



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 9/23/2015

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>156</u>	Skilled (SNF)	<u>154</u>	<u>56,740</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>154</u>	<u>56,740</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>730</u>	<u>355</u>	<u>13,603</u>	<u>14,688</u>	8
9	SNF/PED					9
10	ICF	<u>10,821</u>	<u>10,094</u>	<u>32</u>	<u>20,947</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,551</u>	<u>10,449</u>	<u>13,635</u>	<u>35,635</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.80%

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 9/7/1988

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/26/1988 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 154 and days of care provided 12,274

Medicare Intermediary CGS Administrators LLC

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name &amp; ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	483,309	133,926	32,455	649,690		649,690		649,690		1
2	Food Purchase		251,082		251,082		251,082	(1,833)	249,249		2
3	Housekeeping	481,732	66,641		548,373		548,373		548,373		3
4	Laundry	114,879	25,344		140,223		140,223		140,223		4
5	Heat and Other Utilities			197,059	197,059		197,059	(9,272)	187,787		5
6	Maintenance	84,913	137	291,888	376,938		376,938	(1,398)	375,540		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,164,833</b>	<b>477,130</b>	<b>521,402</b>	<b>2,163,365</b>		<b>2,163,365</b>	<b>(12,503)</b>	<b>2,150,862</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,707,854	269,977	16,746	3,994,577		3,994,577		3,994,577		10
10a	Therapy	215,109			215,109		215,109		215,109		10a
11	Activities	68,082	57,263	2,668	128,013		128,013		128,013		11
12	Social Services	106,207	30,064	5,090	141,361		141,361		141,361		12
13	CNA Training										13
14	Program Transportation			7,387	7,387		7,387		7,387		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>4,097,252</b>	<b>357,304</b>	<b>61,891</b>	<b>4,516,447</b>		<b>4,516,447</b>		<b>4,516,447</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	79,431		752,760	832,191		832,191	(395,343)	436,848		17
18	Directors Fees										18
19	Professional Services			55,790	55,790		55,790	2,932	58,722		19
20	Dues, Fees, Subscriptions & Promotions			91,036	91,036		91,036	(58,727)	32,309		20
21	Clerical & General Office Expenses	264,260	79,108	309,407	652,775		652,775	(10,271)	642,504		21
22	Employee Benefits & Payroll Taxes			1,027,645	1,027,645		1,027,645		1,027,645		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,467	4,467		4,467	12,500	16,967		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			137,098	137,098		137,098	544	137,642		26
27	Other (specify):*							59,410	59,410		27
28	<b>TOTAL General Administration</b>	<b>343,691</b>	<b>79,108</b>	<b>2,378,203</b>	<b>2,801,002</b>		<b>2,801,002</b>	<b>(388,955)</b>	<b>2,412,047</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,605,776</b>	<b>913,542</b>	<b>2,961,496</b>	<b>9,480,814</b>		<b>9,480,814</b>	<b>(401,458)</b>	<b>9,079,356</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oakbrook Healthcare Centre

#0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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			102,500	102,500		102,500	439,041	541,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,448	201,448		201,448	245,886	447,334			32
33	Real Estate Taxes			109,962	109,962		109,962		109,962			33
34	Rent-Facility & Grounds			1,830,050	1,830,050		1,830,050	(1,830,050)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,243,960	2,243,960		2,243,960	(1,145,123)	1,098,837			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		742,465	1,359,002	2,101,467		2,101,467		2,101,467			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,763	226,763		226,763		226,763			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		742,465	1,585,765	2,328,230		2,328,230		2,328,230			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,605,776	1,656,007	6,791,221	14,053,004		14,053,004	(1,546,581)	12,506,423			45

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

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

# **0034694**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	(9,272)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(108,862)	30		9
10	Interest and Other Investment Income	(1,738)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(733)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,976)	21		24
25	Fund Raising, Advertising and Promotional	(60,410)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(174,854)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (501,845)		\$	30

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

		1	2	
		<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)	(1,044,736)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,044,736)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,546,581)		37

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

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

		1	2	3	4	
		<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>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Commissions	\$ (1,100)	02	1
2	Bank Charges	(3,612)	21	2
3	Legal Fees - Collections	(11,964)	21	3
4	Deferred Maintenance Costs (allocated for 2014)	1,701	06	4
5	Building Co - License and Fees	(250)	20	5
6	Building Co - Accounting Fees	(1,800)	19	6
7	Additional R&M	3,814	06	7
8	Capitalized R&M	(19,125)	06	8
9	Marketing Expenses	(108,322)	43	9
10	Building Co - Capitalized R&M	(34,196)	06	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>	(174,854)		49

Oakbrook Healthcare Centre

Report Period Beginning:                     ID#                    0034694                      
 Ending:   01/01/15                      
  12/31/15                    

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

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													1
2	Food Purchase	(1,833)											(1,833)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,272)											(9,272)	5
6	Maintenance	(47,806)	45,807	601									(1,398)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(58,911)</b>	<b>45,807</b>	<b>601</b>									<b>(12,503)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(395,343)									(395,343)	17
18	Directors Fees													18
19	Professional Services	(1,800)	1,800	2,932									2,932	19
20	Fees, Subscriptions & Promotions	(60,660)	250	1,683									(58,727)	20
21	Clerical & General Office Expenses	(161,552)		151,281									(10,271)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			12,500									12,500	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			544									544	26
27	Other (specify):*			59,410									59,410	27
28	<b>TOTAL General Administration</b>	<b>(224,012)</b>	<b>2,050</b>	<b>(166,993)</b>									<b>(388,955)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(282,923)</b>	<b>47,857</b>	<b>(166,392)</b>									<b>(401,458)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	(108,862)	544,293	3,610									439,041	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,738)	209,717	37,907									245,886	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,830,050)										(1,830,050)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(110,600)</b>	<b>(1,076,040)</b>	<b>41,517</b>									<b>(1,145,123)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(108,322)		108,322										43
44	<b>TOTAL Special Cost Centers</b>	<b>(108,322)</b>		<b>108,322</b>										<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(501,845)</b>	<b>(1,028,183)</b>	<b>(16,553)</b>									<b>(1,546,581)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,830,050	Oak Brook Associates Property LLC	100.00%	\$	(1,830,050)	1
2	V	32 Interest		Oak Brook Associates Property LLC	100.00%	209,717	209,717	2
3	V	30 Depreciation		Oak Brook Associates Property LLC	100.00%	544,293	544,293	3
4	V	06 Maintenance		Oak Brook Associates Property LLC	100.00%	45,807	45,807	4
5	V	20 License and Fees		Oak Brook Associates Property LLC	100.00%	250	250	5
6	V	19 Accounting Fees		Oak Brook Associates Property LLC	100.00%	1,800	1,800	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,830,050			\$ 801,867	\$ * (1,028,183)	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	19 Professional Services	\$	Lancaster, LTD	100.00%	\$ 2,932	\$ 2,932
16	V	21 Clerical Expenditures		Lancaster, LTD	100.00%	151,281	151,281
17	V	27 Employee Benefits		Lancaster, LTD	100.00%	12,723	12,723
18	V	24 Seminar and Travel		Lancaster, LTD	100.00%	10,683	10,683
19	V	17 Administrative Consulting		Lancaster, LTD	100.00%	237,970	237,970
20	V	43 Marketing Fees		Lancaster, LTD	100.00%	108,322	108,322
21	V	20 Dues, Fees and Subscriptions		Lancaster, LTD	100.00%	1,683	1,683
22	V	30 Depreciation		Lancaster, LTD	100.00%	3,610	3,610
23	V	06 Repairs and Maintenance		Lancaster, LTD	100.00%	601	601
24	V	27 Payroll Taxes		Lancaster, LTD	100.00%	39,618	39,618
25	V	32 Interest		Lancaster, LTD	100.00%	37,907	37,907
26	V	24 Education		Lancaster, LTD	100.00%	1,817	1,817
27	V	26 Insurance		Lancaster, LTD	100.00%	544	544
28	V						
29	V	17 Officer's Salaries		Lancaster, LTD	100.00%	119,447	119,447
30	V	27 Payroll Taxes - Officers		Lancaster, LTD	100.00%	7,069	7,069
31	V	17 Management Fees	752,760	Lancaster, LTD	100.00%		(752,760)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 752,760			\$ 736,207	\$ * (16,553)

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	<b>Total</b>		\$ 0			\$	\$	0 *	0 39

\* 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		\$			\$	\$	0	15	
16	V							0	16	
17	V							0	17	
18	V							0	18	
19	V							0	19	
20	V							0	20	
21	V							0	21	
22	V							0	22	
23	V							0	23	
24	V							0	24	
25	V							0	25	
26	V							0	26	
27	V							0	27	
28	V							0	28	
29	V							0	29	
30	V							0	30	
31	V							0	31	
32	V							0	32	
33	V							0	33	
34	V							0	34	
35	V							0	35	
36	V							0	36	
37	V							0	37	
38	V							0	38	
39	<b>Total</b>		\$ 0			\$	0	\$ *	0	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:				
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
15	V		\$				\$	0	15		
16	V							0	16		
17	V							0	17		
18	V							0	18		
19	V							0	19		
20	V							0	20		
21	V							0	21		
22	V							0	22		
23	V							0	23		
24	V							0	24		
25	V							0	25		
26	V							0	26		
27	V							0	27		
28	V							0	28		
29	V							0	29		
30	V							0	30		
31	V							0	31		
32	V							0	32		
33	V							0	33		
34	V							0	34		
35	V							0	35		
36	V							0	36		
37	V							0	37		
38	V							0	38		
39	<b>Total</b>		\$ 0				\$	0	\$ *	0	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:				
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
15	V		\$				\$	0	15		
16	V							0	16		
17	V							0	17		
18	V							0	18		
19	V							0	19		
20	V							0	20		
21	V							0	21		
22	V							0	22		
23	V							0	23		
24	V							0	24		
25	V							0	25		
26	V							0	26		
27	V							0	27		
28	V							0	28		
29	V							0	29		
30	V							0	30		
31	V							0	31		
32	V							0	32		
33	V							0	33		
34	V							0	34		
35	V							0	35		
36	V							0	36		
37	V							0	37		
38	V							0	38		
39	<b>Total</b>		\$ 0				\$	0	\$ *	0	39

\* 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

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		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
15	V		\$				\$	0	15		
16	V							0	16		
17	V							0	17		
18	V							0	18		
19	V							0	19		
20	V							0	20		
21	V							0	21		
22	V							0	22		
23	V							0	23		
24	V							0	24		
25	V							0	25		
26	V							0	26		
27	V							0	27		
28	V							0	28		
29	V							0	29		
30	V							0	30		
31	V							0	31		
32	V							0	32		
33	V							0	33		
34	V							0	34		
35	V							0	35		
36	V							0	36		
37	V							0	37		
38	V							0	38		
39	<b>Total</b>		\$ 0				\$	0	\$ *	0	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:				
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
15	V		\$				\$	0	15		
16	V							0	16		
17	V							0	17		
18	V							0	18		
19	V							0	19		
20	V							0	20		
21	V							0	21		
22	V							0	22		
23	V							0	23		
24	V							0	24		
25	V							0	25		
26	V							0	26		
27	V							0	27		
28	V							0	28		
29	V							0	29		
30	V							0	30		
31	V							0	31		
32	V							0	32		
33	V							0	33		
34	V							0	34		
35	V							0	35		
36	V							0	36		
37	V							0	37		
38	V							0	38		
39	<b>Total</b>		\$ 0				\$	0	\$ *	0	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:				
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)				
15	V		\$				\$	0	15		
16	V							0	16		
17	V							0	17		
18	V							0	18		
19	V							0	19		
20	V							0	20		
21	V							0	21		
22	V							0	22		
23	V							0	23		
24	V							0	24		
25	V							0	25		
26	V							0	26		
27	V							0	27		
28	V							0	28		
29	V							0	29		
30	V							0	30		
31	V							0	31		
32	V							0	32		
33	V							0	33		
34	V							0	34		
35	V							0	35		
36	V							0	36		
37	V							0	37		
38	V							0	38		
39	<b>Total</b>		\$ 0				\$	0	\$ *	0	39

\* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	<b>Total</b>		\$ 0			\$	\$	0 *	0 39

\* 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:

01/01/15

Ending:

12/31/15

## 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	5.00%	See Attached	16.00	33.33%	Alloc. Salary	\$ 66,668	17-7	1	
2	Cheryl Morris	VP-Operations	Administrative	5.00%	See Attached	16.00	33.33%	Alloc. Salary	52,779	17-7	2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 119,447		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:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	3	\$ 200,004	\$ 200,004	16	\$ 66,668	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	3	10,918		16	3,639	2
3	17	Cheryl Morris	Hours Worked	48	3	158,337	158,337	16	52,779	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	3	10,291		16	3,430	4
5										5
6	19	Professional Services	Census Days	118,590	3	9,757		35,635	2,932	6
7	21	Clerical Expenditures	Census Days	118,590	3	503,450	440,712	35,635	151,281	7
8	27	Employee Benefits	Census Days	118,590	3	42,342		35,635	12,723	8
9	24	Seminar and Travel	Census Days	118,590	3	35,553		35,635	10,683	9
10	17	Administrative Consulting	Census Days	118,590	3	791,941	791,941	35,635	237,970	10
11	43	Marketing Fees	Census Days	118,590	3	360,485	331,141	35,635	108,322	11
12	20	Dues, Fees and Subscriptions	Census Days	118,590	3	5,601		35,635	1,683	12
13	30	Depreciation	Census Days	118,590	3	12,013		35,635	3,610	13
14	06	Repairs and Maintenance	Census Days	118,590	3	1,999		35,635	601	14
15	27	Payroll Taxes	Census Days	118,590	3	131,845		35,635	39,618	15
16	32	Interest	Census Days	118,590	3	126,152		35,635	37,907	16
17	24	Education	Census Days	118,590	3	6,047		35,635	1,817	17
18	26	Insurance	Census Days	118,590	3	1,812		35,635	544	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,408,547	\$ 1,922,135		\$ 736,207	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$			0	1		
2								0	2		
3								0	3		
4								0	4		
5								0	5		
6								0	6		
7								0	7		
8								0	8		
9								0	9		
10								0	10		
11								0	11		
12								0	12		
13								0	13		
14								0	14		
15								0	15		
16								0	16		
17								0	17		
18								0	18		
19								0	19		
20								0	20		
21								0	21		
22								0	22		
23								0	23		
24								0	24		
25	<b>TOTALS</b>				\$	0	\$	0	\$	0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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Street Address \_\_\_\_\_

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1	2	3	4	5	6	7	8	9	
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1					\$			0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	<b>TOTALS</b>				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

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**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	<b>TOTALS</b>				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694 Report Period Beginning: 01/01/15 Ending: 12/31/15

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_) \_\_\_\_\_

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending: 12/31/15

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$			0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	Harston Investment		X	Long Term Loan			\$	\$ 3,450,000		\$ 201,448	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6	Shareholder Loan		X					2,800,000		209,717	6								
7	Allocated from Lancaster LTD		X							37,907	7								
8											8								
9	<b>TOTAL Facility Related</b>					\$	\$ 6,250,000			\$ 449,072	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(1,738)	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (1,738)	14								
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 6,250,000			\$ 447,334	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* 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.)

Facility Name & ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>																		
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>																		
	<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>																		

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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 2014 report.		\$	<b>110,000</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>108,962</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,038)</b>		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>111,000</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>109,962</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>90,148</u>		8	
	2011	<u>97,072</u>		9	
	2012	<u>103,189</u>		10	
	2013	<u>106,662</u>		11	
	2014	<u>108,962</u>		12	
<b>2015 Accrual: \$108,962 x 1.02 = \$111,000 (Rounded)</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		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.**





**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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1988</u>	<u>\$ 830,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 830,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	154	1988	1976	\$ 3,586,000	\$ 544,293	35	\$ 102,457	\$ (441,836)	\$ 3,075,849	4
5		1994	1994	25,000		35	714	714	15,651	5
6		1992	1992	1,863,459		20	93,173	93,173	1,268,931	6
7										7
8										8
<b>Improvement Type**</b>										
9	Various	1988		8,828		20			8,828	9
10	Various	1989		92,298		20	29	29	92,298	10
11	Various	1990		24,448		20	52	52	24,448	11
12	Various	1991		2,212		20			2,212	12
13	Various	1992		1,275,149		20			1,275,149	13
14	Various	1993		289,021		20			289,021	14
15	Various	1994		10,459		20			10,459	15
16	Various	1995		52,918		20	923	923	49,115	16
17	Various	1996		28,192		20	1,409	1,409	27,386	17
18	Various	1997		73,030		20	3,652	3,652	68,302	18
19	Various	1998		20,335		20	1,017	1,017	17,688	19
20	Various	1999		69,554		20	3,477	3,477	57,651	20
21	Various	2001		44,318		20	691	691	27,383	21
22	Various	2002		2,340		20	117	117	1,599	22
23	Various	2003		10,250		20	683	683	8,312	23
24	Various	2005		201,387		20	3,484	3,484	122,756	24
25	Various	2007		426,299		20	43,905	43,905	373,192	25
26	Various	2008		340,022		20	37,972	37,972	281,624	26
27	Various	2009		12,058		20	1,206	1,206	8,442	27
28	Various	2011		48,890		20	8,147	8,147	36,000	28
29										29
30										30
31										31
32										32
33										33
34										34
35										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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		754,001			38,285	38,285	38,285	67
68								68
69			102,500			(102,500)		69
70		\$ 9,260,468	\$ 646,793		\$ 341,393	\$ (305,400)	\$ 7,180,581	70

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

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,260,468	\$ 646,793		\$ 341,393	\$ (305,400)	\$ 7,180,581	1
2	Concrete Slab & Drainage Pipes In Bath	2012	6,480		20	648	648	2,538	2
3	Renovation - 6 Resident Rooms - Preconstruction (Demolition)	2012	1,600		20	160	160	627	3
4	6 Resident Rooms-Framing & Installing Drywalls & Door Frames	2012	4,100		20	410	410	1,606	4
5	6 Resident Rooms-Install Drop Ceiling, Doors & Drywall Painting	2012	2,500		20	250	250	979	5
6	Related Electrical Work In 6 Renovated Resident Rooms	2012	1,540		20	308	308	1,206	6
7	Carpet In Corridor Including Design Fee	2012	14,082		20	2,816	2,816	10,560	7
8	Electric Work At Nurses Station	2012	6,857		20	1,371	1,371	4,799	8
9	27 Pcs Heating / Cooling Wall Units For Rooms	2012	21,700		20	4,340	4,340	15,190	9
10	5 Resident Rms-Laying Vinyl Wood Plank Flooring & Cove	2012	4,969		20	497	497	1,657	10
11	Renovating 5 Resident Rooms-Light Fixtures Hanging Style	2012	603		20	60	60	200	11
12	Built In Wardrobes With Drawers & Shelves-5 Resident Rooms	2012	4,026		20	402	402	1,340	12
13	Window Treatment, Faux Wood Blinds & Artwork-5 Resident Rm	2012	2,765		20	277	277	923	13
14	Fire Equipment & Sprinklers For All Rooms	2012	62,602		20	6,260	6,260	19,823	14
15	Vinyl Flooring At Elevator Lobby	2012	4,984		20	997	997	3,240	15
16	Patient Hoyer Lift Affixed To Ceiling	2012	6,280		20	1,256	1,256	4,187	16
17	16 Dtv Receivers/Modulators/Switches & Dish Antenna	2012	5,036		20	1,007	1,007	3,944	17
18	Light Fixtures For New Dining Room	2012	3,349		20	335	335	1,061	18
19	Vinyl Floor,Cove Bases,Crown Molding,Cabinets - Dining Room	2012	77,676		20	15,535	15,535	49,194	19
20	New Ceiling, Molding, Doors & Wall Finish - 13 Resident Rooms	2013	121,550		20	12,155	12,155	31,400	20
21	Vinyl Flooring & Cove Bases For 13 Resident Rooms	2013	16,483		20	3,297	3,297	8,517	21
22	Wardrobes, Nightstands & Fixtures For 13 Resident Rooms	2013	17,527		20	3,505	3,505	9,055	22
23	Overbed Light Fixtures & Blinds For 13 Resident Rooms	2013	11,954		20	2,391	2,391	6,177	23
24	Demolish Walls, Tiles, Ceilings, Fixtures - 13 Resident Rooms	2013	110,445		20	11,045	11,045	28,533	24
25	New Fixtures / Fittings / Tiles - 13 Baths With Resident Rooms	2013	13,275		20	1,328	1,328	3,430	25
26	Remove Wall, Ceiling-Add New Ceiling, Wall, Fixtures-Rm #204	2013	12,629		20	1,263	1,263	3,266	26
27	Remove Old-Install New Fittings, Tiles, Mirror-Bathroom Of #204	2013	6,408		20	641	641	1,652	27
28	Vinyl Flooring, Cove Base, Overbed Light Fixture-Room #204	2013	1,567		20	313	313	809	28
29	Window Treatments For Room #204	2013	1,000		20	200	200	517	29
30	Ceiling Mounted Patient Hoyer Lift	2013	6,280		20	1,256	1,256	3,663	30
31	Sprinkler System In 10 Resident Rooms	2013	8,614		20	861	861	2,368	31
32	25 Camera Cctv Security System With Dvr Around Facility	2013	11,000		20	2,200	2,200	5,500	32
33	Tiles, Wallpaper, Cove, Mirror, Fixtures For 2 Public Bathrooms	2013	5,943		20	594	594	1,436	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,836,292	\$ 646,793		\$ 419,371	\$ (227,422)	\$ 7,409,978	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 9,836,292	\$ 646,793		\$ 419,371	\$ (227,422)	\$ 7,409,978		1
2	Quartz Top, Wall Unit & Attached Desk For Nurses Station	2014 3,572		20	714	714	1,309		2
3	Wall Mounted Pantry & Trim Attached To Nurses Station	2014 4,178		20	836	836	1,532		3
4	Dining Room Base Cabinets With Quartz Top At Nurses Station	2014 12,555		20	2,511	2,511	4,604		4
5	Cylinder Replacement For Elevator System	2014 20,523		20	2,052	2,052	3,762		5
6	14 Unit Audible & Visual Nurses Call Station	2014 29,750		20	5,950	5,950	10,413		6
7	Vinyl Floor & Coves For 6 Resident Rooms	2014 9,052		20	1,810	1,810	2,112		7
8	Fixtures, Wallpaper, Artwork For 6 Resident Rooms	2014 9,307		20	1,861	1,861	2,171		8
9	Window Treatments, Blinds & Panels For 6 Resident Rooms	2014 6,346		20	1,269	1,269	1,481		9
10	Vanity Lights, Mirrors, Shelves For Baths In 6 Resident Rooms	2014 3,030		20	606	606	707		10
11	Repair Walk In Freezer	2015 3,871		20	194	194	194		11
12	Boiler Repair	2015 2,629		20	131	131	131		12
13	Replace Water Heater	2015 10,056		20	503	503	503		13
14	Repaired Wiring For Phone System	2015 2,569		20	128	128	128		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	<b>TOTAL (lines 1 thru 33)</b>	\$ 9,953,730	\$ 646,793		\$ 437,938	\$ (208,855)	\$ 7,439,027		34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,953,730	\$ 646,793		\$ 437,938	\$ (208,855)	\$ 7,439,027	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 9,953,730	\$ 646,793		\$ 437,938	\$ (208,855)	\$ 7,439,027	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 9,953,730	\$ 646,793		\$ 437,938	\$ (208,855)	\$ 7,439,027	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 9,953,730	\$ 646,793		\$ 437,938	\$ (208,855)	\$ 7,439,027	34

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

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>PT Gym - Demolition, Plumbing, Electrical, Sprinkler, Drywall</b>	2015	105,800		20	5,290	5,290	5,290	9
10	<b>3 Gardenview Room - Demolition, Plumbing, Electrical, Sprinkler</b>	2015	81,700		20	4,085	4,085	4,085	10
11	<b>4 Resid Rm - 2 New bathrooms, Electrical, Sprinkler, Drywall</b>	2015	98,000		20	4,900	4,900	4,900	11
12	<b>2 Resid Rm - Shower, Framing, Electrical, Plumbing, Flooring</b>	2015	51,300		20	2,565	2,565	2,565	12
13	<b>3 Resid Rm - Shower, Electric, Plumbing, Flooring</b>	2015	76,950		20	3,848	3,848	3,848	13
14	<b>Front Entry Drive - Parking Lot Repair, Asphalt, Curbs</b>	2015	123,382		20	6,169	6,169	6,169	14
15	<b>3 Resid Rm - Plumbing, Electrical, Sprinklers and Drywall</b>	2015	62,322		20	3,116	3,116	3,116	15
16	<b>6 Resid Rm - Dividers, Wallpaper, Cove Base, and Lighting</b>	2015	13,753		20	688	688	688	16
17	<b>7 Resid Rms - Flooring, Cove Base, Wallpaper, Lightings, Tiling</b>	2015	47,384		20	2,369	2,369	2,369	17
18	<b>Physical Therapy Room - Flooring, Cove Base, Carpeting</b>	2015	23,355		20	1,168	1,168	1,168	18
19	<b>Front Offices - Carpeting and Window Treatments</b>	2015	10,023		20	501	501	501	19
20	<b>6 Resid Rm - Flooring, Cove Base, Lighting, Tiling</b>	2015	25,836		20	1,292	1,292	1,292	20
21	<b>Office - Installed New Wall, Electrical Outlets, Fixtures, Patch/Pai</b>	2015	5,850		20	293	293	293	21
22	<b>PT Room - Installed Divider and Permit Fee</b>	2015	4,446		20	222	222	222	22
23	<b>Offices - Installed and Painted Crown Moulding/Curtains</b>	2015	2,600		20	130	130	130	23
24	<b>Dining Room and PT Room - New Windows with Awning</b>	2015	16,500		20	825	825	825	24
25	<b>3 Offices - Paint/Installed New Carpet/Base Moulding</b>	2015	4,800		20	825	825	825	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 754,001	\$		\$ 38,285	\$ 38,285	\$ 38,285	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 754,001	\$		\$ 38,285	\$ 38,285	\$ 38,285	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 754,001	\$		\$ 38,285	\$ 38,285	\$ 38,285	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 471,394	\$ 3,610	\$ 78,577	\$ 74,967	10	\$ 380,041	71
72	Current Year Purchases	250,258		25,026	25,026	10	25,026	72
73	Fully Depreciated Assets	1,342,382				10	1,342,382	73
74								74
75	TOTALS	\$ 2,064,034	\$ 3,610	\$ 103,603	\$ 99,993		\$ 1,747,449	75

D. Vehicle Costs. (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)	\$ 12,847,764	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 650,403	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 541,541	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (108,862)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,186,476	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	Building - step up - 2015	\$ 1,159,367	\$	\$	86
87	Land - step up - 2015	212,090			87
88					88
89					89
90					90
91	TOTALS	\$ 1,371,457	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 55,000	92
93			93
94			94
95		\$ 55,000	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		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								5
6								6
7	TOTAL				\$			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. 2016 \$ \_\_\_\_\_

13. 2017 \$ \_\_\_\_\_

14. 2018 \$ \_\_\_\_\_

\* 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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 571,691	\$		\$ 571,691	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			114,252			114,252	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			647,792			647,792	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				670,299		670,299	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					25,267	72,166		97,433	13
14	TOTAL			\$		\$ 1,359,002	\$ 742,465		\$ 2,101,467	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: **01/01/15**Ending: **12/31/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,621,130	2,621,130	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	97,852	97,852	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	100,000	100,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,818,982	\$ 2,818,982	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,042,090	13
14	Buildings, at Historical Cost		4,745,367	14
15	Leasehold Improvements, at Historical Cost	2,324,690	6,399,433	15
16	Equipment, at Historical Cost	1,316,183	1,883,975	16
17	Accumulated Depreciation (book methods)	(3,054,661)	(8,548,815)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		55,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 586,212	\$ 5,577,050	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,405,194	\$ 8,396,032	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 795,755	\$ 840,643	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,182	25,182	28
29	Short-Term Notes Payable		2,800,000	29
30	Accrued Salaries Payable	732,816	732,816	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,041	16,041	31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,000	111,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	1,115,862		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,796,656	\$ 4,525,682	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,450,000	3,450,000	39
40	Mortgage Payable			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>	\$ 3,450,000	\$ 3,450,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,246,656	\$ 7,975,682	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,841,462)	\$ 420,350	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,405,194	\$ 8,396,032	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>(1,173,095)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</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>(1,173,094)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>(1,668,368)</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>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>(1,668,368)</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>(2,841,462)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning: 01/01/15

Ending:

12/31/15

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 14,347,137	1
2	Discounts and Allowances for all Levels	(6,209,351)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,137,786	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,426,810	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,426,810	8
<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	696,413	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,096	19
20	Radiology and X-Ray	50,148	20
21	Other Medical Services	50,230	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 808,887	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,738	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,738	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	9,415	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,415	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,384,636	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,163,365	31
32	Health Care	4,516,447	32
33	General Administration	2,801,002	33
<b>B. Capital Expense</b>			
34	Ownership	2,243,960	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,101,467	35
36	Provider Participation Fee	226,763	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,053,004	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,668,368)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,668,368)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,909,512	44
45	Private Pay - Net Inpatient Revenue	2,717,032	45
46	Medicare - Net Inpatient Revenue	3,010,824	46
47	Other-(specify) <u>Insurance</u>	500,418	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,137,786	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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

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

# **0034694**

Report Period Beginning:

**01/01/15**

Ending:

**12/31/15**

**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	1,941	2,660	\$ 128,400	\$ 48.27	1
2	Assistant Director of Nursing	1,813	2,099	83,010	39.55	2
3	Registered Nurses	53,472	60,030	1,693,188	28.21	3
4	Licensed Practical Nurses	22,115	24,313	535,286	22.02	4
5	CNAs & Orderlies	84,783	93,221	1,224,811	13.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,911	15,121	215,109	14.23	8
9	Activity Director	1,989	2,286	34,235	14.98	9
10	Activity Assistants	2,497	2,727	33,847	12.41	10
11	Social Service Workers	5,619	6,122	106,207	17.35	11
12	Dietician	1,989	2,086	49,567	23.76	12
13	Food Service Supervisor					13
14	Head Cook	5,215	6,158	99,309	16.13	14
15	Cook Helpers/Assistants	24,172	27,190	334,433	12.30	15
16	Dishwashers					16
17	Maintenance Workers	3,908	4,634	84,913	18.32	17
18	Housekeepers	29,101	34,229	481,732	14.07	18
19	Laundry	7,035	8,117	114,879	14.15	19
20	Administrator	1,891	2,126	79,431	37.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,675	4,514	115,398	25.56	23
24	Clerical	10,343	11,692	148,862	12.73	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	1,877	2,140	43,159	20.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	277,346	311,465	\$ 5,605,776 *	\$ 18.00	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	1,161	\$ 32,455	01-03	35
36	Medical Director	789	30,000	09-03	36
37	Medical Records Consultant	182	4,704	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	273	8,179	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	111	2,668	11-03	44
45	Social Service Consultant	170	5,090	12-03	45
46	Other(specify)				46
47	Dementia Consultant	Monthly	3,163	10-03	47
48	Infection Control Consultant	Per Visit	700	10-03	48
49	TOTAL (lines 35 - 48)	2,686	\$ 86,959		49

**C. CONTRACT NURSES**

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

**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		
Jina Lebert-Davies	Administrator	0.00%	\$ 79,431	Workers' Compensation Insurance	\$ 90,222	IDPH License Fee	\$ 11,990		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,603		
				FICA Taxes	428,842	Health Care Worker Background Check	923		
				Employee Health Insurance	468,236	(Indicate # of checks performed <u>23</u> )			
				Employee Meals		Patient Background Checks	695 6,280		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	5,178		
				Retirement Plan/Union Pension	27,753	License and Fees	4,652		
				Other Employee Benefits	12,592	Allocated from Lancaster LTD	1,683		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,431	TOTAL (agree to Schedule V, line 22, col.8)		\$ 32,310			
B. Administrative - Other							Less: Public Relations Expense ( )		
Description			Amount				Non-allowable advertising ( )		
Management Fees - Lancaster, LTD			\$ 752,760				Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 752,760	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services							Description		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount		
FR&R/Marcum LLP	Accounting		\$ 6,585				Out-of-State Travel \$		
Richard Peelo & Associates	Accounting		2,250						
Personnel Planners	Payroll Tax Consultant		1,265						
See Attached	Legal		2,568				In-State Travel		
Health Data Systems	Data Processing		9,203						
E-Health Solutions	Data Processing		33,919						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 55,790	TOTAL			\$	Seminar Expense 4,467	
								Allocated from Lancaster LTD 12,500	
								Entertainment Expense ( )	
								TOTAL (agree to Sch. V, line 24, col. 8) \$ 16,967	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	2013	\$ 5,103	3	\$	\$	\$	\$	\$	\$	\$ 1,701	\$ 1,701	\$ 1,701												
2																									
3																									
4																									
5																									
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20	<b>TOTALS</b>		\$ 5,103		\$	\$	\$	\$	\$	\$	\$ 1,701	\$ 1,701	\$ 1,701												

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

01/01/15

Ending:

12/31/15**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. \$ 36,492 Line 10-02
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 226,763  
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No 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? 100% Ln 14
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.