



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	4,020	2,241	10,170	16,431	8
9	SNF/PED					9
10	ICF	15,827	17,398	180	33,405	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,847	19,639	10,350	49,836	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.52%

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 9,456

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 31st Dec 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

**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	482,009	49,273	12,477	543,759		543,759		543,759		1
2	Food Purchase		317,995		317,995	(16,972)	301,023	(1,163)	299,860		2
3	Housekeeping	436,475	90,792		527,267		527,267		527,267		3
4	Laundry	132,476	38,307	2,910	173,693		173,693		173,693		4
5	Heat and Other Utilities			215,545	215,545		215,545		215,545		5
6	Maintenance	73,643	78,470	149,769	301,882		301,882	7,257	309,139		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,124,603	574,837	380,701	2,080,141	(16,972)	2,063,169	6,094	2,069,263		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			46,500	46,500		46,500		46,500		9
10	Nursing and Medical Records	3,646,490	388,435	206,087	4,241,012		4,241,012		4,241,012		10
10a	Therapy			18,282	18,282		18,282		18,282		10a
11	Activities	147,123	37,840		184,963		184,963		184,963		11
12	Social Services	57,817		6,366	64,183		64,183		64,183		12
13	CNA Training		420	600	1,020		1,020		1,020		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,851,430	426,695	277,835	4,555,960		4,555,960		4,555,960		16
	<b>C. General Administration</b>										
17	Administrative	107,201		257,040	364,241		364,241	(143,423)	220,818		17
18	Directors Fees										18
19	Professional Services			29,396	29,396		29,396	11,674	41,070		19
20	Dues, Fees, Subscriptions & Promotions			18,459	18,459		18,459	(4,644)	13,815		20
21	Clerical & General Office Expenses	169,361	55,649	70,424	295,434		295,434	58,418	353,852		21
22	Employee Benefits & Payroll Taxes			673,589	673,589	16,972	690,561	8,759	699,320		22
23	Inservice Training & Education			1,391	1,391		1,391	2,872	4,263		23
24	Travel and Seminar			7,585	7,585		7,585	1,239	8,824		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			8,089	8,089		8,089	38,046	46,135		26
27	Other (specify):*							18,996	18,996		27
28	<b>TOTAL General Administration</b>	276,562	55,649	1,065,973	1,398,184	16,972	1,415,156	(8,063)	1,407,093		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,252,595	1,057,181	1,724,509	8,034,285		8,034,285	(1,969)	8,032,316		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			109,064	109,064		109,064	378,407	487,471		30
31	Amortization of Pre-Op. & Org.							494	494		31
32	Interest			288,000	288,000		288,000	376,142	664,142		32
33	Real Estate Taxes			95,470	95,470		95,470		95,470		33
34	Rent-Facility & Grounds			1,803,611	1,803,611		1,803,611	(1,800,000)	3,611		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,296,145	2,296,145		2,296,145	(1,044,957)	1,251,188		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		413,307	1,145,192	1,558,499		1,558,499		1,558,499		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	<b>TOTAL Special Cost Centers</b>		413,307	1,230,602	1,643,909		1,643,909		1,643,909		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,252,595	1,470,488	5,251,256	11,974,339		11,974,339	(1,046,926)	10,927,413		45

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



Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Actual Expenses in 2009	\$ (2,772)	6	1
2	Allocated expenses for 2008	1,416	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>	(1,356)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,163)	0	0	0	0	0	0	0	0	0	0	(1,163)	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	(1,356)	2,218	6,395	0	0	0	0	0	0	0	0	7,257	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,519)</b>	<b>2,218</b>	<b>6,395</b>	<b>0</b>	<b>6,094</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	(143,423)	0	0	0	0	0	0	0	0	0	(143,423)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,674	8,000	0	0	0	0	0	0	0	0	11,674	19
20	Fees, Subscriptions & Promotions	(57,539)	52,520	375	0	0	0	0	0	0	0	0	(4,644)	20
21	Clerical & General Office Expenses	(28,113)	85,560	971	0	0	0	0	0	0	0	0	58,418	21
22	Employee Benefits & Payroll Taxes	0	8,759	0	0	0	0	0	0	0	0	0	8,759	22
23	Inservice Training & Education	0	2,872	0	0	0	0	0	0	0	0	0	2,872	23
24	Travel and Seminar	0	1,239	0	0	0	0	0	0	0	0	0	1,239	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	38,046	0	0	0	0	0	0	0	0	38,046	26
27	Other (specify):*	0	18,996	0	0	0	0	0	0	0	0	0	18,996	27
28	<b>TOTAL General Administration</b>	<b>(85,652)</b>	<b>30,197</b>	<b>47,392</b>	<b>0</b>	<b>(8,063)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(88,171)</b>	<b>32,415</b>	<b>53,787</b>	<b>0</b>	<b>(1,969)</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	163,623	2,956	211,828	0	0	0	0	0	0	0	0	378,407	30
31	Amortization of Pre-Op. & Org.	0	0	494	0	0	0	0	0	0	0	0	494	31
32	Interest	(30,597)	37,912	368,827	0	0	0	0	0	0	0	0	376,142	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>133,026</b>	<b>40,868</b>	<b>(1,218,851)</b>	<b>0</b>	<b>(1,044,957)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	44,855	73,283	(1,165,064)	0	0	0	0	0	0	0	0	(1,046,926)	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 Management Fee	\$ 257,040	Lancaster, LTD.	100.00%	\$	(257,040)	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%	18,996	18,996	3	
4	V	19 Professional Services		Lancaster, LTD.	100.00%	3,674	3,674	4	
5	V	21 Clerical Expenses		Lancaster, LTD.	100.00%	85,560	85,560	5	
6	V	22 Employee Benefits		Lancaster, LTD.	100.00%	8,759	8,759	6	
7	V	24 Seminars & Travel		Lancaster, LTD.	100.00%	1,239	1,239	7	
8	V	6 Repairs Maintenance		Lancaster, LTD.	100.00%	2,218	2,218	8	
9	V	17 Administrative Consulting		Lancaster, LTD.	100.00%	77,745	77,745	9	
10	V	32 Interest including Direct Interest		Lancaster, LTD.	100.00%	37,912	37,912	10	
11	V	30 Depreciation		Lancaster, LTD.	100.00%	2,956	2,956	11	
12	V	20 Dues, Fees and Sub/Marketing Fees		Lancaster, LTD.	100.00%	52,520	52,520	12	
13	V	23 Education and Inservice		Lancaster, LTD.		2,872	2,872	13	
14	Total		\$ 257,040			\$ 330,323	\$ *	73,283	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		\$	\$ (1,800,000)
16	V	32 Interest Income	16,379	OakBrook Associates		385,206	368,827
17	V	30 Depreciation		OakBrook Associates		211,828	211,828
18	V	31 Amortization		OakBrook Associates		494	494
19	V	20 Licenses and Fees		OakBrook Associates		375	375
20	V	26 Mortgage Insurance Premium		OakBrook Associates		38,046	38,046
21	V	21 State Replacement Tax		OakBrook Associates		971	971
22	V	19 Legal Fees		OakBrook Associates		8,000	8,000
23	V	6 Maintenance fees and Supplies		OakBrook Associates		6,395	6,395
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,816,379			\$ 651,315	\$ * (1,165,064)

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

Facility Name &amp; ID Number

Oakbrook Healthcare Centre

#

0034694

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

## 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	0.05	See Attached	5	10.42	Lancaster	\$ 17,936	17-7	1
2	Cheryl Morris	VP-Operations	Administrative	0.05	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-2009

Ending: -Dec-2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	2,190,720	7	31,315		257,040	3,674	10
11	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	257,040	85,560	11
12	22	Employee Benefits	Management Fees	2,190,720	7	74,654		257,040	8,759	12
13	24	Seminars & Travel	Management Fees	2,190,720	7	10,564		257,040	1,239	13
14	17	Administrative consulting	Management Fees	2,190,720	7	662,608	662,608	257,040	77,745	14
15	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	257,040	50,522	15
16	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		257,040	2,218	16
17	30	Depreciation	Management Fees	2,190,720	7	25,194		257,040	2,956	17
18	20	Dues,Fees and Subscriptions	Management Fees	2,190,720	7	17,027		257,040	1,998	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		257,040	17,056	19
20	32	Interest	Management Fees	2,190,720	7	57,668		257,040	6,766	20
21	23	Education and Inservice	Management Fees	2,190,720	7	24,476		257,040	2,872	21
22	32	*Direct Interest*							31,146	22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 330,323	25

Facility Name & ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Cambridge Realty Capital		X	Mortgage	\$50,706.91	11/1/98	\$ 8,152,700	\$	11/30/34		\$ 385,206	1							
2												2							
3	Replacement Reserve		X								(6,300)	3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Harston Investments		X	Working Capital							288,000	6							
7	JP Morgan Chase Bank		X	Working Capital							6,766	7							
8												8							
9	<b>TOTAL Facility Related</b>				\$50,706.91		\$ 8,152,700	\$			\$ 673,672	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12	Interest											12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 8,152,700	\$			\$ 673,672	15							

Less: Interest Income (9,530)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 38,046

Line #

26

664,142

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>78,000</b>	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.)		\$	<b>83,470</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>5,470</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>90,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>95,470</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>65,096</b>	8	
	2005	<b>68,051</b>	9	
	2006	<b>72,055</b>	10	
	2007	<b>76,948</b>	11	
	2008	<b>83,470</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.**



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2009 Ending:

31-Dec-2009

**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).

\*\*\*None\*\*\*

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

1. Total Amount Incurred: \$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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Nursing Care Facility</u>			\$ <u>830,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>830,000</b>	<b>3</b>

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1992	\$ 1,863,459	\$ 59,157	40	\$ 53,242	\$ (5,915)	\$ 885,888	4
5			1994	25,000	641	35	714	73	10,285	5
6			1998	3,586,000	91,949	35	179,300	87,351	1,852,000	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1988	8,142	286	20		(286)	8,142	9
10	Various		1989	92,298	3,426	20	1,564	(1,862)	92,298	10
11	Various		1990	24,448	595	20	1,236	641	22,035	11
12	Various		1991	2,212	70	15	111	41	1,772	12
13	Various		1992	1,275,149	40,483	20	63,756	23,273	1,050,175	13
14	Various		1993	233,429	6,201	15	11,021	4,820	210,507	14
15	Various		1994	12,341	317	15	618	301	10,267	15
16	Various		1995	43,953	473	15	3,734	3,261	27,704	16
17	Room #112 Remodeling		1996	2,285	59	15	114	55	1,541	17
18	Nurses; Call Station		1996	10,545	270	15	527	257	6,770	18
19	Ceramic Tiled Bathroom and Tub Room		1996	15,362	394	20	768	374	9,930	19
20	Rehab Room		1997	31,848	817	15	1,592	775	19,788	20
21	Fire Doors		1997	3,013	77	15	151	74	1,876	21
22	Physical Therapy Room		1997	6,749	173	15	337	164	4,189	22
23	12 Bathrooms Vented		1997	8,670	222	15	434	212	5,285	23
24	Roof Improvements		1997	7,150	183	15	358	175	4,300	24
25	Excelon Vinyl Tiles-1st Floor		1997	15,600	400	15	780	380	9,175	25
26	Excelon Vinyl Tiles-1st Floor		1998	6,204	159	15	310	151	3,569	26
27	New Roof		1998	3,850	99	15	193	94	1,878	27
28	Custom Cabinets		1998	3,285	84	15	164	80	1,596	28
29	Fire Alarm Switch		1998	6,996	179	15	350	171	3,359	29
30	3 Shower rooms Rehab		1999	15,560	399	15	778	379	7,338	30
31	Hot Water Heater		1999	7,269	186	15	363	177	3,346	31
32	Parking Lot Asphalt		1999	28,900	741	15	1,445	704	13,443	32
33	Rehab Resident Rooms		1999	17,825	457	15	891	434	8,213	33
34	Aquarium		2001	4,441	114	15	114		993	34
35	Picture Window		2001	14,403	369	15	369		3,183	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

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2009 Ending: 31-Dec-2009

## 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	\$	15	\$	\$	\$ 16,986	37
38	Carpet-Bookkeeping & Lounge	2001	2,715	70	15	70		604	38
39	Vinyl Tiles Hallway	2001	9,815	252	15	252		2,069	39
40	Auto Door	2002	2,340	60	15	117	57	897	40
41	Concrete Patio	2003	10,250	302	15	683	381	4,269	41
42	Tree Concrete Pads W/Rails	2005	12,073	310	15	1,206	896	5,330	42
43	Construction of Town Square	2005	108,391	2,779	15	2,779		13,085	43
44	Fittings & Fixtures for Town Square	2005	83,613	7,467	15	8,361	894	39,715	44
45	New PT Room & Therapy Suites	2007	427,549	10,962	15	42,755	31,793	106,887	45
46	Metal Sidings to Roof Vents	2007	11,500		15	1,150	1,150	2,875	46
47	Construction - Alzheimers Unit	2008	379,716	9,736	15	37,972	28,236	53,794	47
48	2-Insulated Hotwater Tanks (175 Gal)	2009	12,058	297	15	1,206	909	1,206	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)		\$ 8,453,791	\$ 241,215		\$ 421,885	\$ 180,670	\$ 4,528,562	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	\$ 363,805	\$ 46,645	\$ 53,171	\$ 6,526	10	\$ 102,990	71
72	Current Year Purchases	55,032	33,018	8,073	(24,945)	10	8,073	72
73	Fully Depreciated Assets	896,547	14	1,386	1,372	10	896,547	73
74	*Lancaster Allocation*		2,956	2,956			16,097	74
75	TOTALS	\$ 1,315,384	\$ 82,633	\$ 65,586	\$ (17,047)		\$ 1,023,707	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)	\$ 10,599,175	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 323,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 487,471	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 163,623	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,552,269	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \*\*\*Oakbrook Property Associates\*\*\*

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>3,611</u>			5
6								6
7	TOTAL				\$ <u>3,611</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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

\* 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	25	395		420
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		600		600
9	<b>TOTALS</b>	\$ 25	\$ 995	\$	\$ 1,020
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 1,020			

**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	1
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>17</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	\$		\$ 409,590	\$		\$ 409,590	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			122,698			122,698	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			469,195			469,195	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			143,709			143,709	8
9	Pharmacy	39-2	# of prescripts				327,688		327,688	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>*Medical Supplies*</u>	39-2					34,967		34,967	12
13	Other (specify): <u>***Bed Rentals***</u>	39-2					50,652		50,652	13
14	TOTAL			\$		\$ 1,145,192	\$ 413,307		\$ 1,558,499	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**# **0034694**Report Period Beginning: **1-Jan-2009**Ending: **31-Dec-2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **31-Dec-2009** (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	\$ (143,297)	\$ 1,287,457	1
2	Cash-Patient Deposits	36,823	36,823	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,450,111	1,450,111	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,599	38,599	6
7	Other Prepaid Expenses	13,856	395,022	7
8	Accounts Receivable (owners or related parties)	2,256,538	2,256,538	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,652,630	\$ 5,464,550	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	1,995,673	4,883,401	15
16	Equipment, at Historical Cost	935,550	1,271,431	16
17	Accumulated Depreciation (book methods)	(1,910,858)	(4,567,819)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(261,886)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,020,365	\$ 6,017,324	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,672,995	\$ 11,481,874	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 322,164	\$ 322,164	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,414	75,414	28
29	Short-Term Notes Payable	40,033	40,033	29
30	Accrued Salaries Payable	800,638	800,638	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,516	23,516	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,000	90,000	32
33	Accrued Interest Payable		31,884	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 (sum of lines 26 thru 37)</b>	\$ 1,351,765	\$ 1,383,649	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,576,411	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,400,000	\$ 9,976,411	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,751,765	\$ 11,360,060	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 921,230	\$ 121,814	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,672,995	\$ 11,481,874	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,243,480</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>1,243,480</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>677,750</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,000,000)</b>	<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>(322,250)</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>921,230</b>	<b>24</b> *

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

**XVI. STATEMENT OF CHANGES IN EQUITY**

		Totals after consolidation	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(221,000)</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>(221,000)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,842,814	<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	(1,500,000)	<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>342,814</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>121,814</b>	<b>24</b> *

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

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009

**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	\$ 13,298,544	1
2	Discounts and Allowances for all Levels	(3,581,830)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,716,714</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,438,890	6
7	Oxygen	14,675	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,453,565</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	341,910	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,390	19
20	Radiology and X-Ray	44,278	20
21	Other Medical Services	50,635	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 449,213</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	30,597	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 30,597</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending Commissions</u>	2,000	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,000</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 12,652,089</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,080,141	31
32	Health Care	4,555,960	32
33	General Administration	1,398,184	33
<b>B. Capital Expense</b>			
34	Ownership	2,296,145	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,558,499	35
36	Provider Participation Fee	85,410	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,974,339</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>677,750</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 677,750</b>	<b>43</b>

\* 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\*\*

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

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

# **0034694**

Report Period Beginning: **1-Jan-2009**

Ending:

**31-Dec-2009**

**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	1,981	2,324	\$ 107,778	\$ 46.38	1
2	Assistant Director of Nursing	1,877	2,102	73,484	34.96	2
3	Registered Nurses	50,150	53,942	1,564,820	29.01	3
4	Licensed Practical Nurses	5,891	5,993	141,586	23.63	4
5	CNAs & Orderlies	121,336	131,434	1,717,803	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,905	2,293	41,251	17.99	9
10	Activity Assistants	14,273	15,549	105,872	6.81	10
11	Social Service Workers	2,012	2,260	57,817	25.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,546	34,756	482,009	13.87	15
16	Dishwashers					16
17	Maintenance Workers	4,050	4,331	73,644	17.00	17
18	Housekeepers	32,368	36,832	436,474	11.85	18
19	Laundry	9,704	10,972	132,476	12.07	19
20	Administrator	1,966	2,190	107,201	48.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,520	12,657	169,361	13.38	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	1,974	2,102	41,019	19.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,553	319,737	\$ 5,252,595 *	\$ 16.43	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	359	\$ 12,477	1-3	35
36	Medical Director	1,250	46,500	9-3	36
37	Medical Records Consultant	160	4,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	37	1,236	10a-3	40
41	Occupational Therapy Consultant	351	9,928	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	217	7,118	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	205	6,366	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,579	\$ 87,945		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,473	\$ 201,767	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,473	\$ 201,767		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joanne Bedrosian	Administrator	N/A	\$ 107,201	Workers' Compensation Insurance	\$ 73,912	IDPH License Fee	\$ 1,550	
				Unemployment Compensation Insurance	32,535	Advertising: Employee Recruitment	1,485	
				FICA Taxes	385,319	Health Care Worker Background Check		
				Employee Health Insurance	152,973	(Indicate # of checks performed <u>141</u> )	1,410	
				Employee Meals	16,972	Patient Background Checks	2,420	
				Illinois Municipal Retirement Fund (IMRF)*		***Promotional Advertising***	5,019	
				***Retirement Plan Contributions***	12,959	***Dues & Subscriptions***	1,381	
				***Uniforms***	9,951	***Licenses and Fees***	5,194	
				***Othr Employee Benefits***	5,940	***Lancaster Allocation***	52,520	
				***Lancaster Allocation***	8,759	***Oakbrook Associates***	375	
						Less: Public Relations Expense	(52,520)	
						Non-allowable advertising	(4,979)	
						Yellow page advertising	(40)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 107,201	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 699,320		\$ 13,815		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-Lancaaster, Ltd			\$ 257,040				Out-of-State Travel	\$
							In-State Travel	1,119
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 257,040				Seminar Expense	6,466
							***Lancaster Allocation***	1,239
C. Professional Services								
Vendor/Payee	Type	Amount						
Personnel Planners	Payroll Tax Consultant	\$ 1,674						
Frost Ruttenberg & Rothblatt	Accounting	1,895						
Richard Peelo & Assoc.	Accounting	2,250						
Accu-Med Services, Inc.	Data Processing	4,831						
Health Data Systems	Data Processing	6,952						
Caffarelli & Siegel, Ltd.	Legal	320						
Law Office of Carter Korey	Legal	8,999						
William Lasko	Legal	2,475						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 29,396	TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
				\$			TOTAL	
							\$ 8,824	

\* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1	Painting & Decorating	2008	\$ 2,000	3	\$	\$	\$ 333	\$ 667	\$ 667	\$ 333	\$	\$	\$
2	Painting & Decorating	2009	1,722	3				574	574	574			
3	Painting & Decorating	2009	1,050	3				175	350	350	175		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$ 4,772		\$	\$	\$ 333	\$ 1,416	\$ 1,591	\$ 1,257	\$ 175	\$	\$

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 68,752 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 85,410  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 16,972 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/a
  - c. What percent of all travel expense relates to transportation of nurses and patients? None
  - d. Have vehicle usage logs been maintained? N/A
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.