FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051862

Facility Name: OAKRIDGE HEALTHCARE CENTER

Address: 323 OAKRIDGE AVENUE (Number) HILLSIDE (City) 60162 (Zip Code)

County: COOK

Telephone Number: (708) 547-6595 **Fax #** (708) 547-1971

HFS ID Number:

Date of Initial License for Current Owners: 01/01/12

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) ELI ATKIN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	15	Intermediate (ICF)	15	5,475	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,328	1,550	4,814	9,692	8
9	SNF/PED					9
10	ICF	11,832	36	24	11,892	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,160	1,586	4,838	21,584	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.01%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/12

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,991

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,795	15,838	4,817	178,450		178,450		178,450			1
2	Food Purchase		136,278		136,278	(19,601)	116,677	(728)	115,949			2
3	Housekeeping	137,292	22,321		159,613		159,613		159,613			3
4	Laundry	8,806	11,372	5,591	25,769		25,769		25,769			4
5	Heat and Other Utilities			83,272	83,272		83,272		83,272			5
6	Maintenance	66,424	18,004	20,675	105,103		105,103	10,011	115,114			6
7	Other (specify):*			8,907	8,907		8,907		8,907			7
8	TOTAL General Services	370,317	203,813	123,262	697,392	(19,601)	677,791	9,283	687,074			8
	B. Health Care and Programs											
9	Medical Director			12,760	12,760		12,760		12,760			9
10	Nursing and Medical Records	1,147,938	73,158	5,465	1,226,561		1,226,561		1,226,561			10
10a	Therapy	98,586	17,276		115,862		115,862		115,862			10a
11	Activities	98,085	6,722		104,807		104,807		104,807			11
12	Social Services			351	351		351		351			12
13	CNA Training											13
14	Program Transportation			881	881		881		881			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,344,609	97,156	19,457	1,461,222		1,461,222		1,461,222			16
	C. General Administration											
17	Administrative	28,732		133,611	162,343		162,343	(36,260)	126,083			17
18	Directors Fees											18
19	Professional Services			66,936	66,936		66,936	879	67,815			19
20	Dues, Fees, Subscriptions & Promotions			42,281	42,281		42,281	(20,225)	22,056			20
21	Clerical & General Office Expenses	26,210	18,979	189,012	234,201		234,201	(72,922)	161,279			21
22	Employee Benefits & Payroll Taxes			266,970	266,970	19,601	286,571		286,571			22
23	Inservice Training & Education							331	331			23
24	Travel and Seminar			3,138	3,138		3,138		3,138			24
25	Other Admin. Staff Transportation			26,847	26,847		26,847	(21,992)	4,855			25
26	Insurance-Prop.Liab.Malpractice			92,300	92,300		92,300		92,300			26
27	Other (specify):*			67,376	67,376		67,376	(42,840)	24,536			27
28	TOTAL General Administration	54,942	18,979	888,471	962,392	19,601	981,993	(193,029)	788,964			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,769,868	319,948	1,031,190	3,121,006		3,121,006	(183,746)	2,937,260			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: OAKRIDGE HEALTHCARE CENTER **#0051862** **Report Period Beginning: 01/01/2015** **Ending: 12/31/2015**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,817	
	REPAIRS & MAINTENANCE		0	
				4,817
3	**HOUSEKEEPING**			
			0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,591	
				5,591
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,965	
	ELECTRICITY		25,169	
	WATER		26,226	
	CABLE TV - LOBBY		4,912	
				83,272
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,080	
	PAINTING & DECORATING		465	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,498	
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,185	
	FIRE SERVICE		6,447	
				20,675
7	**OTHER**			
	SCAVENGER		7,310	
	SECURITY SERVICE		1,597	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		353	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	75	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	337	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	NURSING	XVIII B 38-2	2,500	
	DENTAL SERVICES		2,200	
				5,465
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		351	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	

				8,907
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,760	12,760

				351
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER **#0051862** **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		881	
				881
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	133,611	133,611
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,913	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	39,023	
				66,936
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,575	
	EMPLOYEE WANT ADS	XIX F	190	
	CONTRIBUTIONS	VI 20 XIX F	7,500	
	DUES & SUBSCRIPTIONS	XIX F	15,360	
	LICENSES & PERMITS	XIX F	3,326	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	145	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,168	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,017	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				42,281
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		612	
	EQUIPMENT REPAIR & MAINTENANCE		699	
	OUTSIDE CLERICAL SERVICES		172,828	
	PENALTIES / OVERDRAFT CHARGES	VI 18	83	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,790	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	135,395	
	UNEMPLOYMENT COMPENSATION	XIX D	67,331	
	WORKERS COMPENSATION INSURANC	XIX D	51,723	
	HOSPITALIZATION INSURANCE	XIX D	0	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,521	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
				266,970
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	
				0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,138	
	TRAVEL	XIX G	0	
				3,138
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		26,847	
				26,847
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		92,300	
				92,300
27	**OTHER**			
	BAD DEBTS	VI 24	67,376	
				67,376

GRAND TOTAL COLUMN 3 OTHER **1,031,190**

MESSENGER SERVICE	0	
		189,012

OAKRIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2015

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	136,278
LESS SALES TAX	(728)
NET FOOD	135,550
TOTAL PATIENT CENSUS	21,584
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	64,752
ADD # EMPLOYEE MEALS/DAY	30
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	10,950
PATIENT MEALS	64,752
ADD EMPLOYEE MEALS	10,950
TOTAL MEALS/YEAR	75,702
NET FOOD	135,550
DIVIDE TOTAL MEALS/YEAR	75,702
COST PER MEAL	1.79
TIMES EMPLOYEE MEALS	10,950
EMPLOYEE MEAL RECLASSIFICATION	**19,601**

OAKRIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2015

LEGAL FEE

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
5/30/2013	STONE,MCGUIRE SIEGEL	5,136.08	GENERAL

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER #0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			10,636	10,636		10,636	50,444	61,080			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,152	69,152		69,152	149,016	218,168			32
33	Real Estate Taxes			191,835	191,835		191,835		191,835			33
34	Rent-Facility & Grounds			252,000	252,000		252,000	(252,000)				34
35	Rent-Equipment & Vehicles			11,884	11,884		11,884		11,884			35
36	Other (specify):* **computer software**			443	443		443		443			36
37	**TOTAL Ownership**			535,950	535,950		535,950	(52,540)	483,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,928	111,439	203,367		203,367	5,095	208,462			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,303	162,303		162,303		162,303			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		91,928	273,742	365,670		365,670	5,095	370,765			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,769,868	411,876	1,840,882	4,022,626		4,022,626	(231,191)	3,791,435			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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,283)	30		9
10	Interest and Other Investment Income	(528)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(728)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(83)	21		18
19	Entertainment		20		19
20	Contributions	(10,668)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,376)	27		24
25	Fund Raising, Advertising and Promotional	(9,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(145)	20		28
29	Other-Attach Schedule	(22,604)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,990)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(117,201)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (117,201)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (231,191)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OAKRIDGE HEALTHCARE CENTER

ID# 0051862

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	NON ALLOWABLE TRANSPORTATION	(21,992)	25	2
3	BANK CHARGE	(612)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29

30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,604)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(728)	0	0	0	0	0	0	0	0	0	0	(728)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	10,011	0	0	0	0	0	0	0	0	10,011	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(728)	0	10,011	0	0	0	0	0	0	0	0	9,283	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(36,260)	0	0	0	0	0	0	0	0	(36,260)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	879	0	0	0	0	0	0	0	0	879	19
20	Fees, Subscriptions & Promotions	(20,388)	0	163	0	0	0	0	0	0	0	0	(20,225)	20
21	Clerical & General Office Expenses	(695)	0	(72,227)	0	0	0	0	0	0	0	0	(72,922)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	331	0	0	0	0	0	0	0	0	331	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(21,992)	0	0	0	0	0	0	0	0	0	0	(21,992)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(67,376)	0	24,536	0	0	0	0	0	0	0	0	(42,840)	27
28	**TOTAL General Administration**	(110,451)	0	(82,578)	0	0	0	0	0	0	0	0	(193,029)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,179)	0	(72,567)	0	0	0	0	0	0	0	0	(183,746)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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)	
	D. Ownership													
30	Depreciation	(2,283)	52,727	0	0	0	0	0	0	0	0	0	50,444	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(528)	149,544	0	0	0	0	0	0	0	0	0	149,016	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(252,000)	0	0	0	0	0	0	0	0	0	(252,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,811)	(49,729)	0	0	0	0	0	0	0	0	0	(52,540)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	5,095	0	0	0	0	0	0	0	0	5,095	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	5,095	0	0	0	0	0	0	0	0	5,095	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(113,990)	(49,729)	(67,472)	0	0	0	0	0	0	0	0	(231,191)	45

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
ELISHA ATKIN	50	MCALLISTER NURSING & REHAB LLC	TINLEY PARK	OAKRIDGE		REALTY
YAEL ATKIN	50			NURSING AND		
				REHAB PROP, LLC		
				INNOVATIVE MGT		MANAGEMENT
				MCALLISTER		REALTY
				PROPERTY,LLC		

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 252,000	OAKRIDGE NURSING AND REHAB PROPERTIES, LLC		$	$ (252,000)	1
2	V	30	DEPRECIATION				52,727	52,727	2
3	V	32	INTEREST				149,544	149,544	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 252,000			$ 202,271	$ * (49,729)	14

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] 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	39	THERAPY EXPENSE	$ 105,056	INNOVATIVE MANAGEMENT		$	$ (105,056)	15
16	V	21	OUTSIDE CLERICAL	172,828				(172,828)	16
17	V	17	MANAGEMENT FEES	133,611				(133,611)	17
18	V	6	MAINT SUPERVISOR				10,011	10,011	18
19	V	17	ADMINISTRATOR- ELI ATKIN				45,152	45,152	19
20	V	17	ADMINISTRATION- JOEL ATKIN				36,024	36,024	20
21	V	17	ASSISTANT ADMINISTRATOR				16,175	16,175	21
22	V	21	CLERICAL SALARIES				97,242	97,242	22
23	V	39	REHAB DIRECTOR				19,953	19,953	23
24	V	39	REHAB ASSISTANTS				90,198	90,198	24
25	V	27	EMPLOYEE BENEFITS				24,536	24,536	25
26	V	19	DATA PROCESSING				879	879	26
27	V	20	DUES & SUBSCRIPTIONS				76	76	27
28	V	20	LICENSES & PERMITS				87	87	28
29	V	21	OFFICE EXPENSE				3,359	3,359	29
30	V	23	SEMINARS				331	331	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			$ 411,495			$ 344,023	$ * (67,472)	39

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ELISHA ATKIN	50	MCALLISTER NURSING & REHAB	TINLEY PARK	OAKRIDGE	HILLSIDE	REALTY	1
2	YAEL ATKIN	50			NURSING AND			2
3					REHAB PROP, LLC			3
4								4
5					MCALLISTER	TINLEY PARK	REALTY	5
6					PROPERTY,LLC			6
7								7
8					INNOVATIVE	MORTON GROVE	MANAGEMENT	8
9					MANAGEMENT			9
10					ASSOCIATES			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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TZVI ATKIN	OTHER ADMIN	administration		mcallister nursing	see attached	15.00	SALARY	$ 14,465	17-7	1
2					15,552			P/R TAXES	1,087	27-7	2
3	JOEL ATKIN	OTHER ADMIN	ADMININSTATION AND		mcallister nursing	see attached	6.67	SALARY	36,024	17-7	3
4			FINANCIAL SERVICES		37,975			P/R TAXES	1,951	27-7	4
5	ELISHA ATKIN	ADMINISTRATOR	administration	50.00	mcallister nursing	see attached	66.67	SALARY	45,152	17-7	5
6					47,291			P/R TAXES	2,139	27-7	6
7	YOSEF TZADOK	CLERICAL	ASSIST IN FIN ANALYSIS		mcallister nursing	see attached]		SALARY	14,465	17-7	7
8					15,572			P/R TAXES	1,107	27-7	8
9	COREY FUCHS	CLERICAL			mcallister nursing	see attached		SALARY	9,041	17-7	9
10					9,733			P/R TAXES	692	27-7	10
11											11
12											12
13								TOTAL	$ 126,123		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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	TOTALS					$	$		$	25

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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 [X] NO [ ]

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

Name of Related Organization: INNOVATIVE MANAGEMENT ASSOCIATES,
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE ILL 60053
Phone Number: (708) 798-2272
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT SUPERVISOR	DIRECT	1	1	$ 10,011	$ 10,011	1	$ 10,011	1
2	17	ADMINISTRATOR- ELI ATKIN	DIRECT	1	1	45,152	45,152	1	45,152	2
3	17	ADMINISTRATION- JOEL ATK	DIRECT	1	1	36,024	36,024	1	36,024	3
4	17	ASSISTANT ADMINISTRATOR	DIRECT	1	1	16,175	16,175	1	16,175	4
5	21	CLERICAL SALARIES	DIRECT	1	1	97,242	97,242	1	97,242	5
6	39	REHAB DIRECTOR	DIRECT	1	1	19,953	19,953	1	19,953	6
7	39	REHAB ASSISTANTS	DIRECT	1	1	90,198	90,198	1	90,198	7
8	27	EMPLOYEE BENEFITS	DIRECT	1	1	24,536		1	24,536	8
9	19	DATA PROCESSING	AVAILABLE BEDS	233,246	6	7,695		26,645	879	9
10	20	DUES & SUBSCRIPTIONS	AVAILABLE BEDS	233,246	6	667		26,645	76	10
11	20	LICENSES & PERMITS	AVAILABLE BEDS	233,246	6	763		26,645	87	11
12	21	OFFICE EXPENSE	AVAILABLE BEDS	233,246	6	29,405		26,645	3,359	12
13	23	SEMINARS	AVAILABLE BEDS	233,246	6	2,899		26,645	331	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 380,720	$ 314,755		$ 344,023	25

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY						$	$			$	1
2												2
3	BANK LEUMI		X	MORTGAGE	$20,425.40	12/27/12	3,000,000	2,740,525			145,058	3
4	BANK LEUMI		X	CONSTRUCTION	$1,890.48	10/31/14	100,000	78,540	10/08/19		4,486	4
5												5
	Working Capital											
6	BANK LEUMI		X	LINE OF CREDIT	INT ONLY	REVOL		374,586			19,689	6
7	DEPENDABLE FINANCE		X	INSURANCE POLICY FIN							2,091	7
8												8
9	TOTAL Facility Related				$22,315.88		$ 3,100,000	$ 3,193,651			$ 171,324	9
	B. Non-Facility Related*											
10	BED TAX										3,998	10
11	MISC VENDORS			LATE FEES							37,318	11
12	COOK COUNTY R/E TAX			LATE FEES							6,056	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 47,372	14
15	TOTALS (line 9+line14)						$ 3,100,000	$ 3,193,651			$ 218,696	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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.)**

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 182,026	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.)		$ 197,081	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,054	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 176,781	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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 191,835	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010		8
2011	148,100	9
2012	154,761	10
2013	161,726	11
2014	176,781	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 100% of $176,780.74 2014 RE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO $20,300 OF THE 2013 RE TAX BILL AND 100% OF THE $176,780.74 2014 REAL ESTATE TAX BILL

	FOR BHF USE ONLY		
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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKRIDGE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051862

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-413-052-0000	NURSING HOME	$ 91,860.16	$ 91,860.16
2.	15-17-413-067-0000	NURSING HOME	$ 84,920.58	$ 84,920.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 176,780.74	$ 176,780.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES ___X___ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,970 B. General Construction Type: Exterior BRICK Frame CONCRETE WOOD Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

N/A

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	NURSING HOME	64,978	2009	225,000	2
3	TOTALS	64,978		$ 225,000	3

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73		2009		$ 1,295,561	$ 47,111	27.5	$ 47,111	$	$ 141,333	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VINYL PLANK FLOORING FOR 2 DINING ROOMS AND										9
10	HALLWAYS			2012	16,959	435	27.5	435		1,323	10
11	ROOF			2012	4,950	127	27.5	127		386	11
12	DRAPERIES, CORNICES, WINDOW TREATMENTS IN										12
13	RESIDENT ROOMS & PUBLIC AREA			2012	18,857	1,326	7	2,694	1,368	9,427	13
14	TILING AND FLOORING DONE IN 2 DINING ROOMS										14
15	AND HALLWAY			2013	11,200	287	39	287		706	15
16	LIGHTING IN ALL HALLWAYS THRUOUT BUILDING			2013	3,549	91	39	91		224	16
17	BASEBOARDS FOR DINING ROOMS AND HALLWAY			2013	7,900	203	39	203		499	17
18	VINYL			2013	8,899	228	39	228		561	18
19	SECURITY SYSTEM FOR PATIO, NURSES STATION,										19
20	FRONT LOBBY, 2 DINING ROOMS, ACTIVITY ROOM,										20
21	BREAK ROOM, 6 HALLWAYS, 2 BY BOILER ROOM,										21
22	1 OUTSIDE BY BACK ENTRANCE, AND 1 IN OFFICE										22
23	AREA			2013	11,314	290	39	290		713	23
24											24
25											25
26	HEATING BOILER			2013	12,800	328	39	328		806	26
27	NURSES STATION-OPEN CENTER OF EXISTING NURSES										27
28	STATION AND CLOSE OFF CURRENT OPEN AREA.										28
29	REPLACE EXISTING COUNTER TOP. INSTALL TILE. IN										29
30	HALLWAY, REMOVE ALL TILES, DRYWALL AND WORK										30
31	AROUND CEILING PIPING, INSTALL THE HANDRAIL										31
32	SKINS, WALL GUARDS. THERAPY ROOM- REMOVE										32
33	EXISTING WOOD PANEL THAT SITS UNDERNEATH										33
34	WALL VINYL. DRYWALL TOP PORTION AND PAINT.										34
35	REMOVE EXISTING FLOORING AND REPLACE WITH A										35
36	VINYL PLANK FLOORING			2013	21,300	546	39	546		1,342	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	
37	SALES TAX AND DELIVERY CHARGE ON VINYL		$	$		$	$	$	37
38	FLOORING, DRAPERIES, CORNICES, WINDOW								38
39	TREATMENTS, CHAIRS, AND BED THROWS	2013	7,084	182	39	182		447	39
40	RESILIENT FLOORING IN THE LOBBY AND IN THE								40
41	LIBRARY/CONFERENCE ROOM	2014	25,000	909	39	909		1,629	41
42	REMOVED AND REPLACED 3 PHASE DISCONNECT AND								42
43	CONTRO BOARD ON ROOF TOP UNIT. INSTALLED								43
44	NEW 5 TON GAS FIRED ROOF TOP UNIT, REMOVED								44
45	OLD UNIT	2014	10,168	370	39	370		663	45
46	PAINTING WALLS, CEILING, BATHROOM WALLS AND	2014	10,911	2,182	5	2,182		2,546	46
47	BATHROOM CEILINGS IN RESIDENT ROOMS								47
48	NUMBERED 1-22								48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,466,452	$ 54,615		$ 55,983	$ 1,368	$ 162,605	70

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 47,385	$ 4,446	$ 4,738	$ 292	10 YRS	$ 13,494	71
72	Current Year Purchases	7,170	4,302	359	(3,943)	10 YRS	359	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 54,555	$ 8,748	$ 5,097	$ (3,651)		$ 13,853	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)	$ 1,746,007	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,363	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,080	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,283)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 176,458	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 252,000			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 252,000 **			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: *

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	$

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: $ 11,884 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

* 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.

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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)	
TOTAL TRAINED	

(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.

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			105,056			105,056	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				90,314		90,314	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Radiology,laboratory					6,383	1,614		7,997	13
14	TOTAL			$		$ 111,439	$ 91,928		$ 203,367	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.

STATE OF ILLINOIS

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER **#** 0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2015 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 147,301	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (100,000))	1,146,973		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,317		6
7	Other Prepaid Expenses	1,750		7
8	Accounts Receivable (owners or related parties)	580,664		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,018,005	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	21,909		15
16	Equipment, at Historical Cost	75,692		16
17	Accumulated Depreciation (book methods)	(61,741)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,860	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,053,865	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 469,667	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	374,586		29
30	Accrued Salaries Payable	58,955		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,292		31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,781		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OAKRIDGE PROPERTIES	559,352		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,654,633	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	70,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 70,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,724,633	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 329,232	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,053,865	$	48

***(See instructions.)**

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 83,917	1
2	Restatements (describe):		2
3	**ROUNDING**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 83,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,499	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(186)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **OUT OF PERIOD EXPENSES**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 245,313	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 329,232	24 *

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,199,189	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,199,189	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	50,941	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 50,941	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	912	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 912	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	528	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 528	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,251,570	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	697,392	31
32	Health Care	1,461,222	32
33	General Administration	962,392	33
	B. Capital Expense		
34	Ownership	535,950	34
	C. Ancillary Expense		
35	Special Cost Centers	203,367	35
36	Provider Participation Fee	162,303	36
	D. Other Expenses (specify):		
37	Other Expenses Adj	(16,555)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,006,071	40
41	**Income before Income Taxes (line 30 minus line 40)****	245,499	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 245,499	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,400,613	44
45	Private Pay - Net Inpatient Revenue	279,728	45
46	Medicare - Net Inpatient Revenue	1,033,392	46
47	Other-(specify) VETERAN	485,456	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,199,189	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO** If not, please attach a reconciliation.**

*** **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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,126	2,255	$ 87,451	$ 38.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,879	7,300	213,538	29.25	3
4	Licensed Practical Nurses	12,550	13,192	345,505	26.19	4
5	CNAs & Orderlies	42,533	44,803	501,444	11.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,966	1,966	98,586	50.15	8
9	Activity Director	2,029	2,086	33,426	16.02	9
10	Activity Assistants	4,218	4,418	64,659	14.64	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	84	84	1,934	23.02	13
14	Head Cook	2,079	2,162	27,029	12.50	14
15	Cook Helpers/Assistants	10,677	11,237	128,832	11.46	15
16	Dishwashers					16
17	Maintenance Workers	3,990	4,184	66,424	15.88	17
18	Housekeepers	12,825	13,185	137,292	10.41	18
19	Laundry	805	856	8,806	10.29	19
20	Administrator					20
21	Assistant Administrator	1,136	1,160	28,732	24.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,620	1,745	26,210	15.02	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,517	110,633	$ 1,769,868 *	$ 16.00	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,817	1-3	35
36	Medical Director	O	12,760	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	2,575	10-3	38
39	Pharmacist Consultant	H	337	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,489		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	ADMINISTRATOR		$
YISROEL KRAMER	ASST ADMIN		28,732
	OTHER ADMIN		
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 28,732

B. Administrative - Other

Description	Amount
INNOVATIVE- MANAGEMENT FEES	$ 133,611
TOTAL (agree to Schedule V, line 17, col. 3)	$ 133,611
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		66,936
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 66,936

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 51,723
Unemployment Compensation Insurance		67,331
FICA Taxes		135,395
Employee Health Insurance		0
Employee Meals		19,601
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		12,521
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 286,571

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	190
Health Care Worker Background Check	3,017
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	10,668
MARKETING/ADV/PROMO	9,720
LICENSES/DUES/SUBSCRIPTIONS	18,686
MGMT CO ALLOC	163
TRUST/FRANCHISE/CONTRIB/ETC	(10,668)
Less: Public Relations Expense	(0)
Non-allowable advertising	(9,575)
Yellow page advertising	(145)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,056

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,138
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,138

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER **#** 0051862 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(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?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **162,303**
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. $ **19,601** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
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:

(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.