

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

<p>I. IDPH License ID Number: <u>0051862</u></p> <p>Facility Name: <u>OAKRIDGE HEALTHCARE CENTER</u></p> <p>Address: <u>323 OAKRIDGE AVENUE</u> <u>HILLSIDE</u> <u>60162</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 547-6595</u> Fax # <u>(708) 547-1971</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/01/12</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>SANFORD BOKOR</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>ELI ATKIN</u> (Title) <u>ADMINISTRATOR</u> </td> </tr> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u> </td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ELI ATKIN</u> (Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ELI ATKIN</u> (Title) <u>ADMINISTRATOR</u>							
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KBKB, LTD.</u> <u>8140 RIVER DRIVE, MORTON GROVE, IL 60053</u> (Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>							

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER

0051862 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	15	Intermediate (ICF)	15	5,475	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,483	1,483	3,724	13,690	8
9	SNF/PED					9
10	ICF	7,872	548	510	8,930	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,355	2,031	4,234	22,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.89%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/12

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

YES Date 01/01/12 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 1,909

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,093	15,568	5,472	181,133		181,133		181,133		1
2	Food Purchase		130,263		130,263	(17,849)	112,414	(1,901)	110,513		2
3	Housekeeping	11,115	7,702		18,817		18,817		18,817		3
4	Laundry		11,543	58,858	70,401		70,401		70,401		4
5	Heat and Other Utilities			87,654	87,654		87,654		87,654		5
6	Maintenance	43,840	26,162	114,868	184,870		184,870		184,870		6
7	Other (specify):*			11,722	11,722		11,722		11,722		7
8	TOTAL General Services	215,048	191,238	278,574	684,860	(17,849)	667,011	(1,901)	665,110		8
	B. Health Care and Programs										
9	Medical Director			8,760	8,760		8,760		8,760		9
10	Nursing and Medical Records	1,205,158	118,426	7,950	1,331,534		1,331,534		1,331,534		10
10a	Therapy	153,356			153,356		153,356		153,356		10a
11	Activities	86,169	7,816		93,985		93,985		93,985		11
12	Social Services			1,530	1,530		1,530		1,530		12
13	CNA Training										13
14	Program Transportation			1,689	1,689		1,689		1,689		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,444,683	126,242	19,929	1,590,854		1,590,854		1,590,854		16
	C. General Administration										
17	Administrative	49,411		177,000	226,411		226,411		226,411		17
18	Directors Fees										18
19	Professional Services			49,047	49,047		49,047		49,047		19
20	Dues, Fees, Subscriptions & Promotions			33,032	33,032		33,032	(23,379)	9,653		20
21	Clerical & General Office Expenses	131,546	17,258	25,836	174,640		174,640	(13,002)	161,638		21
22	Employee Benefits & Payroll Taxes			337,005	337,005	17,849	354,854	(28,355)	326,499		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			15,741	15,741		15,741	(15,741)			25
26	Insurance-Prop.Liab.Malpractice			82,162	82,162		82,162		82,162		26
27	Other (specify):*			30,122	30,122		30,122	(30,122)			27
28	TOTAL General Administration	180,957	17,258	749,945	948,160	17,849	966,009	(110,599)	855,410		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,840,688	334,738	1,048,448	3,223,874		3,223,874	(112,500)	3,111,374		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,472
	REPAIRS & MAINTENANCE	0
		0
		5,472
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
	CONTRACTED LAUNDRY SERVICE	58,858
		58,858
5	HEAT & OTHER UTILITIES	
	GAS HEAT	22,194
	ELECTRICITY	27,345
	WATER	33,469
	CABLE TV - LOBBY	4,646
		0
		87,654
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,339
	PAINTING & DECORATING	300
	BUILDING REPAIRS	650
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,628
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	7,933
	EXTERMINATING SERVICE	2,275
	FIRE SERVICE	4,336
	CONTRACTED BUILDING MAINTENANCE	89,407
		0
		0
		0
		114,868
7	OTHER	
	SCAVENGER	10,706
	SECURITY SERVICE	1,016
		0
		0
		11,722
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,760
		8,760

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	3,300
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,646
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	2,004
		0
		0
		7,950
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	1,530
	SOCIAL WORKER XVIII B 45-2	0
		1,530
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	1,689
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	177,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	15,933
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	33,114
		0
		49,047
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	8,036
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	7,843
	EMPLOYEE WANT ADS XIX F	925
	CONTRIBUTIONS VI 20 XIX F	7,500
	DUES & SUBSCRIPTIONS XIX F	4,846
	LICENSES & PERMITS XIX F	3,182
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	700
	PATIENT BACKGROUND CHECKS XIX F	0
		33,032
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,945
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	13,002
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	10,889
	MESSENGER SERVICE	0
		0
		25,836

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	140,813
	UNEMPLOYMENT COMPENSATION XIX D	94,076
	WORKERS COMPENSATION INSURANC XIX D	52,614
	HOSPITALIZATION INSURANCE XIX D	19,290
	EMPLOYEE BENEFITS - OTHER XIX D	1,792
	EMPLOYEE PHYSICAL EXAMS XIX D	65
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	28,355
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		337,005
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	15,741
		15,741
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	82,162
		82,162
27	OTHER	
	BAD DEBTS VI 24	30,122
		30,122

GRAND TOTAL COLUMN 3 OTHER

1,048,448

OAKRIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	130,263
LESS SALES TAX	<u>(1,901)</u>
NET FOOD	128,362
TOTAL PATIENT CENSUS	22,620
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	67,860
ADD # EMPLOYEE MEALS/DAY	30
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	67,860
ADD EMPLOYEE MEALS	<u>10,950</u>
TOTAL MEALS/YEAR	78,810
NET FOOD	128,362
DIVIDE TOTAL MEALS/YEAR	<u>78,810</u>
COST PER MEAL	1.63
TIMES EMPLOYEE MEALS	<u>10,950</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>17,849</u></u>

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER

#0051862

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,826	9,826	9,826	64,723	74,549				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,526	25,526	25,526	123,481	149,007				32
33	Real Estate Taxes			161,422	161,422	161,422		161,422				33
34	Rent-Facility & Grounds			252,000	252,000	252,000	(252,000)					34
35	Rent-Equipment & Vehicles			15,298	15,298	15,298		15,298				35
36	Other (specify):*											36
37	TOTAL Ownership			464,072	464,072	464,072	(63,796)	400,276				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,455		76,455	76,455		76,455				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,129	165,129	165,129		165,129				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76,455	165,129	241,584	241,584		241,584				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,840,688	411,193	1,677,649	3,929,530	3,929,530	(176,296)	3,753,234				45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,416)	30		9
10	Interest and Other Investment Income	(14,766)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,901)	2		13
14	Non-Care Related Interest	(10,932)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,002)	21		18
19	Entertainment	(8,036)	20		19
20	Contributions	(7,500)	20		20
21	Owner or Key-Man Insurance	(28,355)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,122)	27		24
25	Fund Raising, Advertising and Promotional	(7,843)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(15,741)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,614)		\$	30

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	2	
		Amount	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)	(31,682)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (31,682)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (176,296)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

OAKRIDGE HEALTHCARE CENTER

ID# 0051862

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NON ALLOWABLE TRANSPORTATION	\$ (15,741)	25	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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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		(15,741)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER# 0051862

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,901)	0	0	0	0	0	0	0	0	0	0	(1,901)	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	(1,901)	0	0	0	0	0	0	0	0	0	0	(1,901)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(23,379)	0	0	0	0	0	0	0	0	0	0	(23,379)	20
21	Clerical & General Office Expenses	(13,002)	0	0	0	0	0	0	0	0	0	0	(13,002)	21
22	Employee Benefits & Payroll Taxes	(28,355)	0	0	0	0	0	0	0	0	0	0	(28,355)	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	(15,741)	0	0	0	0	0	0	0	0	0	0	(15,741)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(30,122)	0	0	0	0	0	0	0	0	0	0	(30,122)	27
28	TOTAL General Administration	(110,599)	0	0	0	0	0	0	0	0	0	0	(110,599)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(112,500)	0	0	0	0	0	0	0	0	0	0	(112,500)	29

STATE OF ILLINOIS

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER# 0051862

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(6,416)	71,139	0	0	0	0	0	0	0	0	0	64,723	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,698)	149,179	0	0	0	0	0	0	0	0	0	123,481	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(252,000)	0	0	0	0	0	0	0	0	0	(252,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(32,114)	(31,682)	0	0	0	0	0	0	0	0	0	(63,796)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(144,614)	(31,682)	0	0	0	0	0	0	0	0	0	(176,296)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELISHA ATKIN	50	MCALLISTER NURSING & REHAB LLC	TINLEY PARK	OAKRIDGE		
Yael ATKIN	50			NURSING AND		
				REHAB PROP, LLC	HILLSIDE	REALTY
				MCALLISTER		
				PROPERTY,LLC	TINLEY PARK	REALTY

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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 252,000	OAKRIDGE NURSING AND REHAB PROPERTIES, LLC		\$	\$(252,000)	1
2	V	30 DEPRECIATION				71,139	71,139	2
3	V	32 INTEREST				149,179	149,179	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 252,000			\$ 220,318	\$ * (31,682)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TZVI ATKIN	ASSISTANT	ADMINISTRATIVE			SEE			\$ 48,057	17-1	1
2		ADMINISTRATOR				ATTACHED					2
3											3
4											4
5	Yael ATKIN	MEMBER	ADMINISTRATIVE	50.00	mcallister-	SEE			88,500	17-3	5
6					12,073	ATTACHED					6
7											7
8	ELISHA ATKIN	MEMBER	ADMINISTRATOR	50.00	mcallister-	SEE			88,500	17-3	8
9					103,138	ATTACHED					9
10											10
11											11
12											12
13								TOTAL	\$ 225,057		13

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

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER

0051862 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY						\$	\$			\$						
2																	
3																	
4																	
5	BANK LEUMI		X	MORTGAGE	\$20,425.40	12/27/12	3,000,000	2,904,074			149,179						
Working Capital																	
6	BANK LEUMI		X	LINE OF CREDIT	INT ONLY	REVOL		470,000			11,987						
7	DEPENDABLE FINANCE		X	INSURANCE POLICY FIN	\$8,411.00	1/4/13	64,681		9/1/13		2,607						
8																	
9	TOTAL Facility Related				\$28,836.40		\$ 3,064,681	\$ 3,374,074			\$ 163,773						
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES													
11	BED TAX			LATE FEES							4,003						
12	COOK COUNTY R/E TAX			LATE FEES							6,929						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,932						
15	TOTALS (line 9+line14)						\$ 3,064,681	\$ 3,374,074			\$ 174,705						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$	148,100		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.)		\$	154,761		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	6,661		3														
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	154,761		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.		\$	161,422		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2009	_____	9																
	2010	_____	10																
	2011	148,100	11																
	2012	154,761	12																
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL																			
THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.																			

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKRIDGE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051862

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-17-413-052-0000</u>	<u>NURSING HOME</u>	\$ <u>80,418.00</u>	\$ <u>80,418.00</u>
2. <u>15-17-413-067-0000</u>	<u>NURSING HOME</u>	\$ <u>74,343.00</u>	\$ <u>74,343.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>154,761.00</u></u>	\$ <u><u>154,761.00</u></u>

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>2009</u>	<u>\$ 225,000</u>	1
2					2
3	TOTALS			\$ 225,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	73	2009		\$ 1,295,561	\$ 47,111	27.5	\$ 47,111	\$	\$ 94,222
5									
6									
7									
8									
Improvement Type**									
9	VINYL PLANK FLOORING FOR 2 DINING ROOMS AND								
10	HALLWAYS		2012	16,959	435	27.5	435		453
11	ROOF		2012	4,950	127	27.5	127		132
12	DRAPERIES, CORNICES, WINDOW TREATMENTS IN								
13	RESIDENT ROOMS & PUBLIC AREA		2012	18,857	2,597	7	2,694	97	4,039
14	VINYL FLOORING, BASEBOARDS, PAINTING, LIGHTS,								
15	DEOMLITION OF WALLS AND FLOORS		2013	11,200	132		132		132
16	LIGHTING		2013	3,549	42		42		42
17	BASEBOARDS		2013	7,900	93		93		93
18	VINYL		2013	8,899	105		105		105
19	SECURITY SYSTEM		2013	11,314	133		133		133
20	HEATING BOILER		2013	12,800	150		150		150
21	NURSES STATION-OPEN CENTER OF EXISTING NURSES								
22	STATION AND CLOSE OFF CURRENT OPEN AREA.								
23	REPLACE EXISTING COUNTER TOP. INSTALL TILE IN								
24	HALLWAY, REMOVE ALL TILES, DRYWALL AND WORK								
25	AROUND CEILING PIPING, INSTALL THE HANDRAIL								
26	SKINS, WALL GUARDS. THERAPY ROOM- REMOVE								
27	EXISTING WOOD PANEL THAT SITS UNDERNEATH								
28	WALL VINYL. DRYWALL TOP PORTION AND PAINT.								
29	REMOVE EXISTING FLOORING AND REPLACE WITH A								
30	VINYL PLANK FLOORING		2013	21,300	250		250		250
31			2013	7,084	83		83		83
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER

0051862

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,420,373	\$ 51,258		\$ 51,355	\$ 97	\$ 99,834	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 29,969	\$ 4,307	\$ 2,997	\$ (1,310)	10 YRS	\$ 4,495	71
72	Current Year Purchases	3,934	2,360	197	(2,163)		197	72
73	Fully Depreciated Assets							73
74	REL PARTY	200,000	23,040	20,000	(3,040)	10 YRS	30,000	74
75	TOTALS	\$ 233,903	\$ 29,707	\$ 23,194	\$ (6,513)		\$ 34,692	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,879,276	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,965	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,549	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,416)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 134,526	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 252,000			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 252,000			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 13,801 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ 1,497	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,497	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 0	\$		\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				69,318		69,318	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology & Lab</u>	39-2					7,137		7,137	12
13	Other (specify):									13
14	TOTAL			\$		\$ 0	\$ 76,455		\$ 76,455	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 **OAKRIDGE HEALTHCARE CENTER**

0051862

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2013**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 28,117	\$ 28,141	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	1,021,296	1,021,296	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,914	135,914	6
7	Other Prepaid Expenses	1,326	1,326	7
8	Accounts Receivable (owners or related parties)	643,081	495,315	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,829,734	\$ 1,681,992	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		225,000	13
14	Buildings, at Historical Cost		1,295,561	14
15	Leasehold Improvements, at Historical Cost	40,766	124,812	15
16	Equipment, at Historical Cost	33,903	233,903	16
17	Accumulated Depreciation (book methods)	(36,701)	(459,761)	17
18	Deferred Charges		80,097	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL		866,665	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 37,968	\$ 2,366,277	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,867,702	\$ 4,048,269	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 507,691	\$ 507,691	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	470,000	470,000	29
30	Accrued Salaries Payable	83,977	83,977	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,173	21,173	31
32	Accrued Real Estate Taxes(Sch.IX-B)	154,761	154,761	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	OAKRIDGE PROPERTIES	528,005		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,765,607	\$ 1,237,602	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,904,074	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)	\$	\$ 2,904,074	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,765,607	\$ 4,141,676	46
47	TOTAL EQUITY(page 18, line 24)	\$ 102,095	\$ (93,407)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,867,702	\$ 4,048,269	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 169,623	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 169,623	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,528)	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	(40,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (67,528)	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)	\$ 102,095	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,866,822	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,866,822	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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***	14,766	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,766	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSION	689	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 689	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,882,277	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	684,860	31
32	Health Care	1,590,854	32
33	General Administration	948,160	33
B. Capital Expense			
34	Ownership	464,072	34
C. Ancillary Expense			
35	Special Cost Centers	76,455	35
36	Provider Participation Fee	165,129	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	(19,725)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,909,805	40
41	Income before Income Taxes (line 30 minus line 40)**	(27,528)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (27,528)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,365,797	44
45	Private Pay - Net Inpatient Revenue	299,796	45
46	Medicare - Net Inpatient Revenue	828,281	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	212,257	47
48	Other-(specify) VETERANS	160,691	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,866,822	49

**TAX RETURN PREPARED ON CASH BASIS

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number **OAKRIDGE HEALTHCARE CENTER**

0051862

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,099	2,138	\$ 65,407	\$ 30.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,594	11,048	320,145	28.98	3
4	Licensed Practical Nurses	9,476	9,978	261,304	26.19	4
5	CNAs & Orderlies	50,513	52,671	558,302	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,960	3,000	153,356	51.12	8
9	Activity Director	2,133	2,179	29,035	13.32	9
10	Activity Assistants	5,732	6,055	57,134	9.44	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,451	3,552	46,429	13.07	14
15	Cook Helpers/Assistants	9,949	10,304	113,664	11.03	15
16	Dishwashers					16
17	Maintenance Workers	2,067	2,235	43,840	19.62	17
18	Housekeepers	1,091	1,091	11,115	10.19	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	2,058	2,097	48,057	22.92	21
22	Other Administrative			1,354		22
23	Office Manager					23
24	Clerical	7,568	7,839	131,546	16.78	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)	109,691	114,187	\$ 1,840,688 *	\$ 16.12	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,472	1-3	35
36	Medical Director	O	8,760	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,004	10-3	38
39	Pharmacist Consultant	H	2,646	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,530	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,412		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ELISHA ATKIN	ADMINISTRATOR		\$ 0	Workers' Compensation Insurance	\$ 52,614	IDPH License Fee	\$	
TZVI ATKIN	ASST ADMIN		48,057	Unemployment Compensation Insurance	94,076	Advertising: Employee Recruitment	925	
HELEN LACEK	OTHER ADMIN		1,354	FICA Taxes	140,813	Health Care Worker Background Check	700	
				Employee Health Insurance	19,290	(Indicate # of checks performed _____)		
				Employee Meals	17,849	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	7,500	
				EMPLOYEE BENEFITS - OTHER	1,792	MARKETING/ADV/PROMO	15,879	
				EMPLOYEE PHYSICAL EXAMS	65	LICENSES/DUES/SUBSCRIPTIONS	8,028	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(7,500)	
				INSURANCE - EXECUTIVE LIFE	28,355	Less: Public Relations Expense	(8,036)	
				INSURANCE - EXECUTIVE LIFE VI 21	(28,355)	Non-allowable advertising	(7,843)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,411	TOTAL (agree to Schedule V, line 22, col.8)	\$ 326,499	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,653	
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Yael Atkin			\$ 88,500				Out-of-State Travel	\$
Elisha Atkin			88,500					
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 177,000	TOTAL			(agree to Sch. V, line 24, col. 8)	\$
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount		
			\$					
SEE SCHEDULE ATTACHED			49,047					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 49,047					

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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 OAKRIDGE HEALTHCARE CENTER

0051862

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES _____ NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 165,129
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. \$ 17,849 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? 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: _____
- (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? YES
Attach invoices and a summary of services for all architect and appraisal fees.