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: 0025056

Facility Name: Oakton Pavillion

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

County: Cook

Telephone Number: (847) 299-5588 **Fax #** (847) 493-6525

HFS ID Number:

Date of Initial License for Current Owners: 01/02/1980

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

(Signed) (Date)
(Print Name and Title) Sanford B. Alper, Principal
(Firm Name & Address) Kessler, Orlean, Silver, P.C., 1101 Lake Cook Road, Suite C, Deerfield Illinois 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 294

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	294	Skilled (SNF)	294	107,604	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	294	TOTALS	294	107,604	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	25,616	16,480	6,953	49,049	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,616	16,480	6,953	49,049	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.58%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Home Meals

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 294 and days of care provided 6,110

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Oakton Pavillion # 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	316,717	35,093		351,810		351,810		351,810			1
2	Food Purchase		367,543		367,543	(77,657)	289,886	(5,279)	284,607			2
3	Housekeeping	125,553	42,912		168,465		168,465		168,465			3
4	Laundry	134,660	23,940		158,600		158,600		158,600			4
5	Heat and Other Utilities			203,744	203,744		203,744		203,744			5
6	Maintenance	132,710	112,634		245,344		245,344		245,344			6
7	Other (specify):* See Attached Sch			49,763	49,763		49,763		49,763			7
8	**TOTAL General Services**	709,640	582,122	253,507	1,545,269	(77,657)	1,467,612	(5,279)	1,462,333			8
	B. Health Care and Programs											
9	Medical Director			35,004	35,004		35,004		35,004			9
10	Nursing and Medical Records	2,142,349	419,171	10,660	2,572,180		2,572,180		2,572,180			10
10a	Therapy	264,933		362,692	627,625		627,625		627,625			10a
11	Activities	186,861	21,913		208,774		208,774		208,774			11
12	Social Services	26,145			26,145		26,145		26,145			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,620,288	441,084	408,356	3,469,728		3,469,728		3,469,728			16
	C. General Administration											
17	Administrative	317,281			317,281		317,281	260,000	577,281			17
18	Directors Fees											18
19	Professional Services			97,821	97,821		97,821	55,095	152,916			19
20	Dues, Fees, Subscriptions & Promotions			42,522	42,522		42,522	(31,038)	11,484			20
21	Clerical & General Office Expenses	312,018		125,528	437,546		437,546	9,288	446,834			21
22	Employee Benefits & Payroll Taxes			502,817	502,817	77,657	580,474	(14,056)	566,418			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,145	4,145		4,145	(579)	3,566			25
26	Insurance-Prop.Liab.Malpractice			263,846	263,846		263,846		263,846			26
27	Other (specify):* Bad Debt Expense			453,677	453,677		453,677	(453,677)				27
28	**TOTAL General Administration**	629,299		1,490,356	2,119,655	77,657	2,197,312	(174,967)	2,022,345			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,959,227	1,023,206	2,152,219	7,134,652		7,134,652	(180,246)	6,954,406			29

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

Facility Name & ID Number Oakton Pavillion #0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							284,232	284,232			30
31	Amortization of Pre-Op. & Org.							3,237	3,237			31
32	Interest							116,218	116,218			32
33	Real Estate Taxes			125,727	125,727		125,727		125,727			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			24,515	24,515		24,515		24,515			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,590,242	1,590,242		1,590,242	(1,036,313)	553,929			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			649,355	649,355		649,355		649,355			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			649,355	649,355		649,355		649,355			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,959,227	1,023,206	4,391,816	9,374,249		9,374,249	(1,216,559)	8,157,690			45

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	122,877	30		9
10	Interest and Other Investment Income	(14,052)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,279)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(579)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(220)	21		18
19	Entertainment				19
20	Contributions	(1,225)	21		20
21	Owner or Key-Man Insurance	(14,056)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(453,677)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,729)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(31,038)	20		28
29	Other-Attach Schedule See Attached Schedule	(225,000)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (625,978)		$	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)	(590,581)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (590,581)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,216,559)		37

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

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

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

Oakton Pavillion

ID# 0025056

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Management Fees	$ (225,000)	21	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**	(225,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakton Pavillion # 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,279)	0	0	0	0	0	0	0	0	0	0	(5,279)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,279)	0	0	0	0	0	0	0	0	0	0	(5,279)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	260,000	0	0	0	0	0	0	0	0	0	260,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	55,095	0	0	0	0	0	0	0	0	0	55,095	19
20	Fees, Subscriptions & Promotions	(31,038)	0	0	0	0	0	0	0	0	0	0	(31,038)	20
21	Clerical & General Office Expenses	(230,174)	239,462	0	0	0	0	0	0	0	0	0	9,288	21
22	Employee Benefits & Payroll Taxes	(14,056)	0	0	0	0	0	0	0	0	0	0	(14,056)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(579)	0	0	0	0	0	0	0	0	0	0	(579)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(453,677)	0	0	0	0	0	0	0	0	0	0	(453,677)	27
28	**TOTAL General Administration**	(729,524)	554,557	0	0	0	0	0	0	0	0	0	(174,967)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(734,803)	554,557	0	0	0	0	0	0	0	0	0	(180,246)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakton Pavillion # 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	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	122,877	161,355	0	0	0	0	0	0	0	0	0	284,232	30
31	Amortization of Pre-Op. & Org.	0	3,237	0	0	0	0	0	0	0	0	0	3,237	31
32	Interest	(14,052)	130,270	0	0	0	0	0	0	0	0	0	116,218	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,440,000)	0	0	0	0	0	0	0	0	0	(1,440,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	108,825	(1,145,138)	0	0	0	0	0	0	0	0	0	(1,036,313)	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)	(625,978)	(590,581)	0	0	0	0	0	0	0	0	0	(1,216,559)	45

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,440,000	Oakton Terrace	100.00%	$	$ (1,440,000)	1
2	V	32	Interest Income	154	Oakton Terrace	100.00%		(154)	2
3	V	17	Consulting Fees		Oakton Terrace	100.00%	260,000	260,000	3
4	V	30	Depreciation		Oakton Terrace	100.00%	161,355	161,355	4
5	V	31	Amortization		Oakton Terrace	100.00%	3,237	3,237	5
6	V	19	Accounting and Legal Fees		Oakton Terrace	100.00%	49,999	49,999	6
7	V	32	Mortgage Interest		Oakton Terrace	100.00%	130,424	130,424	7
8	V	21	Miscellaneous Financial Exp		Oakton Terrace	100.00%	630	630	8
9	V	21	Provision for Income Taxes		Oakton Terrace	100.00%	3,729	3,729	9
10	V	19	Accounting and Legal Fees		FMH Management Company	100.00%	5,096	5,096	10
11	V	21	Miscellaneous Financial Exp		FMH Management Company	100.00%	354	354	11
12	V	21	Management Fee		FMH Management Company	100.00%	225,000	225,000	12
13	V	21	Benefit for Income Taxes		FMH Management Company	100.00%	9,749	9,749	13
14	Total			$ 1,440,154			$ 849,573	$ * (590,581)	14

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Harrold Katz	25.417						1
2	Myrna Palmer Trust	12.708						2
3	Mark Palmer Trust	12.708						3
4	Fred Weiss	25.417						4
5	Mark Skorecky	5.000						5
6	Mike Lewkowitz	4.375						6
7	Jay Lewkowitz Revocable Trust	9.375						7
8	Leonar Solinsky	5.000						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jay Lewkowitz	Administrator	Administrative	9.375%	N/A	40	90.00	Salary	$ 158,173	17-1	1
2	Fred Weiss	General Partner	Administrative	24.420%	N/A	10	20.00	Mng Fees	50,000	17-7	2
3	Jay Lewkowitz	Administrator	Administrative	See Above	N/A			Mng Fees	210,000	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 418,173		13

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Private Bank		X	Building Mortgage	$13,314.00	06/01/08	$ 2,600,000	$ 2,234,994	6/27/13	LIBR+1.75	$ 130,424	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$13,314.00		$ 2,600,000	$ 2,234,994			$ 130,424	9
	B. Non-Facility Related*											
10	Oakton Terrace	X									(154)	10
11	Oakton Pavillion	X									(14,052)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,206)	14
15	TOTALS (line 9+line14)						$ 2,600,000	$ 2,234,994			$ 116,218	15

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

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

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

Facility Name & ID Number Oakton Pavillion **#** 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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.**	$	700,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	405,727	2
3. Under or (over) accrual (line 2 minus line 1).	$	(294,273)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	420,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	125,727	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	551,210	8
	2008	419,713	9
	2009	596,839	10
	2010	400,463	11
	2011	405,727	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 Oakton Pavillion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025056

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

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

Enter the tax index number and real estate tax assessed for 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.	09-29-106-006-000	Oakton Pavillion	$ 405,726.69	$ 405,726.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 405,726.69	$ 405,726.69

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 Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	294		1980	1980	$ 4,171,968	$ 61,056	40	$ 104,229	$ 43,173	$ 4,100,422	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Audit Adjustment			1981	955		20			955	9
10	Audit Adjustment			1983	30,266		20			30,266	10
11	Doors			1985	1,500		10			1,500	11
12	Sidewalk			1985	350		20			350	12
13	Audit Adjustment			1985	9,122		20			9,122	13
14	Decorating			1985	6,905		10			6,905	14
15	Hot Water Heater			1987	12,788		10			12,788	15
16	Light Fixtures			1987	11,288		10			11,288	16
17	Antena Hook Up			1988	4,905		10			4,905	17
18	A/C Compressor			1988	8,000		10			8,000	18
19	Sod / Environment Center			1989	7,282		10			7,282	19
20	Doors / Carpet			1990	3,609		10			3,609	20
21	Boiler Shell			1991	1,760		10			1,760	21
22	Roof			1991	40,000		20			40,000	22
23	Improvements			1991	4,590		10			4,590	23
24	Fire Dapers & Doors			2001	148,267	3,802	39	3,802		43,722	24
25	Sliding Door			2001	10,498		39	269	269	3,094	25
26	White Way Sign			2001	2,082	54	39	54		612	26
27	Remodeling Garden Level			2001	208,312	5,341	39	5,341		61,426	27
28	Smoke Detector			2003	4,320		10	432	432	4,320	28
29	Pump			2003	14,118		10	1,410	1,410	14,118	29
30	Electircal Circuits			2004	6,811	175	39	175		1,575	30
31	Elevator Modernization			2004	24,393	625	39	625		5,625	31
32	Shed			2004	3,566		7			3,566	32
33	Plumbing Improvements			2004	44,749	1,148	39	1,148		10,329	33
34	Elevator Modernization			2005	86,956	2,230	39	2,230		17,836	34
35	Pantry Reovation			2005	8,155	209	39	209		1,672	35
36	Asphalt Work			2005	22,835	1,349	15	2,169	820	12,176	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Electrical Improvements	2005	$ 1,730	$ 44	39	$ 44	$	$ 352	37
38	Outside Lights	2006	2,816	72	39	72		504	38
39	Plumbing Improvements	2006	3,100	79	39	79		554	39
40	Roof Replacement	2006	131,130	3,362	39	3,362		23,534	40
41	Masonary Renovation	2006	12,415	319	39	319		2,228	41
42	Steel Window Lintel Replacement	2006	48,850	1,252	39	1,252		8,769	42
43	Steel Window Lintel Replacement	2006	4,100	105	39	105		736	43
44	Tuckpointing and Brick Replacement	2006	25,000	641	39	641		4,487	44
45	Elevator Power Unit	2006	9,959	255	39	255		1,785	45
46	Roof Exhaust Fan	2006	2,080	54	39	54		373	46
47	Roof Drains	2006	10,850	278	39	278		1,946	47
48	Sewage Pump	2007	3,905	101	39	101		602	48
49	Chilled Water Coils	2007	29,744	763	39	763		4,577	49
50	Fire Alarm System	2007	10,625	272	39	272		1,632	50
51	Cooling Tower Monitor	2007	2,560	66	39	66		396	51
52	Carpentry, Tiling, Ceiling, Plubming, Electrical work-1st Floor	2009	15,000	385	39	385		1,540	52
53	Rebuild Water Pump	2009	4,580	117	39	117		469	53
54	Kitchen Plumbing Renovation	2009	9,578	245	39	245		982	54
55	Boiler	2009	15,700	403	39	403		1,611	55
56	Boiler Vale	2009	4,995	128	39	128		512	56
57	Tub Room Renovation	2010	9,300	239	39	239		617	57
58	Ejector Pump	2010	7,500	192	39	192		496	58
59	Cement Ramps	2010	4,544	117	39	117		292	59
60	Flagpole	2010	2,093	54	39	54		139	60
61	Awnings	2010	7,997	205	39	205		547	61
62	Recirculating Water Pump	2010	2,750	70	39	70		158	62
63	HVAC Circulating Pump	2010	10,735	275	39	275		665	63
64	Temperature Control Valve	2010	6,200	159	39	159		397	64
65	Laundry Room Ejector Pump	2010	18,787	482	39	482		1,004	65
66	Corridor AHU Pump	2011	11,090	284	39	284		545	66
67	Cooler Tower	2011	53,306	1,367	39	1,367		2,506	67
68	Fence	2011	3,979	102	39	102		153	68
69	Carpentry, Tiling, Ceiling, Plubming, Electrical work-4th Floor	2011	380,155	9,748	39	9,748		17,871	69
70	TOTAL (lines 4 thru 69)		$ 5,767,503	$ 98,224		$ 144,328	$ 46,104	$ 4,506,792	70

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
1	Totals from Page 12A, Carried Forward		$ 5,767,503	$ 98,224		$ 144,328	$ 46,104	$ 4,506,792	1
2	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-3rd Floor	2011	380,155	9,748	39	9,748		16,246	2
3	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-2nd Floor	2011	380,155	9,748	39	9,748		13,809	3
4	Sidewalk	2011	5,690	146	39	146		219	4
5	Voltage Regulator	2011	2,700	69	39	69		104	5
6	Carpentry, Tiling, Ceiling, Plubming, Electrical work-1st Floor	2011	380,155	9,747	39	9,747		11,372	6
7	Concrete Patio	2011	2,970	77	39	77		102	7
8	Expension Tank for AC	2012	13,167	169	39	169		169	8
9	Sprinkler System	2012	39,096	251	39	251		251	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,971,591	$ 128,179		$ 174,283	$ 46,104	$ 4,549,064	34

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 1,019,437	$ 27,596	$ 101,944	$ 74,348	10	$ 726,347	71
72	Current Year Purchases	6,341	3,805	644	(3,161)	10	644	72
73	Fully Depreciated Assets	575,688				10	575,688	73
74								74
75	TOTALS	$ 1,601,466	$ 31,401	$ 102,588	$ 71,187		$ 1,302,679	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Patients	1992 Ford Van	1992	$ 27,300	$	$	$	5	$ 27,300	76
77	Administrative	2009 Accura	2009	36,806	1,775	7,361	5,586	5	19,106	77
78	Administrative	2005 Ford E350	2005	49,451				5	49,451	78
79										79
80	TOTALS			$ 113,557	$ 1,775	$ 7,361	$ 5,586		$ 95,857	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,886,614	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,355	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 284,232	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 122,877	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,947,600	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2012
Ending 12/31/2012

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 [X] NO
16. Rental Amount for movable equipment: $ 24,515 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$ 9,765		$	$		$ 9,765	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs	28,939					28,939	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs	73					73	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-3	# of prescrpts	6,959					6,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 45,736		$	$		$ 45,736	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.

STATE OF ILLINOIS

Facility Name & ID Number Oakton Pavillion **#** 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 **(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	$ 739,028	$ 788,706	1
2	Cash-Patient Deposits	22,885	22,885	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,700,993	4,706,406	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,437	43,437	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,988,362	2,514,514	8
9	Other(specify): R/E Tax Reserve	495,809	495,809	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,990,514	$ 8,571,757	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		4,171,968	14
15	Leasehold Improvements, at Historical Cost		2,275,692	15
16	Equipment, at Historical Cost		2,238,954	16
17	Accumulated Depreciation (book methods)		(5,796,828)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Loan Costs		1,338	22
23	Other(specify): Deposits		6,675	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 3,097,799	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,990,514	$ 11,669,556	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,015	$ 120,015	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,885	22,885	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,764	95,764	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	420,000	420,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		8,419	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,279,473	1,588,796	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,938,137	$ 2,255,879	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,234,994	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,234,994	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,938,137	$ 4,490,873	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,052,377	$ 7,178,683	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,990,514	$ 11,669,556	48

***(See instructions.)**

Facility Name & ID Number Oakton Pavillion # 0025056 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 968,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 968,175	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,084,202	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,084,202	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,052,377	24 *

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 8,612,326	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,612,326	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,198,794	6
7	Oxygen	8,194	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,206,988	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	3,352	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	21,196	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,548	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,052	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,052	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	375,537	28
28a	Management Fee	225,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 600,537	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,458,451	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,545,269	31
32	Health Care	3,469,728	32
33	General Administration	2,119,655	33
	B. Capital Expense		
34	Ownership	1,590,242	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	649,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,374,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,084,202	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,084,202	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	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 Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,127	$ 86,806	$ 40.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,182	32,305	734,616	22.74	3
4	Licensed Practical Nurses	16,986	17,854	382,648	21.43	4
5	CNAs & Orderlies	80,451	85,452	938,279	10.98	5
6	CNA Trainees					6
7	Licensed Therapist	5,352	5,596	245,383	43.85	7
8	Rehab/Therapy Aides	1,472	1,472	19,550	13.28	8
9	Activity Director	1,583	1,640	22,845	13.93	9
10	Activity Assistants	14,657	15,787	164,016	10.39	10
11	Social Service Workers	1,522	1,820	26,145	14.37	11
12	Dietician					12
13	Food Service Supervisor	1,787	1,885	37,564	19.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,524	27,965	279,153	9.98	15
16	Dishwashers					16
17	Maintenance Workers	8,081	8,828	132,710	15.03	17
18	Housekeepers	13,180	14,648	125,553	8.57	18
19	Laundry	12,532	13,705	134,660	9.83	19
20	Administrator	2,080	2,269	158,173	69.71	20
21	Assistant Administrator	2,080	2,267	159,108	70.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,899	18,879	312,018	16.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,448	254,499	$ 3,959,227 *	$ 15.56	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		$		35
36	Medical Director	288	35,004	9-3	36
37	Medical Records Consultant	82	3,701	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	$ 38,705		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 323,915	10a-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 323,915		53

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jay Lewkowitz	Administrator	9.375	$ 158,173
Maureen Krahl	Assistant Admin	0.000	159,108
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 317,281

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
Kessler, Orlean, Silver & Co.	Accounting	$ 29,304
Richard Peelo	Accounting	4,500
Dowd, Dowd, & Mertes, Ltd	Legal	11,771
Feldman Law Offices, Ltd	Legal	5,000
Polsinelli Shughart	Legal	8,204
Wrman Law, P.C.	Legal	27,184
American Arbitration Assoc.	Legal	3,500
American Profit Recovery	Collection Agency	3,858
First Real Estate Service	Appraisal Service	3,000
Legat Architects	Consulting Services	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 97,821

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,710
Unemployment Compensation Insurance	70,596
FICA Taxes	296,871
Employee Health Insurance	56,844
Employee Meals	77,657
Illinois Municipal Retirement Fund (IMRF)*	
Employee Welfare	22,740
TOTAL (agree to Schedule V, line 22, col.8)	$ 566,418

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 72)	720
Patient Background Checks	
Advertising	31,038
Dues & Subscriptions	2,734
Licenses & Fees	8,030
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(31,038)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,484

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **52,733** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **649,355**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **77,657** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **N/A**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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