56	Fire dampers and smoke detectors	3/9/2011	2,125	54	39	54	(0)	109	56
57	Plumbing	4/4/2011	2,800	72	39	72	0	144	57
58	Lights	4/28/2011	3,165	81	39	81	0	162	58
59	Ejector pumps and control panel	5/22/2011	1,385	36	39	36	0	71	59
60	Replace ventor motor on stove	11/30/2012	2,318	59	39	10	(50)	59	60
61	Ceiling tiles	9/1/2012	1,833	47	39	16	(31)	47	61
62	Fire sprinkler for elevator pit and hallway	6/15/2012	4,100	105	39	61	(44)	105	62
63	Painting of resident rooms	2/1/2012	1,920	49	39	45	(4)	49	63
64	Painting of resident rooms	3/1/2012	7,600	195	39	162	(32)	195	64
65	Painting of resident rooms	4/1/2012	10,950	281	39	211	(70)	281	65
66	Painting of resident rooms	5/1/2012	4,300	110	39	74	(37)	110	66
67	Painting of resident rooms	6/1/2012	3,350	86	39	50	(36)	86	67
68	Painting of resident rooms	7/1/2012	5,200	133	39	67	(67)	133	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,660,032	$ 68,212		$ 67,835	$ (377)	$ 121,083	70

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 2,106,371	$ 290,579	$ 184,319	$ (106,260)	5 years	$ 522,425	71
72	Current Year Purchases	45,045	45,045	3,459	(41,586)	5 years	45,045	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,151,416	$ 335,624	$ 187,778	$ (147,846)		$ 567,470	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)	$ 4,911,448	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 403,836	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 255,613	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (148,223)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 688,553	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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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.

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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		hrs	$		$ 119,431	$		$ 119,431	1
2	Licensed Speech and Language Development Therapist		hrs			67,043			67,043	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			112,870			112,870	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				248,200		248,200	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						17,812		17,812	13
14	TOTAL			$		$ 299,344	$ 266,012		$ 565,356	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 Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 51,303	$ 58,503	1
2	Cash-Patient Deposits	400	400	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,743,862	2,743,862	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,663	48,663	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)**	$ 2,844,228	$ 2,851,428	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	660,032	660,032	15
16	Equipment, at Historical Cost	151,415	2,151,415	16
17	Accumulated Depreciation (book methods)	(174,501)	(688,557)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		500,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(55,558)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 636,946	$ 4,667,332	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,481,174	$ 7,518,760	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,091,342	$ 1,091,342	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,348	261,348	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	Related Party Working Capital	1,325,000	1,325,000	36
37	Related Party Working Capital	1,910,231	1,910,231	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,587,921	$ 4,587,921	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,500,000	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)**	$	$ 4,500,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,587,921	$ 9,087,921	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,106,747)	$ (1,569,161)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,481,174	$ 7,518,760	48

***(See instructions.)**

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (884,259)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (884,259)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(222,488)	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)**	$ (222,488)	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)**	$ (1,106,747)	24 *

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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,565,892	1
2	Discounts and Allowances for all Levels	843,783	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,409,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	20,346	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,346	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	66	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	961	28
28a	Miscellaneous	20,650	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,611	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,451,698	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	891,294	31
32	Health Care	4,089,631	32
33	General Administration	1,356,806	33
	B. Capital Expense		
34	Ownership	1,409,944	34
	C. Ancillary Expense		
35	Special Cost Centers	566,012	35
36	Provider Participation Fee	360,499	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,674,186	40
41	**Income before Income Taxes (line 30 minus line 40)****	(222,488)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (222,488)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,093,389	44
45	Private Pay - Net Inpatient Revenue	40,661	45
46	Medicare - Net Inpatient Revenue	2,195,341	46
47	Other-(specify) commercial insurance	80,284	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,409,675	49

* **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.**

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	1,808	1,904	$ 91,695	$ 48.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,209	22,603	688,963	30.48	3
4	Licensed Practical Nurses	22,501	24,426	682,851	27.96	4
5	CNAs & Orderlies	56,474	61,794	631,318	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	19,450	21,364	520,161	24.35	8
9	Activity Director	5,389	6,137	65,931	10.74	9
10	Activity Assistants					10
11	Social Service Workers	1,976	2,099	39,145	18.65	11
12	Dietician	15,737	17,516	195,453	11.16	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,094	51,309	24.50	17
18	Housekeepers	12,292	13,282	138,817	10.45	18
19	Laundry	6,253	6,666	67,134	10.07	19
20	Administrator	2,024	2,238	116,498	52.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	10,162	10,946	165,891	15.16	23
24	Clerical					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	1,856	2,057	29,530	14.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,051	195,126	$ 3,484,696 *	$ 17.86	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	429	$ 15,000	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	616	30,803	10-3	38
39	Pharmacist Consultant	165	8,239	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	43	1,505	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,252	$ 55,547		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIE DERZSY	ADMIN		$ 22,370
DEBRA PATTY-SMITH	ADMIN		94,128
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,498

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	$ 18,492
JOHNSON,GOLDBERG,BROWN	ACCOUNTING	2,500
INFINITY HEALTHCARE MGT	MANAGEMENT CO	192,000
MTS CONSULTING	PROFESSIONAL FEES	1,284
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 214,276

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,997
Unemployment Compensation Insurance	88,127
FICA Taxes	238,512
Employee Health Insurance	101,851
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
UNIFORMS	12,913
PENISION	19,064
EMPLOYEE	73,323
TOTAL (agree to Schedule V, line 22, col.8)	$ 627,787

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IL COUNCIL	7,158
COOK COUNTY COLLECTOR	248
SECRETARY OF STATE	250
VILLAGE OF OAK LAWN	1,633
FILING FEES	1,367
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,646

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILAGE	564
AUTO ALLOWANCE	592
SEMINARS	749
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,905

**See instructions.

Facility Name & ID Number Oak Lawn Respiratory & Rehab # 0051144 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 Oak Lawn Respiratory & Rehab **#** 0051144 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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. $ **43,574** 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. $ **360,499**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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. N/A
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.