



Facility Name & ID Number Oakbrook Healthcare Centre# 0034694 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-2008

## 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	<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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,600</u>	<u>2,909</u>	<u>9,573</u>	<u>18,082</u>	8
9	SNF/PED					9
10	ICF	<u>14,363</u>	<u>18,281</u>	<u>30</u>	<u>32,674</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,963</u>	<u>21,190</u>	<u>9,603</u>	<u>50,756</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 88.90%

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)

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, 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 9,192Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 31st Dec 2008 Fiscal Year: 31st Dec 2008

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	426,060	38,271	12,606	476,937		476,937		476,937			1
2	Food Purchase		302,347		302,347	(16,104)	286,243	(1,185)	285,058			2
3	Housekeeping	421,846	96,189		518,035		518,035		518,035			3
4	Laundry	124,479	38,889	7,799	171,167		171,167		171,167			4
5	Heat and Other Utilities			222,274	222,274		222,274		222,274			5
6	Maintenance	70,543	48,550	193,480	312,573		312,573	2,351	314,924			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>1,042,928</b>	<b>524,246</b>	<b>436,159</b>	<b>2,003,333</b>	<b>(16,104)</b>	<b>1,987,229</b>	<b>1,166</b>	<b>1,988,395</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			18,985	18,985		18,985		18,985			9
10	Nursing and Medical Records	3,206,785	350,358	93,392	3,650,535		3,650,535		3,650,535			10
10a	Therapy			5,162	5,162		5,162		5,162			10a
11	Activities	248,926	41,598		290,524		290,524		290,524			11
12	Social Services	56,399		5,542	61,941		61,941		61,941			12
13	CNA Training		124	900	1,024		1,024		1,024			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>3,512,110</b>	<b>392,080</b>	<b>123,981</b>	<b>4,028,171</b>		<b>4,028,171</b>		<b>4,028,171</b>			16
	<b>C. General Administration</b>											
17	Administrative	110,213		196,560	306,773		306,773	(94,144)	212,629			17
18	Directors Fees											18
19	Professional Services			28,999	28,999		28,999	13,441	42,440			19
20	Dues, Fees, Subscriptions & Promotions			20,762	20,762		20,762	(6,734)	14,028			20
21	Clerical & General Office Expenses	131,238	48,028	79,919	259,185		259,185	44,191	303,376			21
22	Employee Benefits & Payroll Taxes			636,255	636,255	16,104	652,359	13,723	666,082			22
23	Inservice Training & Education			801	801		801	187	988			23
24	Travel and Seminar			6,468	6,468		6,468	374	6,842			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,368	36,368		36,368	38,594	74,962			26
27	Other (specify):*							16,501	16,501			27
28	<b>TOTAL General Administration</b>	<b>241,451</b>	<b>48,028</b>	<b>1,006,132</b>	<b>1,295,611</b>	<b>16,104</b>	<b>1,311,715</b>	<b>26,133</b>	<b>1,337,848</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,796,489</b>	<b>964,354</b>	<b>1,566,272</b>	<b>7,327,115</b>		<b>7,327,115</b>	<b>27,299</b>	<b>7,354,414</b>			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-2008 Ending:

31-Dec-2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			90,894	90,894		90,894	373,370	464,264			30
31	Amortization of Pre-Op. & Org.							494	494			31
32	Interest			288,000	288,000		288,000	409,722	697,722			32
33	Real Estate Taxes			80,048	80,048		80,048		80,048			33
34	Rent-Facility & Grounds			1,803,182	1,803,182		1,803,182	(1,800,000)	3,182			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,262,124	2,262,124		2,262,124	(1,016,414)	1,245,710			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		423,902	987,964	1,411,866		1,411,866		1,411,866			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	<b>TOTAL Special Cost Centers</b>		423,902	1,073,608	1,497,510		1,497,510		1,497,510			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,796,489	1,388,256	4,902,004	11,086,749		11,086,749	(989,115)	10,097,634			45

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	107,746	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	(1,185)	2		13
14	Non-Care Related Interest	(64,073)	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	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,302)	21		24
25	Fund Raising, Advertising and Promotional	(46,077)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(931)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(381)	20		28
29	Other-Attach Schedule Deferred Maintenance Cost	(1,667)	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (39,020)		\$	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)	(950,095)	Pg 6 &6A	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (950,095)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (989,115)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	51
					52

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Actual expenses in 2008	\$ (2,000)	6	1
2	Allocated expenses for 2008	333	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,667)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,185)	0	0	0	0	0	0	0	0	0	0	(1,185)	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	(1,667)	4,018	0	0	0	0	0	0	0	0	0	2,351	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,852)</b>	<b>4,018</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,166</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(94,144)	0	0	0	0	0	0	0	0	0	(94,144)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,043	8,398	0	0	0	0	0	0	0	0	13,441	19
20	Fees, Subscriptions & Promotions	(46,458)	39,724	0	0	0	0	0	0	0	0	0	(6,734)	20
21	Clerical & General Office Expenses	(33,383)	76,643	931	0	0	0	0	0	0	0	0	44,191	21
22	Employee Benefits & Payroll Taxes	0	13,723	0	0	0	0	0	0	0	0	0	13,723	22
23	Inservice Training & Education	0	187	0	0	0	0	0	0	0	0	0	187	23
24	Travel and Seminar	0	374	0	0	0	0	0	0	0	0	0	374	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	38,594	0	0	0	0	0	0	0	0	38,594	26
27	Other (specify):*	0	16,501	0	0	0	0	0	0	0	0	0	16,501	27
28	<b>TOTAL General Administration</b>	<b>(79,841)</b>	<b>58,051</b>	<b>47,923</b>	<b>0</b>	<b>26,133</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(82,693)</b>	<b>62,069</b>	<b>47,923</b>	<b>0</b>	<b>27,299</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2008 Ending:

Summary B

31-Dec-2008

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	107,746	7,342	258,282	0	0	0	0	0	0	0	0	373,370	30
31	Amortization of Pre-Op. & Org.	0	0	494	0	0	0	0	0	0	0	0	494	31
32	Interest	(64,073)	74,602	399,193	0	0	0	0	0	0	0	0	409,722	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	<b>TOTAL Ownership</b>	<b>43,673</b>	<b>81,944</b>	<b>(1,142,031)</b>	<b>0</b>	<b>(1,016,414)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(39,020)</b>	<b>144,013</b>	<b>(1,094,108)</b>	<b>0</b>	<b>(989,115)</b>	<b>45</b>							

**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 Management Fee Income	\$ 196,560	Lancaster, Ltd.	100.00%	\$	\$ (196,560)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	35,872	35,872	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	16,501	16,501	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	5,043	5,043	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	76,643	76,643	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	13,723	13,723	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	374	374	7
8	V	6 Repairs and Maintenance		Lancaster, Ltd.	100.00%	4,018	4,018	8
9	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	66,544	66,544	9
10	V	32 Interest including Direct Interest		Lancaster, Ltd.	100.00%	74,602	74,602	10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	7,342	7,342	11
12	V	20 Dues, Fees and Sub/Marketing Fees		Lancaster, Ltd.	100.00%	39,724	39,724	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	187	187	13
14	Total		\$ 196,560			\$ 340,573	\$ * 144,013	14

\* 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-2008 Ending: 31-Dec-2008

## 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		\$	(1,800,000)	15
16	V	32	Interest Income	24,298	OakBrook Associates		423,491	399,193	16
17	V	30	Depreciation		OakBrook Associates		258,282	258,282	17
18	V	31	Amortization		OakBrook Associates		494	494	18
19	V	19	Accounting Fees		OakBrook Associates		7,695	7,695	19
20	V	26	Mortgage Insurance Premium		OakBrook Associates		38,594	38,594	20
21	V	21	State Replacement Tax		OakBrook Associates		931	931	21
22	V	19	Legal Fees		OakBrook Associates		703	703	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			\$ 1,824,298			\$ 730,190	\$ * (1,094,108)	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-2008 Ending: 31-Dec-2008

## 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	\$ 17,936	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See Attached	5	10.42	Lancaster	17,936	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	\$ 35,872		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-2008

Ending: -Dec-2008

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	\$ 172,189	\$ 172,189	5	\$ 17,936	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		5	970	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	5	17,936	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		5	970	4
5										5
6										6
7										7
8										8
9										9
10	19	Professional Services	Management Fees	1,694,700	7	43,482		196,560	5,043	10
11	21	Clerical Expenses	Management Fees	1,694,700	7	660,800	590,769	196,560	76,643	11
12	22	Employee Benefits	Management Fees	1,694,700	7	118,314		196,560	13,723	12
13	24	Seminars and Travel	Management Fees	1,694,700	7	3,223		196,560	374	13
14	17	Administrative Consulting	Management Fees	1,694,700	7	573,729	573,729	196,560	66,544	14
15	20	Marketing Fees	Management Fees	1,694,700	7	336,332	316,659	196,560	39,010	15
16	6	Repairs and Maintenance	Management Fees	1,694,700	7	34,646		196,560	4,018	16
17	30	Depreciation	Management Fees	1,694,700	7	63,305		196,560	7,342	17
18	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	6,153		196,560	714	18
19	27	Payroll Taxes	Management Fees	1,694,700	7	125,546		196,560	14,561	19
20	23	Education and Inservice	Management Fees	1,694,700	7	1,615		196,560	187	20
21	32	*Direct Interest*	Management Fees	1,694,700	7			196,560	74,602	21
22										22
23										23
24										24
25	TOTALS					\$ 2,330,141	\$ 1,825,535		\$ 340,573	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											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Cambridge Reality Capital		X	Mortgage	\$48,866.91	11/1/98	\$ 8,152,700	\$	11/30/34		\$ 423,491	1								
2												2								
3	Replacement Reserve Deposit		X								(10,185)	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Harstons Investments		X	Working Capital							288,000	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$48,866.91		\$ 8,152,700	\$			\$ 701,306	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 8,152,700	\$			\$ 701,306	15								

Less : Interest Income (3,584)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 38,594 Line # 26

697,722  
Per pg 4 Line 32 Col 8

\* 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 2007 report.		\$	<b>74,900</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>76,948</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,048</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>78,000</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>80,048</b>	<b>7</b>

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<b>61,107</b>	<b>8</b>
	2004	<b>65,096</b>	<b>9</b>
	2005	<b>68,051</b>	<b>10</b>
	2006	<b>72,055</b>	<b>11</b>
	2007	<b>76,948</b>	<b>12</b>

  

	<b>FOR BHF USE ONLY</b>			
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>76,948.00</u>	\$ <u>76,948.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>76,948.00</u>	\$ <u>76,948.00</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        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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: 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	Nursing Care Facility		1988	\$ 830,000	1
2					2
3	TOTALS			\$ 830,000	3

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2008 Ending: 31-Dec-2008

**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				1992	\$ 1,863,459	\$ 59,157	40	\$ 53,242	\$ (5,915)	\$ 832,646	4
5				1994	25,000	641	35	714	73	9,571	5
6				1998	3,586,000	91,949	35	179,300	87,351	1,672,700	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1988	8,142	283	20		(283)	8,142	9
10	Various			1989	92,298	3,426	20	4,614	1,188	90,734	10
11	Various			1990	24,448	595	20	1,241	646	20,799	11
12	Various			1991	2,212	70	15	111	41	1,661	12
13	Various			1992	1,275,149	40,483	20	63,756	23,273	986,419	13
14	Various			1993	233,429	6,201	15	12,111	5,910	199,486	14
15	Various			1994	12,341	317	15	618	301	9,649	15
16	Various			1995	43,953	473	15	2,646	2,173	23,970	16
17	Room #112 Remodeling			1996	2,285	59	15	114	55	1,427	17
18	Nurses' Call Station			1996	10,545	270	15	527	257	6,243	18
19	Ceramic Tiled Bathroom and Tub Room			1996	15,362	394	20	768	374	9,162	19
20	Rehab Room			1997	31,848	817	15	1,592	775	18,196	20
21	Fire Doors			1997	3,013	77	15	151	74	1,725	21
22	Physical Therapy Room			1997	6,749	173	15	337	164	3,852	22
23	12 Bathrooms Vented			1997	8,670	222	15	434	212	4,851	23
24	Roof Improvements			1997	7,150	183	15	358	175	3,942	24
25	Excelon Vinyl Tiles-1st Floor			1997	15,600	400	15	780	380	8,395	25
26	Excelon Vinyl Tiles-1st Floor			1998	6,204	159	15	310	151	3,259	26
27	New Roof			1998	3,850	99	15	193	94	1,685	27
28	Custom Cabinets			1998	3,285	84	15	164	80	1,432	28
29	Fire alarm Switch			1998	6,996	179	15	350	171	3,009	29
30	3 Shower Rooms Rehab			1999	15,560	399	15	778	379	6,560	30
31	Hot Water Heater			1999	7,269	186	15	363	177	2,983	31
32	Parking Lot Asphalt			1999	28,900	741	15	1,445	704	11,998	32
33	Rehab Resident Rooms			1999	17,825	457	15	891	434	7,322	33
34	Aquarium			2001	4,441	114	15	114		879	34
35	Picture Window			2001	14,403	369	15	369		2,814	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	\$ 775	15	\$ 775	\$	\$ 16,986	37
38	Carpet-Bookkeeping & Lounge	2001	2,715	70	15	70		534	38
39	Vinyl Tiles Hallway	2001	9,815	252	15	252		1,817	39
40	Auto Door	2002	2,340	60	15	117	57	780	40
41	Concrete Patio	2003	10,250	319	15	683	364	3,586	41
42	Tree Concrete Pads W/Rails	2005	12,073	310	15	1,207	897	4,124	42
43	Construction of Town Square	2005	108,391	2,779	15	2,779		10,306	43
44	Fittings & Fixtures for Town Square	2005	83,613	10,443	15	8,361	(2,082)	31,354	44
45	New Pt Room & Therapy Suites	2007	427,549	10,962	15	42,755	31,793	64,132	45
46	Metal Sidings to Roof Vents	2007	11,500		15	1,150	1,150	1,725	46
47	Construction - Alzhiemers Unit	2008	379,716	3,657	15	15,822	12,165	15,822	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)		\$ 8,441,733	\$ 238,604		\$ 402,362	\$ 163,758	\$ 4,106,677	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	\$ 282,962	\$ 101,659	\$ 47,788	\$ (53,871)	10	\$ 83,233	71
72	Current Year Purchases	90,899	7,778	4,087	(3,691)	10	4,087	72
73	Fully Depreciated Assets	857,660	1,134	2,684	1,550	10	857,660	73
74	***Lancaster Allocation***		7,342	7,342			13,141	74
75	TOTALS	\$ 1,231,521	\$ 117,913	\$ 61,901	\$ (56,012)		\$ 958,121	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)		\$ 10,503,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 356,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 464,263	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 107,746	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,064,798	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-2008

Ending: 31-Dec-2008

**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>3,182</u>			5
6								6
7	<b>TOTAL</b>				\$ <u>3,182</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	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_  
 13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_  
 14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>96</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></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	41	83		124
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		900		900
9	TOTALS	\$ 41	\$ 983	\$	\$ 1,024
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,024			

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	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>24</b>

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 373,513	\$		\$ 373,513	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			108,773			108,773	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			397,674			397,674	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			108,004			108,004	8
9	Pharmacy	39-2	# of prescrpts				337,950		337,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
	***Medical Supplies***	39-2					39,287		39,287	
13	Other (specify): <b>***Bed Rental***</b>	39-2					46,665		46,665	13
14	<b>TOTAL</b>			\$		\$ 987,964	\$ 423,902		\$ 1,411,866	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-2008

Ending:

31-Dec-2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (162,540)	\$ 465,202	1
2	Cash-Patient Deposits	39,097	39,097	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,627,553	1,627,553	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,661	46,661	6
7	Other Prepaid Expenses	25,375	454,873	7
8	Accounts Receivable (owners or related parties)	2,356,907	2,356,907	8
9	Other(specify): <u>Employee Advances</u>	176	176	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,933,229	\$ 4,990,469	10
<b>B. Long-Term Assets</b>				
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	4,859,355	15
16	Equipment, at Historical Cost	880,517	1,216,398	16
17	Accumulated Depreciation (book methods)	(1,801,794)	(4,246,927)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(261,392)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,050,350	\$ 6,259,631	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,983,579	\$ 11,250,100	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 317,669	\$ 328,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,993	71,993	28
29	Short-Term Notes Payable	168,282	279,480	29
30	Accrued Salaries Payable	685,261	685,261	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,894	18,894	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,000	78,000	32
33	Accrued Interest Payable		32,352	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,340,099	\$ 1,494,690	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,576,410	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,400,000	\$ 9,976,410	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,740,099	\$ 11,471,100	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,243,480	\$ (221,000)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,983,579	\$ 11,250,100	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>895,039</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>895,039</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,348,441	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(1,000,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>348,441</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,243,480</b>	<b>24</b> *

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

**XVI. STATEMENT OF CHANGES IN EQUITY**

		Total after consolidation	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(413,549)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(413,549)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	2,442,549	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(2,250,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>192,549</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(221,000)</b>	<b>24</b> *

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

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694Report Period Beginning: 1-Jan-2008Ending: 31-Dec-2008**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,060,231	1
2	Discounts and Allowances for all Levels	(3,248,731)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,811,500	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,131,366	6
7	Oxygen	16,210	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,147,576	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,227	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	298,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,524	19
20	Radiology and X-Ray	40,836	20
21	Other Medical Services	50,667	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 409,641	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	64,073	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 64,073	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending Commissions</u>	2,400	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,400	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,435,190	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,003,333	31
32	Health Care	4,028,171	32
33	General Administration	1,295,611	33
<b>B. Capital Expense</b>			
34	Ownership	2,262,124	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,411,866	35
36	Provider Participation Fee	85,644	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,086,749	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,348,441	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,348,441	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.

\*Offset on Pg 5 &amp; Pg 9

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

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008

**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	2,026	2,307	\$ 102,926	\$ 44.61	1
2	Assistant Director of Nursing	2,002	2,107	70,848	33.63	2
3	Registered Nurses	44,354	48,557	1,358,452	27.98	3
4	Licensed Practical Nurses	5,556	5,803	139,101	23.97	4
5	CNAs & Orderlies	112,451	121,319	1,496,501	12.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,911	2,099	41,193	19.63	9
10	Activity Assistants	17,307	19,035	207,733	10.91	10
11	Social Service Workers	2,002	2,107	56,399	26.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,686	32,668	426,060	13.04	15
16	Dishwashers					16
17	Maintenance Workers	4,111	4,341	70,543	16.25	17
18	Housekeepers	34,090	37,837	421,846	11.15	18
19	Laundry	9,963	10,942	124,479	11.38	19
20	Administrator	1,945	2,227	110,213	49.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	11,431	12,151	131,238	10.80	23
24	Clerical					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	1,864	2,139	38,957	18.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	280,699	305,639	\$ 4,796,489 *	\$ 15.69	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	332	\$ 12,606	1-3 35
36	Medical Director	51	18,985	9-3 36
37	Medical Records Consultant	109	4,320	10-3 37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	19	636	10a-3 40
41	Occupational Therapy Consultant	102	2,887	10a-3 41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	50	1,639	10a-3 43
44	Activity Consultant			44
45	Social Service Consultant	167	5,542	12-3 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	830	\$ 46,615	49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,454	\$ 89,072	10-3 50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	3,454	\$ 89,072	53

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joanne Bedrosian	Administrator	N/A	\$ 110,213	Workers' Compensation Insurance	\$ 87,420	IDPH License Fee	\$ 1,550	
				Unemployment Compensation Insurance	32,993	Advertising: Employee Recruitment	2,482	
				FICA Taxes	353,721	Health Care Worker Background Check		
				Employee Health Insurance	129,861	(Indicate # of checks performed <u>141</u> )	2,115	
				Employee Meals	16,104	Patient Background Checks <u>153</u>	2,295	
				Illinois Municipal Retirement Fund (IMRF)*		***Promotional Advertising***	6,734	
				***Retirement Plan Contributions***	13,253	***Dues & Subscriptions***	2,754	
				***Uniforms***	12,136	***Licenses and Fees***	2,832	
				***Other Employee Benefits***	6,871	***Lancaster Allocation***	39,724	
				***Lancaster Allocation***	13,723			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,213			Less: Public Relations Expense	(39,724)	
						Non-allowable advertising	(6,353)	
						Yellow page advertising	(381)	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,028	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 666,082	
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Management Fees-Lancaster, Ltd			\$ 196,560	Description	Line #	Amount		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 196,560					
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Payroll Tax Consultant		\$ 1,674				Out-of-State Travel	\$
Frost Ruttenberg & Rothblatt	Accounting		1,795					
Richard Peelo & Assoc.	Accounting		2,250					
Accu-Med Services, Inc.	Data Processing		3,885	***N/A***			In-State Travel	1,473
Health Data Systems	Data Processing		7,344					
Caffarelli & Siegel, Ltd	Legal		1,035					
William Lasko	Legal		3,925					
Stone, Pogrund & Korey	Legal		1,350				Seminar Expense	4,995
Childress, Duffy, Goldblatt, Ltd	Legal		2,521				***Lancaster Allocation***	374
Law Office of Carter Korey	Legal		2,975					
Myers, Miller & Krauskopf	Legal		245					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 28,999	TOTAL		\$	Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	\$ 6,842

\* Attach copy of IMRF notifications

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting & Decorating	2008	\$ 2,000		\$	\$	\$	\$ 333	\$ 667	\$ 667	\$ 333	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,000		\$	\$	\$	\$ 333	\$ 667	\$ 667	\$ 333	\$	\$

