



Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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 N/A

	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	156	Skilled (SNF)	156	56,940	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	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	813	1,215	16,840	18,868	8
9	SNF/PED					9
10	ICF	7,734	8,639	852	17,225	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,547	9,854	17,692	36,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.39%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 156 and days of care provided 14,154

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 01/01/17 Ending: 12/31/17

**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	538,497	136,003	34,817	709,317		709,317		709,317		1
2	Food Purchase		259,343		259,343		259,343	(2,528)	256,815		2
3	Housekeeping	488,146	77,969		566,115		566,115		566,115		3
4	Laundry	126,278	38,758		165,036		165,036		165,036		4
5	Heat and Other Utilities			220,796	220,796		220,796	(9,457)	211,339		5
6	Maintenance	84,158	160	289,698	374,016		374,016	13,151	387,167		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,237,079	512,233	545,311	2,294,623		2,294,623	1,166	2,295,789		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	3,921,507	260,463	15,504	4,197,474		4,197,474		4,197,474		10
10a	Therapy	219,269	29,935		249,204		249,204		249,204		10a
11	Activities	124,419	54,508	448	179,375		179,375		179,375		11
12	Social Services	109,342		6,180	115,522		115,522		115,522		12
13	CNA Training										13
14	Program Transportation			10,415	10,415		10,415		10,415		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,374,537	344,906	62,547	4,781,990		4,781,990		4,781,990		16
	<b>C. General Administration</b>										
17	Administrative	94,386		605,000	699,386		699,386	(354,839)	344,547		17
18	Directors Fees										18
19	Professional Services			71,747	71,747		71,747	2,816	74,563		19
20	Dues, Fees, Subscriptions & Promotions			79,215	79,215		79,215	(33,360)	45,855		20
21	Clerical & General Office Expenses	326,172	17,274	900,654	1,244,100		1,244,100	(570,922)	673,178		21
22	Employee Benefits & Payroll Taxes			905,688	905,688		905,688		905,688		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,527	10,527		10,527	492	11,019		24
25	Other Admin. Staff Transportation			506	506		506		506		25
26	Insurance-Prop.Liab.Malpractice			108,704	108,704		108,704		108,704		26
27	Other (specify):*							64,260	64,260		27
28	<b>TOTAL General Administration</b>	420,558	17,274	2,682,041	3,119,873		3,119,873	(891,553)	2,228,320		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,032,174	874,413	3,289,899	10,196,486		10,196,486	(890,387)	9,306,099		29

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

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

Facility Name &amp; ID Number

Oakbrook Healthcare Centre

#0034694

Report Period Beginning:

01/01/17

Ending:

12/31/17

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			69,479	69,479		69,479	491,449	560,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			220,219	220,219		220,219	260,642	480,861			32
33	Real Estate Taxes			116,459	116,459		116,459		116,459			33
34	Rent-Facility & Grounds			938,002	938,002		938,002	(900,000)	38,002			34
35	Rent-Equipment & Vehicles			1,295	1,295		1,295		1,295			35
36	Other (specify):*							17,990	17,990			36
37	<b>TOTAL Ownership</b>			1,345,454	1,345,454		1,345,454	(129,919)	1,215,535			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		915,118	1,773,730	2,688,848		2,688,848		2,688,848			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,462	218,462		218,462		218,462			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		915,118	1,992,192	2,907,310		2,907,310		2,907,310			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,032,174	1,789,531	6,627,545	14,449,250		14,449,250	(1,020,306)	13,428,944			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	(9,457)	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	112,310	30		9
10	Interest and Other Investment Income	(6,663)	32		10
11	Discounts, Allowances, Rebates & Refunds	(723)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(705)	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	(55)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(718,758)	21		24
25	Fund Raising, Advertising and Promotional	(37,107)	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	(214,948)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (876,106)		\$	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)	(144,200)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (144,200)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,020,306)		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

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

Oakbrook Healthcare Centre

ID# 0034694

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Commissions	\$ (1,100)	02	1
2	Bank Charges	(5,768)	21	2
3	Theft and Damage Loss	(891)	21	3
4	Building Co - License and Fees	(250)	20	4
5	Building Co - Amortization	(938)	36	5
6	Building Co - Legal	(5,500)	19	6
7	Building Co - Accounting	(1,957)	19	7
8	Building Co - Income Tax	(4,562)	21	8
9	Marketing	(123,244)	43	9
10	Building Co - Capitalized R&M	(26,329)	06	10
11	Capitalized R&M	(33,398)	06	11
12	Non-Allowable Legal	(11,010)	19	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>	(214,948)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

01/01/17

Ending:

12/31/17**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	(2,528)											(2,528)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,457)											(9,457)	5
6	Maintenance	(59,727)	71,556	1,322									13,151	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(71,712)</b>	<b>71,556</b>	<b>1,322</b>									<b>1,166</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			(354,839)									(354,839)	17
18	Directors Fees													18
19	Professional Services	(18,467)	7,457	13,826									2,816	19
20	Fees, Subscriptions & Promotions	(37,412)	250	3,802									(33,360)	20
21	Clerical & General Office Expenses	(729,980)	4,562	154,496									(570,922)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			492									492	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			64,260									64,260	27
28	<b>TOTAL General Administration</b>	<b>(785,859)</b>	<b>12,269</b>	<b>(117,963)</b>									<b>(891,553)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(857,571)</b>	<b>83,825</b>	<b>(116,641)</b>									<b>(890,387)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakbrook Healthcare Centre # 0034694 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	112,310	375,995	3,144									491,449	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,663)	232,812	34,493									260,642	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(900,000)										(900,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(938)	18,928										17,990	36
37	<b>TOTAL Ownership</b>	<b>104,709</b>	<b>(272,265)</b>	<b>37,637</b>									<b>(129,919)</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):*	(123,244)		123,244										43
44	<b>TOTAL Special Cost Centers</b>	<b>(123,244)</b>		<b>123,244</b>										<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(876,106)</b>	<b>(188,440)</b>	<b>44,240</b>									<b>(1,020,306)</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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 900,000	Oak Brook Associates Property LLC	100.00%	\$	(900,000)	1
2	V	32 Interest	44	Oak Brook Associates Property LLC	100.00%	232,856	232,812	2
3	V	30 Depreciation		Oak Brook Associates Property LLC	100.00%	375,995	375,995	3
4	V	06 Repairs and Maintenance		Oak Brook Associates Property LLC	100.00%	71,556	71,556	4
5	V	20 License and Fees		Oak Brook Associates Property LLC	100.00%	250	250	5
6	V	36 Amortization of HUD Fees		Oak Brook Associates Property LLC	100.00%	938	938	6
7	V	19 Legal		Oak Brook Associates Property LLC	100.00%	5,500	5,500	7
8	V	19 Accounting		Oak Brook Associates Property LLC	100.00%	1,957	1,957	8
9	V	36 MIP Expense		Oak Brook Associates Property LLC	100.00%	17,990	17,990	9
10	V	21 Income Tax		Oak Brook Associates Property LLC	100.00%	4,562	4,562	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 900,044			\$ 711,604	\$ * (188,440)	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%	\$ 13,826	\$	13,826	15
16	V	21 Clerical Expenditures		Lancaster, LTD	100.00%	154,496		154,496	16
17	V	27 Employee Benefits		Lancaster, LTD	100.00%	24,951		24,951	17
18	V	24 Seminar and Travel		Lancaster, LTD	100.00%	492		492	18
19	V	17 Administrative Consulting		Lancaster, LTD	100.00%	175,161		175,161	19
20	V	43 Marketing Fees		Lancaster, LTD	100.00%	123,244		123,244	20
21	V	20 Dues, Fees and Subscriptions		Lancaster, LTD	100.00%	3,802		3,802	21
22	V	30 Depreciation		Lancaster, LTD	100.00%	3,144		3,144	22
23	V	06 Repairs and Maintenance		Lancaster, LTD	100.00%	1,322		1,322	23
24	V	27 Payroll Taxes		Lancaster, LTD	100.00%	35,311		35,311	24
25	V	32 Interest		Lancaster, LTD	100.00%	34,493		34,493	25
26	V								26
27	V	17 Officer's Salaries		Lancaster, LTD	100.00%	75,000		75,000	27
28	V	27 Payroll Taxes - Officers		Lancaster, LTD	100.00%	3,998		3,998	28
29	V	17 Management Fees	605,000	Lancaster, LTD	100.00%			(605,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 605,000			\$ 649,240	\$ *	44,240	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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:

01/01/17

Ending:

12/31/17

## 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	33.33%	Alloc. Salary	\$ 75,000	17-7	1	
2											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	\$ 75,000		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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

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	\$ 225,000	\$ 225,000	16	\$ 75,000	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	3	11,993		16	3,998	2
3										3
4	19	Professional Services	Census Days	125,568	3	48,101		36,093	13,826	4
5	21	Clerical Expenditures	Census Days	125,568	3	537,494	455,862	36,093	154,496	5
6	27	Employee Benefits	Census Days	125,568	3	86,804		36,093	24,951	6
7	24	Seminar and Travel	Census Days	125,568	3	1,710		36,093	492	7
8	17	Administrative Consulting	Census Days	125,568	3	609,388	596,661	36,093	175,161	8
9	43	Marketing Fees	Census Days	125,568	3	428,766	427,466	36,093	123,244	9
10	20	Dues, Fees and Subscriptions	Census Days	125,568	3	13,226		36,093	3,802	10
11	30	Depreciation	Census Days	125,568	3	10,939		36,093	3,144	11
12	06	Repairs and Maintenance	Census Days	125,568	3	4,600		36,093	1,322	12
13	27	Payroll Taxes	Census Days	125,568	3	122,847		36,093	35,311	13
14	32	Interest	Census Days	125,568	3	120,000		36,093	34,493	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,220,868	\$ 1,704,989		\$ 649,240	25

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/17

Ending: 12/31/17

**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
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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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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.

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:

01/01/17

Ending: 12/31/17

**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: 01/01/17 Ending: 12/31/17

**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:

01/01/17

Ending: 12/31/17

**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 &amp; ID Number

Oakbrook Healthcare Centre

# 0034694

Report Period Beginning:

01/01/17

Ending:

12/31/17

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	Harston Investment		X	Long Term Loan			\$	\$ 7,178,028			\$	42,539	1					
2													2					
3													3					
4													4					
5													5					
	<b>Working Capital</b>																	
6	Shareholder Loan		X					1,800,000				190,317	6					
7	Harston Investment		X									220,219	7					
8	See Supplemental Schedule											34,493	8					
9	<b>TOTAL Facility Related</b>						\$	\$ 8,978,028			\$	487,568	9					
	<b>B. Non-Facility Related*</b>																	
10	Interest Income		X									(6,663)	10					
11	Interest Income - Bldg Co		X									(44)	11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(6,707)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 8,978,028			\$	480,861	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 17,990 Line # 36

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

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2016 report.		\$	<b>115,000</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>114,459</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(541)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>117,000</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>116,459</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>103,189</b>	<b>8</b>
	<b>2013</b>	<b>106,662</b>	<b>9</b>
	<b>2014</b>	<b>108,962</b>	<b>10</b>
	<b>2015</b>	<b>112,342</b>	<b>11</b>
	<b>2016</b>	<b>114,459</b>	<b>12</b>

**2017 Accrual: \$114,459 x 1.02 = \$117,000 (Rounded)**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:

01/01/17

Ending:

12/31/17

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 830,000	1
2					2
3	TOTALS			\$ 830,000	3

**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	156	1988	1976	\$ 3,586,000	\$ 375,995	35	\$ 102,457	\$ (273,538)	\$ 3,280,763	4
5		1994	1994	25,000		35	714	714	17,079	5
6		1992	1992	1,863,459		20	93,173	93,173	1,455,277	6
7										7
8										8
<b>Improvement Type**</b>										
9	Various	1988		8,828		20			8,828	9
10	Various	1989		92,298		20			92,298	10
11	Various	1990		24,448		20			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	50,961	16
17	Various	1996		28,192		20	803	803	28,189	17
18	Various	1997		73,030		20	3,652	3,652	73,030	18
19	Various	1998		20,335		20	1,017	1,017	19,722	19
20	Various	1999		69,554		20	3,477	3,477	64,605	20
21	Various	2001		44,318		20	691	691	28,765	21
22	Various	2002		2,340		20	117	117	1,833	22
23	Various	2003		10,250		20	683	683	9,678	23
24	Various	2005		201,387		20	2,779	2,779	128,314	24
25	Various	2007		426,299		20	43,905	43,905	426,299	25
26	Various	2008		340,022		20	37,972	37,972	340,022	26
27	Various	2009		12,058		20	1,206	1,206	10,854	27
28	Various	2011		48,890		20	5,883	5,883	43,371	28
29	Various	2012		231,149		20	36,929	36,929	187,507	29
30	Various	2013		344,675		20	41,049	41,049	188,421	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		1,050,297			53,100	53,100	142,174	67
68								68
69			69,479			(69,479)		69
70		\$ 10,132,588	\$ 445,474		\$ 430,530	\$ (14,944)	\$ 8,199,279	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:

01/01/17

Ending:

12/31/17

## 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>		\$ 10,132,588	\$ 445,474		\$ 430,530	\$ (14,944)	\$ 8,199,279	1
2	Quartz Top, Wall Unit & Attached Desk For Nurses Station	2014	3,572		20	714	714	2,738	2
3	Wall Mounted Pantry & Trim Attached To Nurses Station	2014	4,178		20	836	836	3,203	3
4	Dining Room Base Cabinets With Quartz Top At Nurses Station	2014	12,555		20	2,511	2,511	9,626	4
5	Cylinder Replacement For Elevator System	2014	20,523		20	2,052	2,052	7,867	5
6	14 Unit Audible & Visual Nurses Call Station	2014	29,750		20	5,950	5,950	22,313	6
7	Vinyl Floor & Coves For 6 Resident Rooms	2014	9,052		20	1,810	1,810	5,733	7
8	Fixtures, Wallpaper, Artwork For 6 Resident Rooms	2014	9,307		20	1,861	1,861	5,894	8
9	Window Treatments, Blinds & Panels For 6 Resident Rooms	2014	6,346		20	1,269	1,269	4,020	9
10	Vanity Lights, Mirrors, Shelves For Baths In 6 Resident Rooms	2014	3,030		20	606	606	1,919	10
11	Repair Walk-In Freezer	2015	3,871		20	194	194	565	11
12	Boiler Repair	2015	2,629		20	131	131	372	12
13	Replace Water Heater	2015	10,056		20	503	503	1,089	13
14	Repaired Wiring For Phone System	2015	2,569		20	128	128	300	14
15	Installed Heat Exchanger	2016	2,880		20	144	144	288	15
16	Replaced Heating/Cooling System	2016	11,125		20	556	556	1,113	16
17	Repaired Primer Pump	2017	6,877		20	344	344	344	17
18	Automatic Transfer Switch	2017	4,819		20	241	241	241	18
19	Repaired Motor And Sump Pump For A/C	2017	5,388		20	269	269	269	19
20	Repaired A/C For Kitchen - Motor/Blades	2017	2,827		20	141	141	141	20
21	New Shadow, Privacy Curtains	2017	2,656		20	133	133	133	21
22	Repaired Ejector Pit In Kitchen/Basin -Main Entrance	2017	2,955		20	148	148	148	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>		\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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		\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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		\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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		\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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)	\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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		\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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)	\$ 10,289,553	\$ 445,474		\$ 451,073	\$ 5,599	\$ 8,267,595	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:

01/01/17

Ending:

12/31/17

## 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									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	15,870	9
10	<b>3 Gardenview Room - Demolition, Plumbing, Electrical, Sprinkler</b>	2015	81,700		20	4,085	4,085	12,255	10
11	<b>4 Resid Rm - 2 New bathrooms, Electrical, Sprinkler, Drywall</b>	2015	98,000		20	4,900	4,900	14,700	11
12	<b>2 Resid Rm - Shower, Framing, Electrical, Plumbing, Flooring</b>	2015	51,300		20	2,565	2,565	7,695	12
13	<b>3 Resid Rm - Shower, Electric, Plumbing, Flooring</b>	2015	76,950		20	3,848	3,848	11,543	13
14	<b>Front Entry Drive - Parking Lot Repair, Asphalt, Curbs</b>	2015	123,382		20	6,169	6,169	18,507	14
15	<b>3 Resid Rm - Plumbing, Electrical, Sprinklers and Drywall</b>	2015	62,322		20	3,116	3,116	9,348	15
16	<b>6 Resid Rm - Dividers, Wallpaper, Cove Base, and Lighting</b>	2015	13,753		20	688	688	2,063	16
17	<b>7 Resid Rms - Flooring, Cove Base, Wallpaper, Lightings, Tiling</b>	2015	47,384		20	2,369	2,369	7,108	17
18	<b>Physical Therapy Room - Flooring, Cove Base, Carpeting</b>	2015	23,355		20	1,168	1,168	3,503	18
19	<b>Front Offices - Carpeting and Window Treatments</b>	2015	10,023		20	501	501	1,503	19
20	<b>6 Resid Rm - Flooring, Cove Base, Lighting, Tiling</b>	2015	25,836		20	1,292	1,292	3,875	20
21	<b>Office - Installed New Wall, Electrical Outlets, Fixtures, Patch/Pai</b>	2015	5,850		20	293	293	878	21
22	<b>PT Room - Installed Divider and Permit Fee</b>	2015	4,446		20	222	222	667	22
23	<b>Offices - Installed and Painted Crown Moulding/Curtains</b>	2015	2,600		20	130	130	390	23
24	<b>Dining Room and PT Room - New Windows with Awning</b>	2015	16,500		20	825	825	2,475	24
25	<b>3 Offices - Paint/Installed New Carpet/Base Moulding</b>	2015	4,800		20	825	825	2,475	25
26	<b>Converted Resident Shower to Social Service Offices</b>	2016	18,200		20	910	910	1,820	26
27	<b>Resident Rooms with Shower - Framing/Electrical/Plumbing</b>	2016	32,450		20	1,623	1,623	3,245	27
28	<b>2 Resident Room with Shower - Framing/Electrical/Plumbing</b>	2016	76,950		20	3,848	3,848	7,695	28
29	<b>6 Resident Rooms - Vinyl/Flooring/Wallpaper/Light Fixtures/Tilin</b>	2016	64,920		20	3,246	3,246	6,492	29
30	<b>4 Resident Room - Vinyl/Flooring/Wallpaper/Light Fixture/Tiling</b>	2016	30,168		20	1,508	1,508	3,017	30
31	<b>Installed 3 ton Mitsubishi HVAC</b>	2016	7,500		20	375	375	750	31
32	<b>Bathrooms - Installed new tiles/sink/light fixtures/patch &amp; paint</b>	2016	7,000		20	350	350	700	32
33	<b>Installed new window in new office</b>	2016	3,500		20	175	175	350	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 994,689	\$		\$ 50,319	\$ 50,319	\$ 138,924	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	<b>Totals from Page 12F, Carried Forward</b>		\$ 994,689	\$		\$ 50,319	\$	\$ 138,924	1
2	Repaired sewer under driveway/installed asphalt	2016	9,400		20	470	470	940	2
3	Repaired elevator - new hydraulic power unit	2017	19,879		20	994	994	994	3
4	Installed fire rated door and frame - Basement/Exterior	2017	2,850		20	143	143	143	4
5	Installed 6 new parking light heads	2017	3,600		20	180	180	180	5
6	Installed hydraulic power unit for elevator	2017	19,879		20	994	994	994	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,050,297	\$		\$ 53,100	\$ 2,780	\$ 142,174	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.

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	\$ 807,197	\$ 3,144	\$ 107,342	\$ 104,198	10	\$ 540,139	71
72	Current Year Purchases	25,130		2,513	2,513	10	2,513	72
73	Fully Depreciated Assets	1,342,382				10	1,342,382	73
74								74
75	TOTALS	\$ 2,174,710	\$ 3,144	\$ 109,855	\$ 106,711		\$ 1,885,034	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)	\$ 13,294,262	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 448,618	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 560,928	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 112,310	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,152,629	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	Land - step up - 2015	\$ 212,090	\$	\$	86
87	Building - step up - 2015	1,159,367			87
88					88
89					89
90					90
91	TOTALS	\$ 1,371,457	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning: 01/01/17

Ending: 12/31/17

**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?

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	Parking Lot				32,400			5
6	Storage				5,602			6
7	TOTAL				\$ 38,002			7

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. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

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: \$ 1,295      Description: See Attached Schedule

(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

\* 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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 675,236				\$ 675,236	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				132,226				132,226	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				880,359				880,359	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					789,503			789,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): _____						85,909	125,615			211,524	13
14	<b>TOTAL</b>						\$ 1,773,730	\$ 915,118			\$ 2,688,848	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,819	\$ 60,632	1
2	Cash-Patient Deposits	24,605	24,605	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,329,270	3,329,270	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,975	59,975	6
7	Other Prepaid Expenses	2,750	56,720	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	255,138	549,896	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,676,557	\$ 4,081,098	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	2,324,689	6,646,876	15
16	Equipment, at Historical Cost	1,344,625	1,969,121	16
17	Accumulated Depreciation (book methods)	(3,216,454)	(9,543,439)	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): <u>See Attached Schedule</u>	10,000	4,545,383	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 462,860	\$ 9,405,398	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,139,417	\$ 13,486,496	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 536,100	\$ 556,098	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,605	24,605	28
29	Short-Term Notes Payable	1,800,000	1,800,000	29
30	Accrued Salaries Payable	243,796	243,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	610,012	610,012	31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,000	117,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	4,453,246	4,453,246	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,784,759	\$ 7,804,757	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,178,028	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>	\$	\$ 7,178,028	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,784,759	\$ 14,982,785	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,645,342)	\$ (1,496,289)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,139,417	\$ 13,486,496	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>(3,351,817)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Restatement</b>	<b>(861)</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>(3,352,678)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(292,664)</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>(292,664)</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>(3,645,342)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Oakbrook Healthcare Centre

# 0034694

Report Period Beginning: 01/01/17

Ending:

12/31/17

**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	\$ 16,383,503	1
2	Discounts and Allowances for all Levels	(7,375,621)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,007,882	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,152,407	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 4,152,407	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	827,969	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,175	19
20	Radiology and X-Ray	75,472	20
21	Other Medical Services	65,195	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 987,811	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	6,663	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,663	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	1,823	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,823	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,156,586	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,294,623	31
32	Health Care	4,781,990	32
33	General Administration	3,119,873	33
<b>B. Capital Expense</b>			
34	Ownership	1,345,454	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,688,848	35
36	Provider Participation Fee	218,462	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,449,250	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(292,664)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (292,664)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,487,332	44
45	Private Pay - Net Inpatient Revenue	2,672,400	45
46	Medicare - Net Inpatient Revenue	3,451,502	46
47	Other-(specify) Insurance/Pending	1,396,648	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 9,007,882	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:

01/01/17

Ending:

12/31/17

**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	1,949	2,326	\$ 120,692	\$ 51.89	1
2	Assistant Director of Nursing	1,733	2,116	88,256	41.71	2
3	Registered Nurses	57,082	62,252	1,875,722	30.13	3
4	Licensed Practical Nurses	21,483	23,607	605,296	25.64	4
5	CNAs & Orderlies	79,096	86,509	1,188,932	13.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,267	15,507	219,269	14.14	8
9	Activity Director	2,021	2,086	38,849	18.62	9
10	Activity Assistants	5,748	6,370	85,570	13.43	10
11	Social Service Workers	5,589	6,183	109,342	17.68	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,086	51,820	24.84	13
14	Head Cook	5,421	6,232	107,581	17.26	14
15	Cook Helpers/Assistants	27,008	29,944	379,096	12.66	15
16	Dishwashers					16
17	Maintenance Workers	3,799	4,298	84,158	19.58	17
18	Housekeepers	29,717	33,676	488,146	14.50	18
19	Laundry	7,093	8,350	126,278	15.12	19
20	Administrator	1,805	2,086	94,386	45.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,932	2,086	58,438	28.01	23
24	Clerical	16,279	17,339	267,734	15.44	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	2,013	2,086	42,609	20.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	285,912	315,139	\$ 6,032,174 *	\$ 19.14	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	1,245	\$ 34,817	01-03	35
36	Medical Director	789	30,000	09-03	36
37	Medical Records Consultant	186	4,800	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	357	10,704	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	Monthly	448	11-03	44
45	Social Service Consultant	207	6,180	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,784	\$ 86,949		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



Facility Name & ID Number Oakbrook Healthcare Centre# 0034694

Report Period Beginning:

01/01/17

Ending:

12/31/17**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. \$ 31,956 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. \$ 218,462  
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