

Facility Name & ID Number Oakton Pavillion

0025056 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	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	<u>294</u>	Skilled (SNF)	<u>294</u>	<u>107,310</u>	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	<u>294</u>	TOTALS	<u>294</u>	<u>107,310</u>	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
9	SNF/PED					9
10	ICF	<u>32,964</u>	<u>43,876</u>	<u>16,399</u>	<u>93,239</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,964</u>	<u>43,876</u>	<u>16,399</u>	<u>93,239</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

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)

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

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 01/20/1980

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 294 and days of care provided 11,047

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	457,710	75,429	500	533,639		533,639		533,639		1
2	Food Purchase		463,801		463,801	(100,100)	363,701	(5,651)	358,050		2
3	Housekeeping	419,867	68,390		488,257		488,257		488,257		3
4	Laundry	158,175	31,420		189,595		189,595		189,595		4
5	Heat and Other Utilities			273,978	273,978		273,978		273,978		5
6	Maintenance	156,966	88,449		245,415		245,415		245,415		6
7	Other (specify):* See Attached Sch			28,488	28,488		28,488		28,488		7
8	TOTAL General Services	1,192,718	727,489	302,966	2,223,173	(100,100)	2,123,073	(5,651)	2,117,422		8
	B. Health Care and Programs										
9	Medical Director			1,158	1,158		1,158		1,158		9
10	Nursing and Medical Records	4,073,429	824,368	82,717	4,980,514		4,980,514		4,980,514		10
10a	Therapy	884,663		110,485	995,148		995,148		995,148		10a
11	Activities	244,764	13,125		257,889		257,889		257,889		11
12	Social Services	93,032			93,032		93,032		93,032		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,295,888	837,493	194,360	6,327,741		6,327,741		6,327,741		16
	C. General Administration										
17	Administrative	125,008		2,322,695	2,447,703		2,447,703	(4,842,695)	(2,394,992)		17
18	Directors Fees										18
19	Professional Services			54,017	54,017		54,017	30,261	84,278		19
20	Dues, Fees, Subscriptions & Promotions			62,957	62,957		62,957	(42,108)	20,849		20
21	Clerical & General Office Expenses	327,391		110,913	438,304		438,304	(5,856)	432,448		21
22	Employee Benefits & Payroll Taxes			1,201,090	1,201,090	100,100	1,301,190		1,301,190		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,602	3,602		3,602		3,602		24
25	Other Admin. Staff Transportation			14,529	14,529		14,529	(2,906)	11,623		25
26	Insurance-Prop.Liab.Malpractice			179,479	179,479		179,479		179,479		26
27	Other (specify):* Bad Debts			153,481	153,481		153,481	(153,481)			27
28	TOTAL General Administration	452,399		4,102,763	4,555,162	100,100	4,655,262	(5,016,785)	(361,523)		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,941,005	1,564,982	4,600,089	13,106,076		13,106,076	(5,022,436)	8,083,640		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:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							195,199	195,199			30
31	Amortization of Pre-Op. & Org.							4,713	4,713			31
32	Interest							134,509	134,509			32
33	Real Estate Taxes			530,208	530,208		530,208		530,208			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			5,577	5,577		5,577		5,577			35
36	Other (specify):*											36
37	TOTAL Ownership			1,975,785	1,975,785		1,975,785	(1,105,579)	870,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,965	160,965		160,965		160,965			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			160,965	160,965		160,965		160,965			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,941,005	1,564,982	6,736,839	15,242,826		15,242,826	(6,128,015)	9,114,811			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	OHF 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	74,698	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,651)	2		13
14	Non-Care Related Interest	(39,124)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,906)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,566)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(153,481)	27		24
25	Fund Raising, Advertising and Promotional	(30,889)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(41,251)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,219)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	(2,988,959)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,205,348)		\$	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	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)	(2,922,667)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,922,667)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,128,015)		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.			\$	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	Exceptional Care Program				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: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Consulting Expesnse	\$ (3,008,000)	17	1
2	Legal Fees (R/E Tax Appeal, On F/S Accrued			2
3	in 2005, Paid in 2006)	19,041	19	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	(2,988,959)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakton Pavillion# 0025056 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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	(5,651)	0	0	0	0	0	0	0	0	0	0	(5,651)	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	(5,651)	0	0	0	0	0	0	0	0	0	0	(5,651)	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	(3,008,000)	(1,834,695)	0	0	0	0	0	0	0	0	0	(4,842,695)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	19,041	11,220	0	0	0	0	0	0	0	0	0	30,261	19
20	Fees, Subscriptions & Promotions	(42,108)	0	0	0	0	0	0	0	0	0	0	(42,108)	20
21	Clerical & General Office Expenses	(6,566)	710	0	0	0	0	0	0	0	0	0	(5,856)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,906)	0	0	0	0	0	0	0	0	0	0	(2,906)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(153,481)	0	0	0	0	0	0	0	0	0	0	(153,481)	27
28	TOTAL General Administration	(3,194,020)	(1,822,765)	0	(5,016,785)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,199,671)	(1,822,765)	0	(5,022,436)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakton Pavillion# 0025056

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	74,698	120,501	0	0	0	0	0	0	0	0	0	195,199	30
31	Amortization of Pre-Op. & Org.	0	4,713	0	0	0	0	0	0	0	0	0	4,713	31
32	Interest	(39,124)	173,633	0	0	0	0	0	0	0	0	0	134,509	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):*	(41,251)	41,251	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,677)	(1,099,902)	0	(1,105,579)	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)	(3,205,348)	(2,922,667)	0	(6,128,015)	45								

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 1,440,000	Oakton Terrace	100.00%	\$	\$ (1,440,000)	1
2	V	32 Interest Income	42,631	Oakton Terrace			(42,631)	2
3	V	17 Consulting Fees		Oakton Terrace		180,000	180,000	3
4	V	30 Depreciation		Oakton Terrace		120,501	120,501	4
5	V	31 Amortization		Oakton Terrace		4,713	4,713	5
6	V	19 Legal & Accounting Fees		Oakton Terrace		10,625	10,625	6
7	V	32 Mortgage Interest		Oakton Terrace		216,264	216,264	7
8	V	21 Miscellaneous Expenses		Oakton Terrace		710	710	8
9	V	36 Replacement Tax		Oakton Terrace		11,054	11,054	9
10	V	17 Management Fee	2,322,695	FMH Management Company			(2,322,695)	10
11	V	17 Consulting Fees		FMH Management Company		308,000	308,000	11
12	V	19 Accounting Fees		FMH Management Company		595	595	12
13	V	36 State Income Tax Expense		FMH Management Company		30,197	30,197	13
14	Total		\$ 3,805,326			\$ 882,659	\$ * (2,922,667)	14

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

Facility Name & ID Number

Oakton Pavillion

0025056

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	Jay Lewkowitz	Administrator	Administrator	9.375%	N/A	40	90.00%	Salary	\$ 125,008	17/1	1
2	Mike Lewkowitz	General Partner	Administrative	4.380%	N/A	0	0.00%	Mgmt Fee	99,000	17/7	2
3	Jay Lewkowitz	Administrator	Administrative	See Above	N/A			Mgmt Fee	339,000	17/7	3
4	Fred Weiss	General Partner	Administrative	25.420%	N/A	10	20.00%	Mgmt Fee	50,000	17/7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 613,008		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

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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

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	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

Facility Name & ID Number

Oakton Pavillion

0025056

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Nat'l Bank		X	Building Mortgage	\$30,193.00	06/01/98	\$ 3,700,060	\$ 2,738,362	06/01/08	7.6700	\$ 216,264	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$30,193.00		\$ 3,700,060	\$ 2,738,362			\$ 216,264	9								
B. Non-Facility Related*																				
10	Oakton Terrace	X									(42,631)	10								
11	Oakton Pavillion										(39,124)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (81,755)	14								
15	TOTALS (line 9+line14)						\$ 3,700,060	\$ 2,738,362			\$ 134,509	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

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 2005 report.		\$	505,000	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.)		\$	510,277	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,277	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	526,000	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.)		\$	534	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 \$ <u>1,603</u> For <u>1999</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(1,603)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	530,208	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	436,418	8
	2002	408,119	9
	2003	448,169	10
	2004	491,059	11
	2005	510,277	12

Based on 1999 Refund allocated % spreadsheet prepared by Fisk, Kart, Katz and Regan, Ltd, we allocated legal fees using the same allocation %.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>09-29-106-006-000</u>	<u>Oakton Pavillion</u>	\$ <u>510,277.00</u>	\$ <u>510,277.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>510,277.00</u>	\$ <u>510,277.00</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

01/01/2006 Ending:

12/31/2006

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 (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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>74,998</u>	<u>1975</u>	<u>\$ 200,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	74,998		\$ 200,000	3

Facility Name & ID Number Oakton Pavillion

0025056

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	294		1980	1980	\$ 4,171,968	\$ 62,768	40	\$ 104,299	\$ 41,531	\$ 3,474,908	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	Antenna 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	1,270	20	2,000	730	32,000	22
23	Improvements		1991		4,590	146	10		(146)	4,590	23
24	Fire Dampers & Doors		2001		148,267	3,802	39	3,802		20,911	24
25	Sliding Door		2001		10,498	814	39	269	(545)	1,480	25
26	White Way Sign		2001		2,082	53	39	53		292	26
27	Remodeling Garden Level		2001		208,312	5,342	39	5,342		29,377	27
28	Smoke Detector		2003		4,320	377	10	432	55	1,728	28
29	Pump		2003		14,118	882	10	1,412	530	5,648	29
30	Electrical Circuits		2004		6,811	175	39	175		525	30
31	Elevator Modernization		2004		24,393	625	39	625		1,875	31
32	Shed		2004		3,566	312	7	509	197	1,527	32
33	Plumbing Improvements		2004		44,749	1,148	39	1,148		3,442	33
34	Elevator Modernization		2005		86,956	2,229	39	2,229		4,459	34
35	Pantry Renovation		2005		8,155	209	39	209		418	35
36	Asphalt Work		2005		22,835	2,169	15	2,169		3,691	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	2005	\$ 1,730	\$ 44	39	\$ 44	\$	\$ 88	37	
38	2006	2,816	60	39	72	12	72	38	
39	2006	3,100	60	39	79	19	79	39	
40	2006	131,130	841	39	3,362	2,521	3,362	40	
41	2006	12,415	106	39	318	212	318	41	
42	2006	48,850	418	39	1,253	835	1,253	42	
43	2006	4,100	35	39	105	70	105	43	
44	2006	25,000	214	39	641	427	641	44	
45	2006	9,959	43	39	255	212	255	45	
46	2006	2,080	9	39	53	44	53	46	
47	2006	10,850	46	39	278	232	278	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)		\$ 5,152,380	\$ 84,197		\$ 131,133	\$ 46,936	\$ 3,692,105	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 436,352	\$ 11,415	\$ 43,635	\$ 32,220	10	\$ 312,913	71
72	Current Year Purchases	43,065	6,214	4,307	(1,907)	10	4,307	72
73	Fully Depreciated Assets	606,345				10	606,345	73
74								74
75	TOTALS	\$ 1,085,762	\$ 17,629	\$ 47,942	\$ 30,313		\$ 923,565	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Patients	1992 Ford Van	1992	\$ 27,300	\$	\$	\$	5	\$ 27,300	76
77	Administrative	2004 Accura	2004	31,170	2,850	6,234	3,384	5	10,494	77
78	Administrative	2005 Ford E350	2005	49,451	15,825	9,890	(5,935)	5	19,780	78
79										79
80	TOTALS			\$ 107,921	\$ 18,675	\$ 16,124	\$ (2,551)		\$ 57,574	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)	\$ 6,546,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,501	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 195,199	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 74,698	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,673,244	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:	<u>1980</u>	<u>294</u>		\$ <u>1,440,000</u>			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 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: \$ 5,577 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

10. Effective dates of current rental agreement:

Beginning 01/01/2007

Ending 12/31/2007

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

Fiscal Year Ending Annual Rent

12. 12/31/2007 \$ 1,440,000

13. /2008 \$ _____

14. /2009 \$ _____

* 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.

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.)

<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>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		3	4
		1	2		
		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.

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

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

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

Facility Name & ID Number Oakton Pavillion

0025056

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 445,394	\$ 1,484,567	1
2	Cash-Patient Deposits	7,153	7,153	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,304,949	3,304,949	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,011	33,011	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,786,063	1,582,464	8
9	Other(specify): <u>See Attached Schedule</u>	214,693	392,131	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,791,263	\$ 6,804,275	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		4,171,968	14
15	Leasehold Improvements, at Historical Cost		1,051,412	15
16	Equipment, at Historical Cost		1,122,682	16
17	Accumulated Depreciation (book methods)		(4,634,025)	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 (specify):			22
23	Other(specify): <u>Loan Costs</u>		76,988	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,989,025	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,791,263	\$ 8,793,300	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,984	\$ 236,984	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,153	7,153	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,731	286,731	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,617	2,617	31
32	Accrued Real Estate Taxes(Sch.IX-B)	526,000	526,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,694	44,971	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	921,000	921,000	36
37	<u>Tenant Tax Reserve</u>		210,944	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,984,179	\$ 2,236,400	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,738,362	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)	\$	\$ 2,738,362	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,984,179	\$ 4,974,762	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,807,084	\$ 3,818,538	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,791,263	\$ 8,793,300	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,568,442	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,568,442	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	238,642	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)	\$ 238,642	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)	\$ 5,807,084	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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,303,286	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,303,286	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,312,533	6
7	Oxygen	8,499	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,321,032	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	4,522	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	686,987	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	30,238	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 721,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	39,124	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,124	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Home Delivered Meals</u>	99,441	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 99,441	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,484,630	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,223,173	31
32	Health Care	6,327,741	32
33	General Administration	4,555,162	33
	B. Capital Expense		
34	Ownership	1,975,785	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	160,965	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,242,826	40
41	Income before Income Taxes (line 30 minus line 40)**	241,804	41
42	Income Taxes	(3,162)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 238,642	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Oakton Pavillion

0025056

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	2,040	2,168	\$ 96,480	\$ 44.50	1
2	Assistant Director of Nursing	2,000	2,160	80,222	37.14	2
3	Registered Nurses	58,995	65,030	1,686,970	25.94	3
4	Licensed Practical Nurses	8,670	9,093	212,591	23.38	4
5	CNAs & Orderlies	153,966	164,944	1,997,166	12.11	5
6	CNA Trainees					6
7	Licensed Therapist	12,913	14,017	439,239	31.34	7
8	Rehab/Therapy Aides	23,867	26,177	445,424	17.02	8
9	Activity Director	2,221	2,867	53,318	18.60	9
10	Activity Assistants	18,418	19,669	191,446	9.73	10
11	Social Service Workers	5,001	5,381	93,032	17.29	11
12	Dietician					12
13	Food Service Supervisor	2,300	2,484	82,418	33.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,500	41,120	375,292	9.13	15
16	Dishwashers					16
17	Maintenance Workers	9,617	10,241	156,966	15.33	17
18	Housekeepers	40,864	44,437	419,867	9.45	18
19	Laundry	17,653	19,381	158,175	8.16	19
20	Administrator	2,080	2,080	125,008	60.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,758	15,205	327,391	21.53	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)	412,863	446,454	\$ 6,941,005 *	\$ 15.55	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	Monthly	\$ 500	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,891	10-3	39
40	Physical Therapy Consultant	Monthly	45,614	10A-3	40
41	Occupational Therapy Consultant	816	52,691	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Podiatry</u>	Monthly	7,380	10A-3	46
47	<u>Dental Consultant</u>	Monthly	4,800	10A-3	47
48					48
49	TOTAL (lines 35 - 48)	816	\$ 114,876		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	752	\$ 44,101	10-3	50
51	Licensed Practical Nurses	880	34,725	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,632	\$ 78,826		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				
Jay Lewkowitz	Administrator	9.375	\$ 125,008	Workers' Compensation Insurance	\$ 89,590	IDPH License Fee	\$				
				Unemployment Compensation Insurance	46,392	Advertising: Employee Recruitment	3,740				
				FICA Taxes	512,032	Health Care Worker Background Check					
				Employee Health Insurance	486,862	(Indicate # of checks performed <u>16</u>)	256				
				Employee Meals	100,100	Patient Background Checks	4,112				
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	7,171				
				Employee Life Insurance	15,521	Licenses	5,570				
				Employee Welfare	50,693	Advertising and Promotions	42,108				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 125,008	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,301,190	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,849	
(List each licensed administrator separately.)								Less: Public Relations Expense ()			
B. Administrative - Other								Non-allowable advertising (30,889)			
Description			Amount					Yellow page advertising (11,219)			
Management Feed			\$ 2,322,695								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,322,695								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Kessler, Orlean, Silver	Accountant		\$ 42,167			\$	Out-of-State Travel	\$			
Richard Peelo	Accountant		4,500								
Dowd, Dowd & Merters, Ltd	Legal		3,654				In-State Travel				
Chicago Area Interpreter	Interpreter		196								
Direct Supply	Space Planner		3,500				Seminar Expense	3,602			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 54,017	TOTAL			\$	Entertainment Expense ()			
(If total legal fees exceed \$5,000, attach copy of invoices.)								(agree to Sch. V, line 24, col. 8)		\$ 3,602	

* Attach copy of IMRF notifications

**See instructions.

