

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0034694

Facility Name: Oakbrook Healthcare Centre

Address: 2013 Midwest Road Oakbrook 60523
 Number City Zip Code

County: DuPage

Telephone Number: (630) 495-0220 **Fax #** (630) 495-9150

HFS ID Number: 36-3601135-001

Date of Initial License for Current Owners: 09/07/88

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2006 to 31-Dec-2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ 29th March 2007
 (Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid Preparer

(Signed) _____
 (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () _____ Fax # () _____

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

Facility Name & ID Number Oakbrook Healthcare Centre

0034694 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

III. STATISTICAL DATA

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

	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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,401	8,309	10,210	30,920	8
9	SNF/PED					9
10	ICF	15,183	6,501	28	21,712	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,584	14,810	10,238	52,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.43%

D. How many bed-hold days during this year were paid by the Department?

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)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started September 7, 1988

J. 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 8,200

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	359,332	54,142	14,757	428,231		428,231		428,231			1
2	Food Purchase		267,911		267,911	(13,596)	254,315	(702)	253,613			2
3	Housekeeping	436,467	81,165		517,632		517,632		517,632			3
4	Laundry	64,532	38,897	1,925	105,354		105,354		105,354			4
5	Heat and Other Utilities			173,830	173,830		173,830		173,830			5
6	Maintenance	88,029	35,417	102,420	225,866		225,866		225,866			6
7	Other (specify):*											7
8	TOTAL General Services	948,360	477,532	292,932	1,718,824	(13,596)	1,705,228	(702)	1,704,526			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	3,084,725	324,055	5,436	3,414,216		3,414,216		3,414,216			10
10a	Therapy			3,299	3,299		3,299		3,299			10a
11	Activities	205,394	28,976		234,370		234,370		234,370			11
12	Social Services	57,258		4,700	61,958		61,958		61,958			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,347,377	353,031	32,935	3,733,343		3,733,343		3,733,343			16
	C. General Administration											
17	Administrative	101,303		248,976	350,279		350,279	(151,915)	198,364			17
18	Directors Fees											18
19	Professional Services			59,043	59,043		59,043	18,900	77,943			19
20	Dues, Fees, Subscriptions & Promotions			35,838	35,838		35,838	(14,948)	20,890			20
21	Clerical & General Office Expenses	143,160	59,200	43,754	246,114		246,114	38,231	284,345			21
22	Employee Benefits & Payroll Taxes			712,079	712,079	13,596	725,675	8,588	734,263			22
23	Inservice Training & Education			2,941	2,941		2,941	1,978	4,919			23
24	Travel and Seminar			4,226	4,226		4,226	3,200	7,426			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			462,473	462,473		462,473	39,610	502,083			26
27	Other (specify):* *Payroll Taxes (Sch VII)							17,173	17,173			27
28	TOTAL General Administration	244,463	59,200	1,569,330	1,872,993	13,596	1,886,589	(39,183)	1,847,406			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,540,200	889,763	1,895,197	7,325,160		7,325,160	(39,885)	7,285,275			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-2006 Ending: 31-Dec-2006

31-Dec-2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			75,381	75,381		75,381	304,490	379,871			30
31	Amortization of Pre-Op. & Org.							494	494			31
32	Interest			288,000	288,000		288,000	397,899	685,899			32
33	Real Estate Taxes			71,051	71,051		71,051		71,051			33
34	Rent-Facility & Grounds			1,803,063	1,803,063		1,803,063	(1,800,000)	3,063			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,237,495	2,237,495		2,237,495	(1,097,117)	1,140,378			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		253,254	779,733	1,032,987		1,032,987		1,032,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		253,254	865,143	1,118,397		1,118,397		1,118,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,540,200	1,143,017	4,997,835	10,681,052		10,681,052	(1,137,002)	9,544,050			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-2006

Ending:

31-Dec-2006

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	114,207	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(702)	2		13
14	Non-Care Related Interest	(66,347)	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	(991)	24		19
20	Contributions	(1,300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,239)	21		24
25	Fund Raising, Advertising and Promotional	(39,682)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,877)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(301)	20		28
29	Other-Attach Schedule ** Page 5A attached **		6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,232)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,120,770)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,120,770)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,137,002)		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

BHF USE ONLY

48		49		50		51		52	
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Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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-2006

Ending:

31-Dec-2006

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	(702)	0	0	0	0	0	0	0	0	0	0	(702)	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	(702)	0	0	0	0	0	0	0	0	0	0	(702)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(151,915)	0	0	0	0	0	0	0	0	0	(151,915)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,810	6,090	0	0	0	0	0	0	0	0	18,900	19
20	Fees, Subscriptions & Promotions	(41,283)	26,335	0	0	0	0	0	0	0	0	0	(14,948)	20
21	Clerical & General Office Expenses	(21,116)	54,470	4,877	0	0	0	0	0	0	0	0	38,231	21
22	Employee Benefits & Payroll Taxes	0	8,588	0	0	0	0	0	0	0	0	0	8,588	22
23	Inservice Training & Education	0	1,978	0	0	0	0	0	0	0	0	0	1,978	23
24	Travel and Seminar	(991)	4,191	0	0	0	0	0	0	0	0	0	3,200	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	39,610	0	0	0	0	0	0	0	0	39,610	26
27	Other (specify):*	0	17,173	0	0	0	0	0	0	0	0	0	17,173	27
28	TOTAL General Administration	(63,390)	(26,370)	50,577	0	(39,183)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,092)	(26,370)	50,577	0	(39,885)	29							

STATE OF ILLINOIS

Facility Name & ID Number Oakbrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-2006 Ending:

Summary B

31-Dec-2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	114,207	607	189,676	0	0	0	0	0	0	0	0	304,490	30
31	Amortization of Pre-Op. & Org.	0	0	494	0	0	0	0	0	0	0	0	494	31
32	Interest	(66,347)	117,038	347,208	0	0	0	0	0	0	0	0	397,899	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	47,860	117,645	(1,262,622)	0	(1,097,117)	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)	(16,232)	91,275	(1,212,045)	0	(1,137,002)	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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 36,999	\$ 36,999	1
2	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	17,173	17,173	2
3	V	17 Management Fee Income	248,976	Lancaster, Ltd.	100.00%		(248,976)	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	12,810	12,810	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	54,470	54,470	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	8,588	8,588	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	4,191	4,191	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	60,062	60,062	8
9	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	25,777	25,777	9
10	V	32 Interest		Lancaster, Ltd.	100.00%	117,038	117,038	10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	607	607	11
12	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	558	558	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	1,978	1,978	13
14	Total		\$ 248,976			\$ 340,251	\$ * 91,275	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)	15
16	V	32 Interest	53,666	OakBrook Associates	100.00%	400,874	347,208	16
17	V	30 Depreciation		OakBrook Associates	100.00%	189,676	189,676	17
18	V	31 Amortization		OakBrook Associates	100.00%	494	494	18
19	V	26 Mortgage Insurance Premium		OakBrook Associates	100.00%	39,610	39,610	19
20	V	19 Accounting Fees		OakBrook Associates	100.00%	5,985	5,985	20
21	V	21 State Replacement Tax		OakBrook Associates	100.00%	4,877	4,877	21
22	V	19 Legal Fees		OakBrook Associates	100.00%	105	105	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,853,666			\$ 641,621	\$ * (1,212,045)	39

* 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-2006 Ending: 31-Dec-2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 18,521	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	18,478	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,999		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-2006

Ending: -Dec-2006

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. Pulaski Road,
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 478-1192

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	5	\$ 18,521	1
2	17	Christopher Vicere-payroll tax	Hours Worked	48	7	9,454		5	985	2
3	17	Cheryl Morris	Hours Worked	48	7	177,385	177,385	5	18,478	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,436		5	983	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		248,976	12,810	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	248,976	54,470	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		248,976	8,588	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		248,976	4,191	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	248,976	60,062	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	248,976	25,777	18
19	32	Interest	Management Fees	2,146,620	7	8,729		248,976	1,012	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		248,976	607	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		248,976	558	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		248,976	15,205	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		248,976	1,978	23
24	32	*Direct Interest*							116,026	24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 340,251	25

Facility Name & ID Number

Oakbrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
	A. Directly Facility Related																	
	Long-Term																	
1	Cambridge Reality Capital		X	Mortgage	\$48,866.91	11/1/98	\$ 8,152,700	\$	11/30/34		\$ 400,874	1						
2												2						
3	HUD		X	Replacement Reserve Deposit							(3,987)	3						
4												4						
5												5						
	Working Capital																	
6	Harstons Investments		X	Working Capital							288,000	6						
7	JP Morgan Chase Bank		X	Working Capital							1,012	7						
8												8						
9	TOTAL Facility Related				\$48,866.91		\$ 8,152,700	\$			\$ 685,899	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 8,152,700	\$			\$ 685,899	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,610 Line # 26* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	68,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	68,051	2
3. Under or (over) accrual (line 2 minus line 1).		\$	51	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	71,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	71,051	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	60,491	8	
	2002	62,409	9	
	2003	61,107	10	
	2004	65,096	11	
	2005	68,051	12	
Accrual for 2006 Report is based on 2005 Taxes adjusted for inflation				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Brook Healthcare Centre, Inc COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 34694

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 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-22-303-035</u>	<u>Long-Term Healthcare</u>	\$ <u>68,050.72</u>	\$ <u>68,050.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>68,050.72</u>	\$ <u>68,050.72</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: \$234464 / \$17275 2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 494 4. Dates Incurred: 26-Oct-98 / Jan 2006

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>1988</u>	<u>\$ 830,000</u>	1
2					2
3	TOTALS			\$ 830,000	3

Facility Name & ID Number Oakbrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156			1992	\$ 1,863,459	\$ 59,157	40	\$ 53,242	\$ (5,915)	\$ 779,404	4
5				1994	25,000	641	35	714	73	8,857	5
6				1998	3,586,000	91,949	35	179,300	87,351	1,134,800	6
7											7
8											8
		Improvement Type**									
9	Various			1988	8,142		20			8,142	9
10	Various			1989	92,298	3,425	20	4,689	1,264	81,431	10
11	Various			1990	24,448	595	20	1,166	571	18,392	11
12	Various			1991	2,212	70	15	110	40	1,439	12
13	Various			1992	1,275,149	40,483	20	63,756	23,273	858,907	13
14	Various			1993	233,429	6,201	15	11,021	4,820	176,354	14
15	Various			1994	12,341	317	15	1,708	1,391	7,323	15
16	Various			1995	43,953	473	15	2,646	2,173	18,678	16
17	Room#112 Remodeling			1996	2,285	58	15	114	56	1,199	17
18	Nurses' Call Station			1996	10,545	270	15	527	257	5,189	18
19	Ceramic Tiled Bathroom and Tub Room			1996	15,362	394	20	768	374	7,626	19
20	Rehab Room			1997	31,848	817	15	1,592	775	15,012	20
21	Fire Doors			1997	3,013	77	15	150	73	1,423	21
22	Physical Therapy Room			1997	6,749	173	15	337	164	3,178	22
23	12 Bathrooms Vented			1997	8,670	222	15	434	212	3,983	23
24	Roof Improvement			1997	7,150	183	15	358	175	3,226	24
25	Excelon Vinyl Tiles-1st Floor			1997	15,600	400	15	780	380	6,835	25
26	Excelon Vinyl Tiles-1st Floor			1988	6,204	159	15	310	151	2,639	26
27	New Roof			1998	3,850	99	15	193	94	1,299	27
28	Custom Cabinets			1998	3,285	84	15	164	80	1,104	28
29	Fire Alarm Switch			1998	6,996	179	15	350	171	2,309	29
30	3 Shower Rooms Rehab			1999	15,560	399	15	778	379	5,004	30
31	Hot Water Heater			1999	7,269	186	15	363	177	2,257	31
32	Parking Lot Asphalt			1999	28,900	741	15	1,445	704	9,108	32
33	Rehab Resident Rooms			1999	17,825	457	15	891	434	5,540	33
34	Aquarium			2001	4,441	114	15	114		651	34
35	Picture Window			2001	14,403	369	15	369		2,076	35
36											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

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	Wander Guard System	2001	\$ 17,385	\$ 1,552	15	\$ 1,552	\$	\$ 15,059	37
38	Carpet-Bookkeeping & Lounge	2001	2,715	70	15	70		394	38
39	Vinyl Tiles Hallway	2001	9,815	252	15	252		1,313	39
40	Auto Door	2002	2,340	60	15	117	57	546	40
41	Concrete Patio	2003	10,250	395	15	683	288	2,220	41
42	Three Concrete Pads W/Rails	2005	12,073	310	15	1,207	897	1,710	42
43	Construction of Town Square	2005	108,391	2,779	15	2,779		4,748	43
44	Fittings & Fixtures for Town Square	2005	83,613	20,477	15	8,361	(12,116)	14,632	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)		\$ 7,622,968	\$ 234,587		\$ 343,410	\$ 108,823	\$ 3,214,007	70

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	\$ 327,631	\$ 14,960	\$ 31,276	\$ 16,316	7	\$ 183,999	71
72	Current Year Purchases	27,781	6,569	3,566	(3,003)	7	3,566	72
73	Fully Depreciated Assets	653,998	8,941	1,012	(7,929)	7	653,998	73
74	** Lancaster Allocation**		607	607		7	5,091	74
75	TOTALS	\$ 1,009,410	\$ 31,077	\$ 36,461	\$ 5,384		\$ 846,654	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)	\$ 9,462,378	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 265,664	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 379,871	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 114,207	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,060,661	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oakbrook Healthcare Centre

0034694

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

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>3,063</u>			5
6								6
7	TOTAL				\$ <u>3,063</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 _____.

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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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 CNA _____</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 CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 307,849	\$		\$ 307,849	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			78,823			78,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			335,101			335,101	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			57,960			57,960	8
9	Pharmacy	39-2	# of prescripts				178,715		178,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **Medical Supplies** **Bed Rental**	39-2 39-2					16,036 58,503		16,036 58,503	13
14	TOTAL			\$		\$ 779,733	\$ 253,254		\$ 1,032,987	14

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

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694Report Period Beginning: 1-Jan-2006

Ending:

31-Dec-2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (117,767)	\$ 1,303,158	1
2	Cash-Patient Deposits	28,814	28,814	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,014,673	2,014,673	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,977	53,977	6
7	Other Prepaid Expenses	47,817	516,447	7
8	Accounts Receivable (owners or related parties)	994,869	994,869	8
9	Other(specify): **Employee Advances**	7,229	7,229	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,029,612	\$ 4,919,167	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	1,971,627	4,052,090	15
16	Equipment, at Historical Cost	813,722	994,288	16
17	Accumulated Depreciation (book methods)	(1,622,098)	(3,447,200)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(260,404)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): **Construction in Progress**		49,207	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,163,251	\$ 6,080,178	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,192,863	\$ 10,999,345	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 598,025	\$ 598,025	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	90,716	90,716	28
29	Short-Term Notes Payable		100,537	29
30	Accrued Salaries Payable	504,056	504,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,832	18,832	31
32	Accrued Real Estate Taxes(Sch.IX-B)	71,000	71,000	32
33	Accrued Interest Payable		33,220	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,282,629	\$ 1,416,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,793,342	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,400,000	\$ 10,193,342	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,682,629	\$ 11,609,728	46
47	TOTAL EQUITY (page 18, line 24)	\$ 510,234	\$ (610,383)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,192,863	\$ 10,999,345	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 378,765	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 378,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	131,469	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 131,469	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)	\$ 510,234	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (953,897)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (953,897)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,343,514	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	(1,000,000)	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)	\$ 343,514	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)	\$ (610,383)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694Report Period Beginning: 1-Jan-2006Ending: 31-Dec-2006**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	\$ 10,582,328	1
2	Discounts and Allowances for all Levels	(2,111,495)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,470,833	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,879,641	6
7	Oxygen	27,011	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,906,652	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	282,072	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,416	19
20	Radiology and X-Ray	15,664	20
21	Other Medical Services	58,137	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 366,289	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	66,347	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 66,347	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Commissions</u>	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)	\$ 10,812,521	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,718,824	31
32	Health Care	3,733,343	32
33	General Administration	1,872,993	33
B. Capital Expense			
34	Ownership	2,237,495	34
C. Ancillary Expense			
35	Special Cost Centers	1,032,987	35
36	Provider Participation Fee	85,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,681,052	40
41	Income before Income Taxes (line 30 minus line 40)**	131,469	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 131,469	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.

*Adjusted on Pg 5**

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

Facility Name & ID Number Oakbrook Healthcare Centre

0034694

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,045	2,262	\$ 93,689	\$ 41.42	1
2	Assistant Director of Nursing	2,045	2,274	67,261	29.58	2
3	Registered Nurses	57,579	62,244	1,410,584	22.66	3
4	Licensed Practical Nurses	6,413	6,978	156,508	22.43	4
5	CNAs & Orderlies	101,889	110,005	1,319,286	11.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,981	2,094	39,151	18.70	9
10	Activity Assistants	15,536	16,519	166,243	10.06	10
11	Social Service Workers	2,005	2,182	57,258	26.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,732	32,487	359,332	11.06	15
16	Dishwashers					16
17	Maintenance Workers	5,895	6,273	88,029	14.03	17
18	Housekeepers	37,861	42,086	436,467	10.37	18
19	Laundry	5,896	6,417	64,532	10.06	19
20	Administrator	1,933	2,213	101,303	45.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,309	12,330	143,160	11.61	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	1,822	2,185	37,397	17.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,941	308,549	\$ 4,540,200 *	\$ 14.71	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	369	\$ 14,757	1-3	35
36	Medical Director	488	19,500	9-3	36
37	Medical Records Consultant	107	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	38	1,259	10a-3	40
41	Occupational Therapy Consultant	20	543	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	46	1,497	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	124	4,700	12-3	45
46	Other(specify)				46
47	**Dementia Consultant**	35	1,212	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,227	\$ 47,692		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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

