



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,504	1,043	10,815	15,362	8	
9	SNF/PED					9	
10	ICF	17,087	18,201	94	35,382	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	20,591	19,244	10,909	50,744	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.12%

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 10,089

Medicare 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 2010 Fiscal Year: 31st Dec 2010

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

**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	483,540	45,881	14,389	543,810		543,810		543,810		1
2	Food Purchase		322,693		322,693	(17,480)	305,213	(753)	304,460		2
3	Housekeeping	446,528	111,072		557,600		557,600		557,600		3
4	Laundry	151,047	25,445		176,492		176,492		176,492		4
5	Heat and Other Utilities			251,700	251,700		251,700		251,700		5
6	Maintenance	74,223	59,568	113,509	247,300		247,300	505	247,805		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,155,338	564,659	379,598	2,099,595	(17,480)	2,082,115	(248)	2,081,867		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			54,625	54,625		54,625		54,625		9
10	Nursing and Medical Records	3,706,520	351,711	60,541	4,118,772		4,118,772		4,118,772		10
10a	Therapy		18,996	36,197	55,193		55,193		55,193		10a
11	Activities	161,719	44,606		206,325		206,325		206,325		11
12	Social Services	206,028		4,823	210,851		210,851		210,851		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,074,267	415,313	156,186	4,645,766		4,645,766		4,645,766		16
	<b>C. General Administration</b>										
17	Administrative	106,053		275,400	381,453		381,453	(88,514)	292,939		17
18	Directors Fees										18
19	Professional Services			46,481	46,481		46,481	18,123	64,604		19
20	Dues, Fees, Subscriptions & Promotions			19,603	19,603		19,603	(6,900)	12,703		20
21	Clerical & General Office Expenses	162,601	52,393	86,042	301,036		301,036	75,146	376,182		21
22	Employee Benefits & Payroll Taxes			676,263	676,263	17,480	693,743	6,528	700,271		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,523	3,523		3,523	378	3,901		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			5,015	5,015		5,015	37,470	42,485		26
27	Other (specify):* <b>Payroll Taxes (Schedule VII)</b>							25,105	25,105		27
28	<b>TOTAL General Administration</b>	268,654	52,393	1,112,327	1,433,374	17,480	1,450,854	67,336	1,518,190		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,498,259	1,032,365	1,648,111	8,178,735		8,178,735	67,088	8,245,823		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			193,655	193,655		193,655	318,355	512,010		30
31	Amortization of Pre-Op. & Org.							494	494		31
32	Interest			288,000	288,000		288,000	381,148	669,148		32
33	Real Estate Taxes			87,036	87,036		87,036		87,036		33
34	Rent-Facility & Grounds			1,817,016	1,817,016		1,817,016	(1,800,000)	17,016		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,385,707	2,385,707		2,385,707	(1,100,003)	1,285,704		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		472,219	1,056,484	1,528,703		1,528,703		1,528,703		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>		472,219	1,141,894	1,614,113		1,614,113		1,614,113		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,498,259	1,504,584	5,175,712	12,178,555		12,178,555	(1,032,915)	11,145,640		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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	<b>111,003</b>	<b>30</b>		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	<b>(753)</b>	<b>2</b>		13
14	Non-Care Related Interest	<b>(13,489)</b>	<b>32</b>		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		<b>20</b>		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	<b>(22,093)</b>	<b>21</b>		24
25	Fund Raising, Advertising and Promotional	<b>(62,179)</b>	<b>20</b>		25
26	Income Taxes and Illinois Personal Property Replacement Tax	<b>(14,782)</b>	<b>21</b>		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		<b>20</b>		28
29	Other-Attach Schedule <b>Page 5A attached</b>	<b>(675)</b>	<b>6</b>		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (2,968)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	<b>(1,029,947)</b>	<b>6&amp;6A</b>	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (1,029,947)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,032,915)</b>		<b>37</b>

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

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

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 1-Jan-2010

Ending: 31-Dec-2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Actual Expenses incurred in 2010	\$ (2,720)	6	1
2	Allocated expenses for 2010 per page 22	2,045	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>	(675)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

1-Jan-2010

Ending:

31-Dec-2010

## 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	(753)	0	0	0	0	0	0	0	0	0	0	(753)	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	(675)	1,180	0	0	0	0	0	0	0	0	0	505	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,428)</b>	<b>1,180</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>(248)</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	(88,514)	0	0	0	0	0	0	0	0	0	(88,514)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,123	8,000	0	0	0	0	0	0	0	0	18,123	19
20	Fees, Subscriptions & Promotions	(62,179)	55,279	0	0	0	0	0	0	0	0	0	(6,900)	20
21	Clerical & General Office Expenses	(36,875)	108,106	3,915	0	0	0	0	0	0	0	0	75,146	21
22	Employee Benefits & Payroll Taxes	0	6,528	0	0	0	0	0	0	0	0	0	6,528	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	378	0	0	0	0	0	0	0	0	0	378	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	37,470	0	0	0	0	0	0	0	0	37,470	26
27	Other (specify):*	0	25,105	0	0	0	0	0	0	0	0	0	25,105	27
28	<b>TOTAL General Administration</b>	<b>(99,054)</b>	<b>117,005</b>	<b>49,385</b>	<b>0</b>	<b>67,336</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(100,482)</b>	<b>118,185</b>	<b>49,385</b>	<b>0</b>	<b>67,088</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

1-Jan-2010 Ending:

Summary B

31-Dec-2010

## 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	111,003	3,803	203,549	0	0	0	0	0	0	0	0	318,355	30
31	Amortization of Pre-Op. & Org.	0	0	494	0	0	0	0	0	0	0	0	494	31
32	Interest	(13,489)	26,831	367,806	0	0	0	0	0	0	0	0	381,148	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>97,514</b>	<b>30,634</b>	<b>(1,228,151)</b>	<b>0</b>	<b>(1,100,003)</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)	(2,968)	148,819	(1,178,766)	0	0	0	0	0	0	0	0	(1,032,915)	45

Facility Name & ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2010

Ending:

31-Dec-2010

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	\$ 275,400	Lancaster, Ltd.	100.00%	\$	(275,400)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	54,948	54,948	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	25,105	25,105	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	10,123	10,123	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	108,106	108,106	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	6,528	6,528	6
7	V	24 Seminars and Travel		Lancaster, Ltd.	100.00%	378	378	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	131,938	131,938	8
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	55,279	55,279	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	3,803	3,803	10
11	V	6 Repairs and Maintenance		Lancaster, Ltd.	100.00%	1,180	1,180	11
12	V	32 Interest		Lancaster, Ltd.	100.00%	6,872	6,872	12
13	V	32 **Direct Interest**		Lancaster, Ltd.	100.00%	19,959	19,959	13
14	Total		\$ 275,400			\$ 424,219	\$ *	148,819 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	11,628	OakBrook Associates		379,434	367,806
17	V	30 Depreciation		OakBrook Associates		203,549	203,549
18	V	31 Amortization		OakBrook Associates		494	494
19	V	19 Accounting Charges		OakBrook Associates		8,000	8,000
20	V	26 Mortgage Insurance Premium		OakBrook Associates		37,470	37,470
21	V	21 State Replacement Tax		OakBrook Associates		3,915	3,915
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,811,628			\$ 632,862	\$ * (1,178,766)

\* 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-2010

Ending:

31-Dec-2010

## 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	7.75	16.15	Lancaster	\$ 27,474	17-7	1
2	Cheryl Morris	VP-Operations	Administrative	0.05	See Attached	7.75	16.15	Lancaster	27,474	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	\$ 54,948		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-2010

Ending: -Dec-2010

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	4	\$ 170,160	\$ 170,160	8	\$ 27,474	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	9,439		8	1,524	2
3	17	Cheryl Morris	Hours Worked	48	4	170,160	170,160	8	27,474	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	9,420		8	1,521	4
5										5
6										6
7	19	Professional Services	Census Days	311,995	4	62,241		50,744	10,123	7
8	21	Clerical Expenses	Census Days	311,995	4	664,683	623,280	50,744	108,106	8
9	22	Employee Benefits	Census Days	311,995	4	40,140		50,744	6,528	9
10	24	Seminars and Travel	Census Days	311,995	4	2,324		50,744	378	10
11	17	Administrative Consulting	Census Days	311,995	4	811,207	811,207	50,744	131,938	11
12	20	Marketing Fees	Census Days	311,995	4	332,596	327,507	50,744	54,095	12
13	20	Dues, Fees and Subscriptions	Census Days	311,995	4	7,277		50,744	1,184	13
14	30	Depreciation	Census Days	311,995	4	23,380		50,744	3,803	14
15	6	Repairs and Maintenance	Census Days	311,995	4	7,255		50,744	1,180	15
16	27	Payroll Taxes	Census Days	311,995	4	135,636		50,744	22,060	16
17	32	Interest	Census Days	311,995	4	42,252		50,744	6,872	17
18										18
19										19
20	32	**Direct Interest**							19,959	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,488,169	\$ 2,102,314		\$ 424,219	25

Facility Name & ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2010 Ending:

31-Dec-2010

**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		11/1/98	\$ 8,152,700	\$	11/30/34		\$ 379,434	1							
2												2							
3	Replacement Reserve		X								(3,186)	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							6,872	7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 8,152,700	\$			\$ 671,120	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	\$			\$ 671,120	15							

Less: Interest Income (1,972)

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

\$ 37,470

Line #

26

669,148

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>90,000</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>87,036</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,964)</b>		3
4. Real Estate Tax accrual used for 2010 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>87,036</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<b>68,051</b>	8	<b>FOR BHF USE ONLY</b>	
	2006	<b>72,055</b>	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
	2007	<b>76,948</b>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2008	<b>83,470</b>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2009	<b>87,036</b>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>***Accrual is based on previous years actuals adjusted for inflation***</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.**



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

1-Jan-2010 Ending:

31-Dec-2010

**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: \$234,464 / \$17,275 2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 494 4. Dates Incurred: Oct 1998 / 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-2010 Ending:

31-Dec-2010

**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	156		1992	\$ 1,863,459	\$ 59,157	40	\$ 53,242	\$ (5,915)	\$ 962,790	4
5			1994	25,000	641	35	714	73	12,081	5
6			1998	3,586,000	91,948	35	179,300	87,352	2,256,192	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1988	17,497		20			17,497	9
10	Various		1989	94,251	3,426	30	4	(3,422)	76,703	10
11	Various		1990	26,318	595	20	392	(203)	25,034	11
12	Various		1991	12,810	70	20	111	41	12,641	12
13	Various		1992	1,284,603	40,483	20	63,756	23,273	1,183,754	13
14	Various		1993	233,429	6,201	15	11,021	4,820	204,009	14
15	Various		1994	56,380	317	15	621	304	54,252	15
16	Various		1995	52,918	473	15	2,646	2,173	41,772	16
17	Room #112 Remodeling		1996	2,285	59	15	114	55	1,712	17
18	Nurses; Call Station		1996	10,545	270	15	527	257	7,556	18
19	Ceramic Tiled Bathroom and Tub Room		1996	15,362	394	20	768	374	11,073	19
20	Rehab Room		1997	31,848	817	15	1,592	775	22,159	20
21	Fire Doors		1997	3,013	77	15	151	74	2,098	21
22	Physical Therapy Room		1997	6,749	173	15	337	164	4,694	22
23	12 Bathrooms Vented		1997	8,670	222	15	434	212	5,925	23
24	Roof Improvements		1997	7,150	183	15	358	175	4,829	24
25	Excelon Vinyl Tiles-1st Floor		1997	15,600	400	15	780	380	10,335	25
26	Excelon Vinyl Tiles-1st Floor		1998	6,204	159	15	310	151	4,030	26
27	New Roof		1998	3,850	99	15	193	94	2,349	27
28	Custom Cabinets		1998	3,285	84	15	164	80	2,002	28
29	Fire Alarm Switch		1998	6,996	179	15	350	171	4,219	29
30	3 Shower rooms Rehab		1999	15,560	399	15	778	379	9,206	30
31	Hot Water Heater		1999	7,269	186	15	363	177	4,148	31
32	Parking Lot Asphalt		1999	28,900	741	15	1,445	704	16,738	32
33	Rehab Resident Rooms		1999	17,825	457	15	891	434	10,174	33
34	Aquarium		2001	4,441	114	15	114		1,107	34
35	Picture Window		2001	14,403	369	15	369		3,552	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	\$	15	\$	\$	\$ 17,385	37
38	Carpet-Bookkeeping & Lounge	2001	2,715	70	15	70		674	38
39	Vinyl Tiles Hallway	2001	9,815	252	15	252		2,321	39
40	Auto Door	2002	2,340	60	15	117	57	1,014	40
41	Concrete Patio	2003	10,250	302	15	683	381	4,902	41
42	Tree Concrete Pads W/Rails	2005	12,073	310	15	1,207	897	6,537	42
43	Construction of Town Square	2005	108,391	2,779	15	2,779		15,864	43
44	Fittings & Fixtures for Town Square	2005	83,613	7,458	15	8,361	903	48,076	44
45	New PT Room & Therapy Suites	2007	427,549	10,962	15	42,755	31,793	149,642	45
46	Metal Sidings to Roof Vents	2007	11,500		15	1,150	1,150	4,025	46
47	Construction - Alzheimers Unit	2008	379,716	9,736	15	37,972	28,236	91,766	47
48	2-Insulated Hotwater Tanks (175 Gal)	2009	12,058	309	15	1,206	897	2,412	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)		\$ 8,540,025	\$ 240,931		\$ 418,397	\$ 177,466	\$ 5,319,249	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	\$ 432,679	\$ 41,342	\$ 60,158	\$ 18,816	10	\$ 231,604	71
72	Current Year Purchases	179,295	114,248	26,762	(87,486)	10	26,762	72
73	Fully Depreciated Assets	897,827	683	2,890	2,207	10	897,827	73
74	*Lancaster Allocation*		3,803	3,803			19,900	74
75	TOTALS	\$ 1,509,801	\$ 160,076	\$ 93,613	\$ (66,463)		\$ 1,176,093	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)	\$ 10,879,826	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 401,007	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 512,010	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 111,003	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,495,342	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		***Off-site Public Storage Space***		3,516			5
6		***Off-site Vehicle Parking Space***		13,500			6
7	TOTAL			\$ 17,016			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: None

(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>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 422,137	\$		\$ 422,137	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			144,812			144,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			489,535			489,535	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs							8
9	Pharmacy	39-2	# of prescripts				369,191		369,191	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					53,667		53,667	12
13	Other (specify): <u>***Bed Rentals***</u>	39-2					49,361		49,361	13
14	<b>TOTAL</b>			\$		\$ 1,056,484	\$ 472,219		\$ 1,528,703	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-2010**

Ending:

**31-Dec-2010****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **31-Dec-2010**

(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	\$ 259,273	\$ 2,384,260	1
2	Cash-Patient Deposits	33,618	33,618	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,460,774	1,460,774	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,552	34,552	6
7	Other Prepaid Expenses	6,100	458,403	7
8	Accounts Receivable (owners or related parties)	3,098,228	3,098,228	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,892,545	\$ 7,469,835	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	1,968,563	4,856,292	15
16	Equipment, at Historical Cost	1,139,968	1,475,849	16
17	Accumulated Depreciation (book methods)	(2,104,513)	(4,965,023)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		276,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(262,380)	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>	\$ 1,004,018	\$ 5,796,935	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,896,563	\$ 13,266,770	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 340,099	\$ 340,099	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,618	33,618	28
29	Short-Term Notes Payable	5,363	128,353	29
30	Accrued Salaries Payable	875,793	875,793	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,656	33,656	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,000	90,000	32
33	Accrued Interest Payable		31,392	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>	\$ 1,378,529	\$ 1,532,911	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,400,000	2,400,000	39
40	Mortgage Payable		7,336,475	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	\$ 9,736,475	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,778,529	\$ 11,269,386	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,118,034	\$ 1,997,384	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,896,563	\$ 13,266,770	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>418,230</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustment for State Replacement tax 2009</b>	<b>(6,376)</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>411,854</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,203,180</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock	<b>502,000</b>	<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Capital Stock</b>	<b>1,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,706,180</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>2,118,034</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>(381,186)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustment for State Replacement tax 2009</b>	<b>(6,376)</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>(387,562)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,381,946</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock	<b>502,000</b>	<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>(500,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Capital Stock</b>	<b>1,000</b>	<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>2,384,946</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>1,997,384</b>	<b>24</b> *

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

**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	\$ 13,781,732	1
2	Discounts and Allowances for all Levels	(3,477,923)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,303,809</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,485,656	6
7	Oxygen	16,566	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,502,222</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,808	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	392,636	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,442	19
20	Radiology and X-Ray	38,114	20
21	Other Medical Services	100,015	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 560,015</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13,489	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 13,489</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>**Vending Commissions**</b>	2,200	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 2,200</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,381,735</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,099,595	31
32	Health Care	4,645,766	32
33	General Administration	1,433,374	33
<b>B. Capital Expense</b>			
34	Ownership	2,385,707	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,528,703	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>\$ 12,178,555</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,203,180</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,203,180</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? Yes If not, please attach a reconciliation.

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

\*\*Offset on pg 5 & 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-2010**

Ending:

**31-Dec-2010**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,045	2,206	\$ 104,702	\$ 47.46	1
2	Assistant Director of Nursing	1,929	2,102	75,130	35.74	2
3	Registered Nurses	56,367	61,788	1,766,991	28.60	3
4	Licensed Practical Nurses	6,505	6,774	146,117	21.57	4
5	CNAs & Orderlies	111,500	121,473	1,571,910	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	1,966	27,835	14.16	9
10	Activity Assistants	10,324	11,244	133,884	11.91	10
11	Social Service Workers	11,501	12,356	206,028	16.67	11
12	Dietician					12
13	Food Service Supervisor	3,730	4,260	88,335	20.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,747	34,739	395,205	11.38	15
16	Dishwashers					16
17	Maintenance Workers	3,883	4,258	74,223	17.43	17
18	Housekeepers	32,194	36,156	446,528	12.35	18
19	Laundry	10,902	12,213	151,047	12.37	19
20	Administrator	1,845	2,182	106,053	48.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,713	11,882	162,601	13.68	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	1,871	2,094	41,670	19.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	298,965	327,693	\$ 5,498,259 *	\$ 16.78	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	436	\$ 14,389	1-3	35
36	Medical Director	1,450	54,625	9-3	36
37	Medical Records Consultant	165	4,416	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	635	20,350	10-3	39
40	Physical Therapy Consultant	362	11,892	10a-3	40
41	Occupational Therapy Consultant	481	13,191	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	358	11,114	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	160	4,823	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,047	\$ 134,800		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,325	\$ 35,775	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,325	\$ 35,775		53



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

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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	Painting & Decorating	2010	2,720	3				454	906	906	454													
5																								
6																								
7																								
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20	<b>TOTALS</b>		\$ 7,492		\$	\$ 333	\$ 1,416	\$ 2,045	\$ 2,163	\$ 1,081	\$ 454	\$												

