

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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

<p>I. IDPH Facility ID Number: <u>0034694</u></p> <p>Facility Name: <u>OakBrook Healthcare Centre</u></p> <p>Address: <u>2013 Midwest Road</u> <u>Oak Brook</u> <u>60523</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 495-0220</u> Fax # <u>(630) 495-9150</u></p> <p>IDPA ID Number: <u>#36-3601135-001</u></p> <p>Date of Initial License for Current Owners: <u>09/07/88</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christopher Vicere</u> Telephone Number: <u>(773) 604-4416</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-Jan-04</u> to <u>31-Dec-04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) <u>25-March-2004</u> (Type or Print Name) <u>Christopher Vicere</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>Vice President - Finance</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (____) _____</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) <u>25-March-2004</u> (Type or Print Name) <u>Christopher Vicere</u>	Paid Preparer	(Title) <u>Vice President - Finance</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
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Paid Preparer	(Title) <u>Vice President - Finance</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) _____ Fax # (____) _____																												

Facility Name & ID Number OakBrook Healthcare Centre# 0034694 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

III. STATISTICAL DATA

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

	1	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>128</u>	Skilled (SNF)	<u>128</u>	<u>46,848</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>28</u>	Intermediate (ICF)	<u>28</u>	<u>10,248</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>57,096</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>13,976</u>	<u>6,496</u>	<u>8,539</u>	<u>29,011</u>	8
9	SNF/PED					9
10	ICF	<u>14,273</u>	<u>8,225</u>	<u>17</u>	<u>22,515</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,249</u>	<u>14,721</u>	<u>8,556</u>	<u>51,526</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.24%D. How many bed-hold days during this year were paid by Public Aid?
None (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)
NoneF. Does the facility maintain a daily midnight census? YesG. 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 September 7, 1988J. Was the facility purchased or leased after January 1, 1978?
YES Date October 26, 1988 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number
of beds certified 128 and days of care provided 7,780Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/04 Fiscal Year: 12/31/04
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number OakBrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

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	329,084	22,489	11,460	363,033		363,033		363,033		1
2	Food Purchase		242,658		242,658	(10,991)	231,667	(660)	231,007		2
3	Housekeeping	358,256	70,670		428,926		428,926		428,926		3
4	Laundry	72,992	45,066	4,757	122,815		122,815		122,815		4
5	Heat and Other Utilities			182,333	182,333		182,333		182,333		5
6	Maintenance	90,648	21,524	74,003	186,175		186,175		186,175		6
7	Other (specify):*										7
8	TOTAL General Services	850,980	402,407	272,553	1,525,940	(10,991)	1,514,949	(660)	1,514,289		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,763,169	224,688	6,852	2,994,709		2,994,709		2,994,709		10
10a	Therapy										10a
11	Activities	153,776	24,811		178,587		178,587		178,587		11
12	Social Services	56,157		5,000	61,157		61,157		61,157		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,973,102	249,499	29,852	3,252,453		3,252,453		3,252,453		16
	C. General Administration										
17	Administrative	98,101		271,440	369,541		369,541	(193,927)	175,614		17
18	Directors Fees										18
19	Professional Services			36,041	36,041		36,041	5,401	41,442		19
20	Dues, Fees, Subscriptions & Promotions			56,578	56,578		56,578	(33,700)	22,878		20
21	Clerical & General Office Expenses	98,312	50,406	63,162	211,880		211,880	46,877	258,757		21
22	Employee Benefits & Payroll Taxes			625,268	625,268	10,991	636,259	43,578	679,837		22
23	Inservice Training & Education			1,540	1,540		1,540		1,540		23
24	Travel and Seminar			5,777	5,777		5,777	5,545	11,322		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,272	7,272		7,272	39,145	46,417		26
27	Other (specify):* *Payroll Taxes (Sch VII)**							10,718	10,718		27
28	TOTAL General Administration	196,413	50,406	1,067,078	1,313,897	10,991	1,324,888	(76,363)	1,248,525		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,020,495	702,312	1,369,483	6,092,290		6,092,290	(77,023)	6,015,267		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

OakBrook Healthcare Centre

#0034694

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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			83,608	83,608		83,608	283,892	367,500			30
31	Amortization of Pre-Op. & Org.							224,805	224,805			31
32	Interest			276,000	276,000		276,000	823,275	1,099,275			32
33	Real Estate Taxes			60,107	60,107		60,107		60,107			33
34	Rent-Facility & Grounds			1,802,486	1,802,486		1,802,486	(1,800,000)	2,486			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,222,201	2,222,201		2,222,201	(468,028)	1,754,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		324,097	484,272	808,369		808,369		808,369			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,644	85,644		85,644		85,644			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		324,097	569,916	894,013		894,013		894,013			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,020,495	1,026,409	4,161,600	9,208,504		9,208,504	(545,051)	8,663,453			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 OakBrook Healthcare Centre

0034694

Report Period Beginning: 1-Jan-04

Ending: 31-Dec-04

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	131,539	30		9
10	Interest and Other Investment Income	(8,963)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(660)	2		13
14	Non-Care Related Interest	4,057	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,897)	21		24
25	Fund Raising, Advertising and Promotional	(55,117)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(175)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 26,784		\$	30

OHF 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)	(571,835)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (571,835)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (545,051)		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

OakBrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-04

Ending: 31-Dec-04

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OakBrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(660)	0	0	0	0	0	0	0	0	0	0	(660)	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	(660)	0	0	0	0	0	0	0	0	0	0	(660)	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	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(193,927)	0	0	0	0	0	0	0	0	0	(193,927)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,401	0	0	0	0	0	0	0	0	0	5,401	19
20	Fees, Subscriptions & Promotions	(55,292)	21,592	0	0	0	0	0	0	0	0	0	(33,700)	20
21	Clerical & General Office Expenses	(43,897)	90,774	0	0	0	0	0	0	0	0	0	46,877	21
22	Employee Benefits & Payroll Taxes	0	43,578	0	0	0	0	0	0	0	0	0	43,578	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,545	0	0	0	0	0	0	0	0	0	5,545	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	39,145	0	0	0	0	0	0	0	0	39,145	26
27	Other (specify):*	0	10,718	0	0	0	0	0	0	0	0	0	10,718	27
28	TOTAL General Administration	(99,189)	(16,319)	39,145	0	(76,363)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(99,849)	(16,319)	39,145	0	(77,023)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **OakBrook Healthcare Centre**

0034694

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	131,539	605	151,748	0	0	0	0	0	0	0	0	283,892 30
31	Amortization of Pre-Op. & Org.	0	0	224,805	0	0	0	0	0	0	0	0	224,805 31
32	Interest	(4,906)	46,960	781,221	0	0	0	0	0	0	0	0	823,275 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	(1,800,000)	0	0	0	0	0	0	0	0	(1,800,000) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	126,633	47,565	(642,226)	0	(468,028) 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)	26,784	31,246	(603,081)	0	(545,051) 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

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 Rental	\$ 1,800,000	OakBrook Associates	100.00%	\$	\$ (1,800,000) 1
2	V	32 Interest	26,922	OakBrook Associates	100.00%	808,143	781,221 2
3	V	30 Depreciation		OakBrook Associates	100.00%	151,748	151,748 3
4	V	31 Amortization		OakBrook Associates	100.00%	224,805	224,805 4
5	V	26 Mortgage Insurance Premium		OakBrook Associates	100.00%	39,145	39,145 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 1,826,922			\$ 1,223,841	\$ * (603,081) 14

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

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

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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 56,123	\$ 56,123 1
2	V	27 Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	2,571	2,571 2
3	V	17 Management Fee Income	271,440	Lancaster, Ltd.	100.00%		(271,440) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	5,401	5,401 4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	90,774	90,774 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	43,578	43,578 6
7	V	24 Education and Seminars		Lancaster, Ltd.	100.00%	5,545	5,545 7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	21,390	21,390 8
9	V	20 Fees and Marketing		Lancaster, Ltd.	100.00%	21,592	21,592 9
10	V	32 Interest		Lancaster, Ltd.	100.00%	46,960	46,960 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	605	605 11
12	V	27 Payroll taxes-Clerical		Lancaster, Ltd.	100.00%	8,147	8,147 12
13	V						
14	Total		\$ 271,440			\$ 302,686	\$ * 31,246 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)
15	V	34 Rental	\$ 1,800,000	OakBrook Associates	100.00%	\$	\$ (1,800,000)
16	V	32 Interest	26,922	OakBrook Associates	100.00%	808,143	781,221
17	V	30 Depreciation		OakBrook Associates	100.00%	151,748	151,748
18	V	31 Amortization		OakBrook Associates	100.00%	224,805	224,805
19	V	26 Mortgage Insurance Premium		OakBrook Associates	100.00%	39,145	39,145
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,826,922			\$ 1,223,841	\$ * (603,081)

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

Facility Name & ID Number OakBrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

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	Laurence Zung	Executive Officer	Administrative	33.33	See Attached	5	10.42	Lancaster	\$ 23,302	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	See Attached	5	10.42	Lancaster	16,434	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	0.00	See Attached	5	10.42	Lancaster	16,387	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,123		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 OakBrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-04 Ending: 31-Dec-04

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lancaster, Ltd.
 Street Address 5061 N. Pulski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 478-3699
 Fax Number (773) 478-1192

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	17	Laurence Zung	Hours Worked	48	7	\$ 223,698	\$ 223,698	5	\$ 23,302	1
2	27	Laurence Zung	Hours Worked	48	7	8,867		5	924	2
3	17	Christopher Vicere	Hours Worked	48	7	157,762	157,762	5	16,434	3
4	27	Christopher Vicere	Hours Worked	48	7	7,911		5	824	4
5	17	Cheryl Morris	Hours Worked	48	7	157,315	157,315	5	16,387	5
6	27	Cheryl Morris	Hours Worked	48	7	7,905		5	823	6
7										7
8										8
9	19	Professional Services	Management Fees	2,360,020	7	46,963		271,440	5,401	9
10	21	Clerical Expenses	Management Fees	2,360,020	7	62,820		271,440	7,225	10
11	22	Employee Benefits	Management Fees	2,360,020	7	378,883		271,440	43,578	11
12	24	Education and Seminars	Management Fees	2,360,020	7	8,842		271,440	1,017	12
13	17	Administrative Consultant	Management Fees	2,360,020	7	185,978	185,978	271,440	21,390	13
14	20	Marketing	Management Fees	2,360,020	7	171,696	155,227	271,440	19,748	14
15	32	Interest	Management Fees	2,360,020	7	131,563		271,440	15,132	15
16	30	Depreciation	Management Fees	2,360,020	7	5,260		271,440	605	16
17	20	Licenses and Fees	Management Fees	2,360,020	7	16,029		271,440	1,844	17
18	24	Travel	Management Fees	2,360,020	7	39,372		271,440	4,528	18
19	21	Salaries-Clerical	Management Fees	2,360,020	7	726,412	726,412	271,440	83,549	19
20	27	Payroll Taxes-Clerical	Management Fees	2,360,020	7	70,836		271,440	8,147	20
21										21
22										22
23	32	Direct Interest							31,828	23
24										24
25	TOTALS					\$ 2,408,112	\$ 1,606,392		\$ 302,686	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	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			
A. Directly Facility Related																		
Long-Term																		
1	Cambridge Reality Capital		X	Mortgage	\$49,956.72	11/1/98	\$ 8,152,700		11/30/34		\$ 808,143	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Harston Investments		X	Working Capital							276,000	6						
7	BankOne		X	Working Capital							15,132	7						
8												8						
TOTAL Facility Related																		
9					\$49,956.72		\$ 8,152,700	\$			\$ 1,099,275	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
TOTAL Non-Facility Related																		
14							\$	\$			\$	14						
TOTALS (line 9+line14)																		
15							\$ 8,152,700	\$			\$ 1,099,275	15						

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 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 Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OakBrook Healthcare Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0034694

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(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>06-22-303-035</u>	<u>Long-Term Healthcare</u>	\$ <u>61,107.00</u>	\$ <u>61,107.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>61,107.00</u>	\$ <u>61,107.00</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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number OakBrook Healthcare Centre# 0034694 Report Period Beginning:1-Jan-04 Ending:31-Dec-04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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: \$ 234,464 / \$ 17,275 2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 224,805 4. Dates Incurred: 26-Oct-98 / Jan-2004

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 Care Facility</u>		<u>1998</u>	<u>\$ 830,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 830,000	3

Facility Name & ID Number OakBrook Healthcare Centre# 0034694

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04**XL 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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	154			\$ 3,586,000	\$ 91,949	40	\$ 179,300	\$ 87,351	\$ 776,200	4
5	144	1992	1994	1,863,459	59,157	35	53,242	(5,915)	672,920	5
6	10	1994		25,000	641	35	714	73	7,429	6
7										7
8										8
Improvement Type**										
9	Various	1988		8,828	285	20	179	(106)	7,963	9
10	Various	1989		92,298	3,425	20	4,684	1,259	72,058	10
11	Various	1990		24,448	595	20	1,164	569	16,060	11
12	Various	1991		2,212	70	15	111	41	1,217	12
13	Various	1992		1,275,149	40,483	20	65,479	24,996	729,672	13
14	Various	1993		287,139	6,201	15	12,111	5,910	153,222	14
15	Various	1994		12,341	317	15	618	301	4,997	15
16	Various	1995		52,918	473	15	923	450	15,109	16
17	Room #112 remodeling	1996		2,285	59	15	114	55	971	17
18	Nurses' call station	1996		10,545	270	15	527	257	4,135	18
19	Ceramic tiled bathroom and tub room	1996		15,362	394	20	768	374	6,090	19
20	Rehab room	1997		31,848	817	15	1,592	775	11,828	20
21	Fire doors	1997		3,013	77	15	151	74	1,121	21
22	Physical Therapy room	1997		6,749	173	15	337	164	2,504	22
23	12 bathrooms vented	1997		8,670	222	15	434	212	3,115	23
24	Roof improvements	1997		7,150	183	15	358	175	2,510	24
25	Excelon vinyl tiles-1st floor	1997		15,600	400	15	780	380	5,275	25
26	Excelon vinyl tiles-1st floor	1998		6,204	159	15	310	151	2,019	26
27	New roof	1998		3,850	99	15	193	94	913	27
28	Custom cabinets	1998		3,285	84	15	164	80	776	28
29	Fire alarm switch	1998		6,996	179	15	350	171	1,609	29
30	3 shower rooms rehab	1999		15,560	399	15	778	379	3,448	30
31	Hot water heater	1999		7,269	186	15	363	177	1,531	31
32	Parking lot asphalt	1999		28,900	741	15	1,445	704	6,218	32
33	Rehab resident rooms	1999		17,825	457	15	891	434	3,758	33
34	Aquarium	2001		4,441	114	15	114		423	34
35	Picture window	2001		14,403	369	15	369		1,338	35
36	Wander guard system	2001		17,385	2,172	15	2,172		11,955	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OakBrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-04

Ending:

31-Dec-04

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Carpet-bookkeeping & lounge	2001	\$ 2,715	\$ 70	15	\$ 70	\$	\$ 254	37
38	Vinyl tiles hallway	2001	9,815	252	15	252		809	38
39	Auto door	2002	2,340	60	15	117	57	312	39
40	Concrete patio	2003	10,250	727	15	683	(44)	854	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,482,252	\$ 212,259		\$ 331,857	\$ 119,598	\$ 2,530,613	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	\$ 328,708	\$ 16,578	\$ 34,303	\$ 17,725	10	\$ 195,212	71
72	Current Year Purchases	10,802	6,481	1,340	(5,141)	10	1,340	72
73	Fully Depreciated Assets	577,455	643		(643)	10	577,455	73
74								74
75	TOTALS	\$ 916,965	\$ 23,702	\$ 35,643	\$ 11,941		\$ 774,007	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,229,217	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,961	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 367,500	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 131,539	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,304,620	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: ***N/A - Related Party 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:				\$			3
4	Additions							4
5		<u>**Off-site Public Storage Space**</u>			<u>2,486</u>			5
6								6
7	TOTAL				\$ <u>2,486</u>			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION: _____</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 AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
1	Licensed Occupational Therapist	39-3	hrs	\$			\$	211,209	\$			\$	211,209		1	
2	Licensed Speech and Language Development Therapist	39-3	hrs					9,380					9,380		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39-3	hrs					225,271					225,271		4	
5	Physician Care		visits												5	
6	Dental Care		visits												6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy	39-2	# of prescripts							272,701			272,701		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Exceptional Care Program														12	
13	Inhalation Therapy	39-3						38,412					38,412			
	Other (specify): Med Sup/Bed Rental	39-2								51,396			51,396		13	
14	TOTAL			\$			\$	484,272	\$	324,097		\$	808,369		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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OakBrook Healthcare Centre

0034694

Report Period Beginning: 1-Jan-04

Ending:

31-Dec-04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-04

(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	\$ (65,776)	\$ 1,444,824	1
2 Cash-Patient Deposits	27,870	27,870	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,421,911	1,421,911	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	34,099	34,099	6
7 Other Prepaid Expenses	23,311	358,761	7
8 Accounts Receivable (owners or related parties)	217,011	217,011	8
9 Other(specify): <u>Employee Advances</u>	4,275	4,275	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,662,701	\$ 3,508,751	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		830,000	13
14 Buildings, at Historical Cost		3,586,000	14
15 Leasehold Improvements, at Historical Cost	1,959,555	3,848,014	15
16 Equipment, at Historical Cost	776,122	896,777	16
17 Accumulated Depreciation (book methods)	(1,473,758)	(2,934,955)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		276,197	19
20 Accumulated Amortization - Organization & Pre-Operating Costs		(259,416)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): <u>Construction In Progress</u>		182,737	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,261,919	\$ 6,425,354	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,924,620	\$ 9,934,105	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 311,395	\$ 311,396	26
27 Officer's Accounts Payable		125,965	27
28 Accounts Payable-Patient Deposits	33,454	33,454	28
29 Short-Term Notes Payable		90,898	29
30 Accrued Salaries Payable	355,730	355,730	30
31 Accrued Taxes Payable (excluding real estate taxes)	14,512	14,512	31
32 Accrued Real Estate Taxes(Sch.IX-B)	62,500	62,500	32
33 Accrued Interest Payable		34,005	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 777,591	\$ 1,028,460	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	2,400,000	2,400,000	39
40 Mortgage Payable		7,989,475	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)	\$ 2,400,000	\$ 10,389,475	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,177,591	\$ 11,417,935	46
47 TOTAL EQUITY(page 18, line 24)	\$ (252,971)	\$ (1,483,830)	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,924,620	\$ 9,934,105	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (248,659)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (248,659)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	295,688	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	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (4,312)	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)	\$ (252,971)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,238,469)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,238,469)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	898,769	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	155,870	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (245,361)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,483,830)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number OakBrook Healthcare Centre

0034694

Report Period Beginning: 1-Jan-04

Ending: 31-Dec-04

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	\$ 9,760,672	1
2	Discounts and Allowances for all Levels	(2,018,288)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,742,384	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,321,812	6
7	Oxygen	26,593	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,348,405	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	9,292	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	272,725	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,024	19
20	Radiology and X-Ray	31,290	20
21	Other Medical Services	61,709	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 402,040	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,963	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,963	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	2,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,504,192	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,525,940	31
32	Health Care	3,252,453	32
33	General Administration	1,313,897	33
B. Capital Expense			
34	Ownership	2,222,201	34
C. Ancillary Expense			
35	Special Cost Centers	808,369	35
36	Provider Participation Fee	85,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,208,504	40
41	Income before Income Taxes (line 30 minus line 40)**	295,688	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 295,688	43

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

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

*** 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 **OakBrook Healthcare Centre**# **0034694**Report Period Beginning: **1-Jan-04**Ending: **31-Dec-04**

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	2,057	2,411	\$ 96,497	\$ 40.02	1
2	Assistant Director of Nursing	2,049	2,419	70,107	28.98	2
3	Registered Nurses	42,909	45,349	1,251,786	27.60	3
4	Licensed Practical Nurses	5,513	6,156	136,441	22.16	4
5	Nurse Aides & Orderlies	105,345	113,081	1,174,984	10.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,964	2,091	35,710	17.08	9
10	Activity Assistants	11,363	12,130	118,066	9.73	10
11	Social Service Workers	1,942	2,267	56,157	24.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,119	32,605	329,084	10.09	15
16	Dishwashers					16
17	Maintenance Workers	5,805	6,554	90,648	13.83	17
18	Housekeepers	34,481	38,079	358,256	9.41	18
19	Laundry	7,545	8,089	72,992	9.02	19
20	Administrator	2,049	2,299	98,101	42.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,274	7,929	98,312	12.40	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	2,033	2,107	33,354	15.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	262,448	283,566	\$ 4,020,495 *	\$ 14.18	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	287	\$ 11,460	1-3	35
36	Medical Director	450	18,000	9-3	36
37	Medical Records Consultant	105	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	132	5,000	12-3	45
46	Other(specify) <u>Dementia Consult</u>	78	2,724	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,052	\$ 41,312		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,383 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 85,644
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,991 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.