



Facility Name & ID Number Oakton Pavillion

# 0025056 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 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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>22,728</u>	<u>18,368</u>	<u>7,325</u>	<u>48,421</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,728</u>	<u>18,368</u>	<u>7,325</u>	<u>48,421</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.12%

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 5,843

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Oakton Pavillion # 0025056 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**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
	<b>A. General Services</b>										
1	Dietary	324,517	27,616		352,133		352,133		352,133		1
2	Food Purchase		349,240		349,240	(72,124)	277,116	(3,292)	273,824		2
3	Housekeeping	122,046	58,118		180,164		180,164		180,164		3
4	Laundry	128,407	9,468		137,875		137,875		137,875		4
5	Heat and Other Utilities			235,465	235,465		235,465		235,465		5
6	Maintenance	133,530	137,955		271,485		271,485		271,485		6
7	Other (specify):* <a href="#">See Attached Sch</a>			50,244	50,244		50,244		50,244		7
8	<b>TOTAL General Services</b>	<b>708,500</b>	<b>582,397</b>	<b>285,709</b>	<b>1,576,606</b>	<b>(72,124)</b>	<b>1,504,482</b>	<b>(3,292)</b>	<b>1,501,190</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			35,004	35,004		35,004		35,004		9
10	Nursing and Medical Records	2,238,748	423,280	3,267	2,665,295		2,665,295		2,665,295		10
10a	Therapy	223,506		317,475	540,981		540,981		540,981		10a
11	Activities	140,419	34,466		174,885		174,885		174,885		11
12	Social Services	51,235			51,235		51,235		51,235		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,653,908</b>	<b>457,746</b>	<b>355,746</b>	<b>3,467,400</b>		<b>3,467,400</b>		<b>3,467,400</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	331,781			331,781		331,781	75,000	406,781		17
18	Directors Fees										18
19	Professional Services			66,791	66,791		66,791	189,270	256,061		19
20	Dues, Fees, Subscriptions & Promotions			61,502	61,502		61,502	(44,217)	17,285		20
21	Clerical & General Office Expenses	284,494		128,117	412,611		412,611	4,351	416,962		21
22	Employee Benefits & Payroll Taxes			505,098	505,098	72,124	577,222	(14,468)	562,754		22
23	Inservice Training & Education										23
24	Travel and Seminar			660	660		660		660		24
25	Other Admin. Staff Transportation			3,235	3,235		3,235	(1,132)	2,103		25
26	Insurance-Prop.Liab.Malpractice			188,317	188,317		188,317		188,317		26
27	Other (specify):*			7,621	7,621		7,621	(7,621)			27
28	<b>TOTAL General Administration</b>	<b>616,275</b>		<b>961,341</b>	<b>1,577,616</b>	<b>72,124</b>	<b>1,649,740</b>	<b>201,183</b>	<b>1,850,923</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,978,683</b>	<b>1,040,143</b>	<b>1,602,796</b>	<b>6,621,622</b>		<b>6,621,622</b>	<b>197,891</b>	<b>6,819,513</b>		<b>29</b>

\*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 &amp; ID Number

Oakton Pavillion

#0025056

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	
	<b>D. Ownership</b>											
30	Depreciation							218,945	218,945			30
31	Amortization of Pre-Op. & Org.							5,209	5,209			31
32	Interest							99,996	99,996			32
33	Real Estate Taxes			345,621	345,621		345,621		345,621			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			24,867	24,867		24,867		24,867			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,810,488	1,810,488		1,810,488	(1,115,850)	694,638			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			419,765	419,765		419,765		419,765			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			419,765	419,765		419,765		419,765			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,978,683	1,040,143	3,833,049	8,851,875		8,851,875	(917,959)	7,933,916			45

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

Facility Name & ID Number **Oakton Pavillion**

# **0025056**

Report Period Beginning:

**01/01/2013**

Ending:

**12/31/2013**

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	53,238	30		9
10	Interest and Other Investment Income	(3,465)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,292)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,132)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,650)	21		20
21	Owner or Key-Man Insurance	(14,468)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,621)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,283)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(44,317)	20		28
29	Other-Attach Schedule See Attached Schedule	(685)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (31,675)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(886,284)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (886,284)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (917,959)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Oakton Pavillion

ID# 0025056

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Trust Fees	\$ (685)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(685)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakton Pavillion

# 0025056

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	(3,292)	0	0	0	0	0	0	0	0	0	0	(3,292)	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	<b>TOTAL General Services</b>	<b>(3,292)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,292)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	75,000	0	0	0	0	0	0	0	0	0	75,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	189,270	0	0	0	0	0	0	0	0	0	189,270	19
20	Fees, Subscriptions & Promotions	(44,317)	100	0	0	0	0	0	0	0	0	0	(44,217)	20
21	Clerical & General Office Expenses	(10,618)	14,969	0	0	0	0	0	0	0	0	0	4,351	21
22	Employee Benefits & Payroll Taxes	(14,468)	0	0	0	0	0	0	0	0	0	0	(14,468)	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	(1,132)	0	0	0	0	0	0	0	0	0	0	(1,132)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,621)	0	0	0	0	0	0	0	0	0	0	(7,621)	27
28	<b>TOTAL General Administration</b>	<b>(78,156)</b>	<b>279,339</b>	<b>0</b>	<b>201,183</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(81,448)</b>	<b>279,339</b>	<b>0</b>	<b>197,891</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakton Pavillion

# 0025056

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	53,238	165,707	0	0	0	0	0	0	0	0	0	218,945	30
31	Amortization of Pre-Op. & Org.	0	5,209	0	0	0	0	0	0	0	0	0	5,209	31
32	Interest	(3,465)	103,461	0	0	0	0	0	0	0	0	0	99,996	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,440,000)	0	0	0	0	0	0	0	0	0	(1,440,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>49,773</b>	<b>(1,165,623)</b>	<b>0</b>	<b>(1,115,850)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(31,675)</b>	<b>(886,284)</b>	<b>0</b>	<b>(917,959)</b>	<b>45</b>								

**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
<a href="#">See Page 6 - Supp for Detail Info</a>						

**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	6	Oakton Terrace	100.00%		(6)	2
3	V	17 Consulting Fees		Oakton Terrace	100.00%	75,000	75,000	3
4	V	30 Depreciation		Oakton Terrace	100.00%	165,707	165,707	4
5	V	31 Amortization		Oakton Terrace	100.00%	5,209	5,209	5
6	V	19 Accounting and Legal Fees		Oakton Terrace	100.00%	185,945	185,945	6
7	V	20 License Fees		Oakton Terrace	100.00%	100	100	7
8	V	32 Mortgage Interest		Oakton Terrace	100.00%	103,467	103,467	8
9	V	21 Miscellaneous Financial Exp		Oakton Terrace	100.00%	8,518	8,518	9
10	V	21 Provision for Income Taxes		Oakton Terrace	100.00%	6,243	6,243	10
11	V	19 Accounting and Legal Fees		FMH Management Compnay	100.00%	3,325	3,325	11
12	V	21 Miscellaneous Financial Exp		FMH Management Compnay	100.00%	208	208	12
13	V							13
14	Total		\$ 1,440,006			\$ 553,722	\$ * (886,284)	14

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

Facility Name & ID Number

Oakton Pavillion

# 0025056

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Harrold Katz	25.417	N/A		Oakton Terrace	Des Plaines	Leasor	1
2	Myrna Palmer Trust	12.708	N/A		FMH Mng Co	Des Plaines	Mng Company	2
3	Mark Palmer Trust	12.708	N/A					3
4	Fred Weiss Revocable Trust	25.417	N/A					4
5	Mark Skorecky	5.000	N/A					5
6	Mike Lewkowitz	4.375	N/A					6
7	Jay Lewkowitz Revocable Trust	9.375	N/A					7
8	Leonard Solinsky	5.000	N/A					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 &amp; ID Number

Oakton Pavillion

# 0025056

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	Jay Lewkowitz	Administrator	Administrative	9.375%	N/A	40	90.00	Salary	\$ 163,192	17-1	1
2	Fred Weiss Revocable Trust	General Partner	Administrative	25.417%	N/A	10	20.00	Mng ees	25,000	17-7	2
3	Jay Lewkowitz	Administrator	Administrative	See Above	N/A			Mng ees	50,000	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 238,192		13

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

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

Facility Name & ID Number Oakton Pavillion

# 0025056 Report Period Beginning: 01/01/2013 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

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Oakton Pavillion

# 0025056

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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		7	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Private Bank		X	Building Mortgage	\$13,314.00	6/1/8	\$ 2,600,000		6/27/13	LIBR+1.75%	\$ 57,377	1						
2	Leumi Bank		X	Building Mortgage	\$17,890.00	07/02/13	2,300,000	2,256,640	07/02/18	4.75%	46,090	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$31,204.00		\$ 4,900,000	\$ 2,256,640			\$ 103,467	9						
<b>B. Non-Facility Related*</b>																		
10	Oakton Terrace	X									(6)	10						
11	Oakton Pavillion	X									(3,465)	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (3,471)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 4,900,000	\$ 2,256,640			\$ 99,996	15						

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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2012 report.			\$ <b>420,000</b>	<b>1</b>															
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.)			\$ <b>383,121</b>	<b>2</b>															
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(36,879)</b>	<b>3</b>															
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>382,500</b>	<b>4</b>															
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>5</b>															
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>6</b>															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>345,621</b>	<b>7</b>															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	<b>2008</b>	<b>419,713</b>	<b>8</b>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>		<b>13</b>	FROM R. E. TAX STATEMENT FOR 2012 \$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>
<b>FOR BHF USE ONLY</b>																			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2012 \$	<b>13</b>																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>																	
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>																	
	<b>2009</b>	<b>596,839</b>	<b>9</b>																
	<b>2010</b>	<b>400,463</b>	<b>10</b>																
	<b>2011</b>	<b>405,727</b>	<b>11</b>																
	<b>2012</b>	<b>383,121</b>	<b>12</b>																

**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 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 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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-29-106-006-000</u>	<u>Oakton Pavillion</u>	\$ <u>383,121.39</u>	\$ <u>383,121.39</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>383,121.39</u></u>	\$ <u><u>383,121.39</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.**

Facility Name & ID Number Oakton Pavillion

# 0025056 Report Period Beginning:

01/01/2013 Ending:

12/31/2013

**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).

N/A

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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>74,998</u>	<u>1975</u>	<u>\$ 200,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>74,998</b>		<b>\$ 200,000</b>	<b>3</b>

Facility Name & ID Number **Oakton Pavillion**# **0025056**

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	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	\$ 61,056	40	\$ 71,546	\$ 10,490	\$ 4,171,968	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Audit Adjustment		1981		955		20			955	9
10	Audit Adjustment		1983		30,266		20			30,266	10
11	Doors		1985		1,500		10			1,500	11
12	Sidewalk		1985		350		20			350	12
13	Audit Adjustment		1985		9,122		20			9,122	13
14	Decorating		1985		6,905		10			6,905	14
15	Hot Water Heater		1987		12,788		10			12,788	15
16	Light Fixtures		1987		11,288		10			11,288	16
17	Antena Hook Up		1988		4,905		10			4,905	17
18	A/C Compressor		1988		8,000		10			8,000	18
19	Sod / Environment Center		1989		7,282		10			7,282	19
20	Doors / Carpet		1990		3,609		10			3,609	20
21	Boiler Shell		1991		1,760		10			1,760	21
22	Roof		1991		40,000		20			40,000	22
23	Improvements		1991		4,590		10			4,590	23
24	Fire Dapers & Doors		2001		148,267	3,802	39	3,802		47,524	24
25	Sliding Door		2001		10,498		39	269	269	3,363	25
26	White Way Sign		2001		2,082	54	39	54		666	26
27	Remodeling Garden Level		2001		208,312	5,341	39	5,341		66,767	27
28	Smoke Detector		2003		4,320		10			4,320	28
29	Pump		2003		14,118		10			14,118	29
30	Electrical Circuites		2004		6,811	175	39	175		1,750	30
31	Elevator Modernization		2004		24,393	625	39	625		6,250	31
32	Shed		2004		3,566		7			3,566	32
33	Plumbing Improvements		2004		44,749	1,148	39	1,148		11,477	33
34	Elevator Modernization		2005		86,956	2,230	39	2,230		20,066	34
35	Pantry Renovation		2005		8,155	209	39	209		1,881	35
36	Asphalt Work		2005		22,835	1,349	15	2,169	820	14,345	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 &amp; ID Number Oakton Pavillion

# 0025056

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	2	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	Electrical Improvements	2005	\$ 1,730	\$ 44	39	\$ 44		\$ 396	37
38	Outside Lights	2006	2,816	72	39	72		576	38
39	Plumbing Improvements	2006	3,100	79	39	79		633	39
40	Roof Replacement	2006	131,130	3,362	39	3,362		26,896	40
41	Masonry Renovation	2006	12,415	319	39	319		2,547	41
42	Steel Window Lintel Replacement	2006	48,850	1,252	39	1,252		10,021	42
43	Steel Window Lintel Replacement	2006	4,100	105	39	105		841	43
44	Tuckpointing and Brick Replacement	2006	25,000	641	39	641		5,128	44
45	Elevator Power Unit	2006	9,959	255	39	255		2,040	45
46	Roof Exhaust Fan	2006	2,080	53	39	53		426	46
47	Roof Drains	2006	10,850	278	39	278		2,224	47
48	Sewage Pump	2007	3,905	101	39	101		703	48
49	Chilled Water Coils	2007	29,744	762	39	762		5,339	49
50	Fire Alarm System	2007	10,625	272	39	272		1,904	50
51	Cooling Tower Monitor	2007	2,560	66	39	66		462	51
52	Carpentry, Tiling, Ceiling, Plumbing, Electrical work 1st Floor	2009	15,000	385	39	385		1,925	52
53	Rebuild Water Pump	2009	4,580	117	39	117		586	53
54	Kitchen Plumbing Renovation	2009	9,578	245	39	245		1,227	54
55	Boiler	2009	15,700	403	39	403		2,014	55
56	Boiler Valve	2009	4,995	128	39	128		640	56
57	Tub Room Renovation	2010	9,300	238	39	238		855	57
58	Ejector Pump	2010	7,500	192	39	192		688	58
59	Cement Ramps	2010	4,544	117	39	117		409	59
60	Flagpole	2010	2,093	53	39	53		192	60
61	Awnings	2010	7,997	205	39	205		752	61
62	Recirculating Water Pump	2010	2,750	70	39	70		228	62
63	HVAC Circulating Pump	2010	10,735	275	39	275		940	63
64	Temperature Control Valve	2010	6,200	159	39	159		556	64
65	Laundry Room Ejector Pump	2010	18,787	481	39	481		1,485	65
66	Corridor AHU Pump	2011	11,090	284	39	284		829	66
67	Cooler Tower	2011	53,306	1,367	39	1,367		3,873	67
68	Fence	2011	3,979	102	39	102		255	68
69	Carpentry, Tiling, Ceiling, Plumbing, Electrical work 4th Floor	2011	380,155	9,747	39	9,747		27,618	69
70	TOTAL (lines 4 thru 69)		\$ 5,767,503	\$ 98,218		\$ 109,797	\$ 11,579	\$ 4,616,589	70

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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,767,503	\$ 98,218		\$ 109,797	\$ 11,579	\$ 4,616,589	1
2	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-3rd Floor	2001	380,155	9,748	39	9,748		25,994	2
3	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-2nd Floor	2001	380,155	9,748	39	9,748		23,557	3
4	Sidewalk	2011	5,690	146	39	146		365	4
5	Voltage Regulator	2011	2,700	69	39	69		173	5
6	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-1st Floor	2011	380,155	9,748	39	9,748		21,120	6
7	Concrete Patio	2011	2,970	76	39	76		178	7
8	Expansion Tank for AC	2012	13,167	337	39	337		506	8
9	Sprinkler System	2012	39,096	1,002	39	1,002		1,253	9
10	Carpentry, Tiling, Ceiling, Plumbing, Electrical work-1, 2, 3 Floor	2013	70,000	1,645	39	1,645		1,645	10
11	Generator Diesel Reserve Tank	2013	12,740	272	39	272		272	11
12	Valve for Heat Air Handler	2013	6,729	173	39	173		173	12
13	Wander System for Dementia Parier	2013	9,481	223	39	223		223	13
14	Circuit Breaker for Electrical Room	2013	5,675	146	39	146		146	14
15	Fire Alarm System	2013	118,703	761	39	761		761	15
16	Tubes for Boiler	2013	20,852	401	39	401		401	16
17	Metal Roof in Ramp Area	2013	1,393	15	39	15		15	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,217,164	\$ 132,728		\$ 144,307	\$ 11,579	\$ 4,693,371	34

\*\*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	\$ 293,234	\$ 18,757	\$ 62,962	\$ 44,205	5-7	\$ 75,522	71
72	Current Year Purchases	21,575	12,447	4,315	(8,132)	5	4,315	72
73	Fully Depreciated Assets	1,308,234				5-10	1,308,234	73
74								74
75	TOTALS	\$ 1,623,043	\$ 31,204	\$ 67,277	\$ 36,073		\$ 1,388,071	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	Administrative	2005 Ford E350	2005	\$ 49,451	\$	\$	\$	5	\$ 49,451	76
77	Administrative	2009 Accura	2009	36,806	1,775	7,361	5,586	5	26,467	77
78										78
79										79
80	TOTALS			\$ 86,257	\$ 1,775	\$ 7,361	\$ 5,586		\$ 75,918	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)	\$ 9,126,464	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,707	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,945	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 53,238	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,157,360	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: Oakton Terrace

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		\$ <u>1,440,000</u>			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 N/A

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: \$ 24,867 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 01/01/2013

Ending 12/31/2013

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

Fiscal Year Ending Annual Rent

12. /2014 \$ \_\_\_\_\_

13. /2015 \$ \_\_\_\_\_

14. /2016 \$ \_\_\_\_\_

\* 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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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	10a-3	# of prescrpts	9,324					9,324	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 9,324		\$	\$		\$ 9,324	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.

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 721,787	\$ 745,503	1
2	Cash-Patient Deposits	25,974	25,974	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	5,222,647	5,222,647	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,185	20,185	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,586,914	2,783,309	8
9	Other(specify): <b>R/E Tax Reserve</b>	592,687	592,687	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 11,170,194	\$ 9,390,305	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		6,693,234	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		2,233,230	16
17	Accumulated Depreciation (book methods)		(5,935,235)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <b>Loan Costs</b> )		34,841	22
23	Other(specify): <b>Deposits</b>		61,265	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 3,287,335	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 11,170,194	\$ 12,677,640	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 126,039	\$ 126,039	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,974	25,974	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,251	107,251	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	382,500	382,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		7,739	35
<b>Other Current Liabilities(specify):</b>				
36	<b>See Attached Schedule</b>	7,024,311	1,438,330	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,666,075	\$ 2,087,833	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,256,640	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 2,256,640	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,666,075	\$ 4,344,473	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,504,119	\$ 8,333,167	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 11,170,194	\$ 12,677,640	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,052,377</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,052,377</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,451,742</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,451,742</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,504,119</b>	<b>24</b> *

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

Facility Name &amp; ID Number Oakton Pavillion

# 0025056

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,679,071	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,679,071	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,201,844	6
7	Oxygen	7,271	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,209,115	8
<b>C. Other Operating Revenue</b>			
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	2,373	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	20,840	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,213	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,465	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,465	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attached Schedule</u>	388,753	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 388,753	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,303,617	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,576,606	31
32	Health Care	3,467,400	32
33	General Administration	1,577,616	33
<b>B. Capital Expense</b>			
34	Ownership	1,810,488	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	419,765	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,851,875	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,451,742	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,451,742	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	49

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

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

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

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

Facility Name & ID Number Oakton Pavillion

# 0025056

Report Period Beginning:

01/01/2013

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	2,080	2,127	\$ 94,204	\$ 44.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,754	27,199	665,971	24.49	3
4	Licensed Practical Nurses	19,737	20,628	443,936	21.52	4
5	CNAs & Orderlies	87,201	91,409	1,034,637	11.32	5
6	CNA Trainees					6
7	Licensed Therapist	4,802	4,986	218,474	43.82	7
8	Rehab/Therapy Aides	359	359	5,032	14.02	8
9	Activity Director	472	472	8,538	18.09	9
10	Activity Assistants	10,673	11,691	131,881	11.28	10
11	Social Service Workers	3,853	3,941	51,235	13.00	11
12	Dietician					12
13	Food Service Supervisor	656	656	14,823	22.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,833	28,694	309,694	10.79	15
16	Dishwashers					16
17	Maintenance Workers	8,326	9,012	133,530	14.82	17
18	Housekeepers	12,985	14,361	122,046	8.50	18
19	Laundry	11,688	12,903	128,407	9.95	19
20	Administrator	2,080	2,266	163,192	72.02	20
21	Assistant Administrator	2,080	2,312	168,589	72.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,379	12,310	284,494	23.11	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)	227,958	245,326	\$ 3,978,683 *	\$ 16.22	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			35	
36	Medical Director	M	35,004	9-3	36
37	Medical Records Consultant	O	3,267	10-3	37
38	Nurse Consultant	N			38
39	Pharmacist Consultant	T			39
40	Physical Therapy Consultant	H			40
41	Occupational Therapy Consultant	L			41
42	Respiratory Therapy Consultant	Y			42
43	Speech Therapy Consultant				43
44	Activity Consultant	F			44
45	Social Service Consultant	E			45
46	Other(specify)	E			46
47		S			47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,271		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 308,151	10a-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ 308,151		53

Facility Name & ID Number **Oakton Pavillion**

# **0025056**

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

Ending: **12/31/2013**

**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	\$ 163,192	Workers' Compensation Insurance	\$ 65,386	IDPH License Fee	\$	
Maureen Krahl	Assistant Admin	0.000	168,589	Unemployment Compensation Insurance	55,125	Advertising: Employee Recruitment		
				FICA Taxes	297,353	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	48,446	Patient Background Checks	70 700	
				Employee Meals	72,124	Advetising	44,317	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,554	
				Employee Welfare	24,320	Licenses & Fees	9,931	
						Licenses & Fees - Oakton Terrace	100	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 331,781			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	(44,317)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 562,754	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,285	
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 & Co.	Accounting		\$ 22,216			\$	Out-of-State Travel	\$
Richard Peelo	Accounting		4,500					
Edward J Molloy Associates	Real Estate Tax Appeal		400					
American Profit	Collection Agency		500				In-State Travel	
Center for Ethics and Advocacy	Consulting Services		3,300					
Legat Architects	Consulting Services		5,554					
Pharmacy Price management	Consulting Services		3,500				Seminar Expense	660
Dowd, Dowd & Mertes, Ltd	Legal Fees		2,714					
Polsinelli Shughart PC	Legal Fees		3,967					
Werman Law, P.C.	Legal Fees		16,140				Entertainment Expense	( )
Law Office of Michael T. Smith	Legal Fees		4,000					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 66,791	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 660

\* 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Oakton Pavillion# 0025056Report Period Beginning: 01/01/2013Ending: 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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,111 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 419,765  
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 benefit on Schedule V. \$ 72,124 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? N/A  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees

Client Name: **Oakton Pavilion - Cost Report**

Date: **12/31/13**

Jrnl #	Item #	DV	Cl	Line	DESCRIPTION	DEBIT	CREDIT	NOTES
	1		3	22		72,124		
			2	2			72,124	
					(Reclassify Employee Meals cost per calculation)			