FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0033712

Facility Name: Oakwood Estate

Address: 2213 Veterans Road (Number) Morton (City) 61550 (Zip Code)

County: Tazewell

Telephone Number: (309) 266-9781 **Fax #** (309) 266-9468

HFS ID Number:

Date of Initial License for Current Owners: 08/08/1988

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 (c)(3)

In the event there are further questions about this report, please contact:
Name: Matthew D. Steffen **Telephone Number:** (309) 266-9781
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 07/01/2011 to 06/30/2012 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) Matthew D. Steffen
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,595			5,595	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,595			5,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.80%

D. How many bed-hold days during this year were paid by the Department?
242 (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 [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/08/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 06/30/2012

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	34,885	1,612	720	37,217	(22)	37,195		37,195			1
2	Food Purchase		30,582		30,582		30,582		30,582			2
3	Housekeeping		633	165	798	165	963		963			3
4	Laundry		1,949		1,949		1,949		1,949			4
5	Heat and Other Utilities			14,849	14,849		14,849		14,849			5
6	Maintenance	15,086	736	5,953	21,775	(35)	21,740		21,740			6
7	Other (specify):*											7
8	**TOTAL General Services**	49,971	35,512	21,687	107,170	108	107,278		107,278			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	36,372	10,947	1,131	48,450	(4,945)	43,505		43,505			10
10a	Therapy	219,537		962	220,499	(2,878)	217,621		217,621			10a
11	Activities		1,295		1,295	518	1,813		1,813			11
12	Social Services	48,539	37	2,794	51,370	(159)	51,211		51,211			12
13	CNA Training					5,215	5,215		5,215			13
14	Program Transportation			6,471	6,471		6,471		6,471			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	304,448	12,279	11,358	328,085	(2,249)	325,836		325,836			16
	C. General Administration											
17	Administrative	16,152			16,152		16,152		16,152			17
18	Directors Fees											18
19	Professional Services			5,309	5,309		5,309		5,309			19
20	Dues, Fees, Subscriptions & Promotions			1,302	1,302		1,302	(229)	1,073			20
21	Clerical & General Office Expenses	15,636	2,334		17,970		17,970		17,970			21
22	Employee Benefits & Payroll Taxes			192,811	192,811	2,834	195,645		195,645			22
23	Inservice Training & Education			816	816		816		816			23
24	Travel and Seminar			776	776		776	(422)	354			24
25	Other Admin. Staff Transportation			349	349		349	(261)	88			25
26	Insurance-Prop.Liab.Malpractice			9,701	9,701		9,701		9,701			26
27	Other (specify):* Mixc			2,781	2,781	(2,830)	(49)		(49)			27
28	**TOTAL General Administration**	31,788	2,334	213,845	247,967	4	247,971	(912)	247,059			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	386,207	50,125	246,890	683,222	(2,137)	681,085	(912)	680,173			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 Number Oakwood Estate #0033712 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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			18,306	18,306		18,306		18,306			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Asset Management Fees											36
37	**TOTAL Ownership**			18,306	18,306		18,306		18,306			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					2,137	2,137		2,137			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,120	38,120		38,120		38,120			42
43	Other (specify):* Facility Bulletin											43
44	**TOTAL Special Cost Centers**			38,120	38,120	2,137	40,257		40,257			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	386,207	50,125	303,316	739,648		739,648	(912)	738,736			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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: ######

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$	6	$	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				9
10	Interest and Other Investment Income		36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance		26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(229)	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	(683)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (912)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (912)		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.			$		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	**TOTAL (C): (sum of lines 38-46)**			$		47

Oakwood Estate

ID# 33712

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day draining transportation income	$	10	1
2	Offset day draining transportation income		14	2
3	Out-of-state Travel (Administrative Staff)	(261)	25	3
4	Depreciation of non-care vehicles		30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming		22	6
7	Out-of-state Travel (Board of Directors)	(422)	24	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**	(683)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estate # 33712 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(229)	0	0	0	0	0	0	0	0	0	0	(229)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(422)	0	0	0	0	0	0	0	0	0	0	(422)	24
25	Other Admin. Staff Transportation	(261)	0	0	0	0	0	0	0	0	0	0	(261)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(912)	0	0	0	0	0	0	0	0	0	0	(912)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(912)	0	0	0	0	0	0	0	0	0	0	(912)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Oakwood Estate** **#** **33712** **Report Period Beginning:** **7/1/2011** **Ending:** **6/30/2012**

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	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**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**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**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**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(912)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(912)**	**45**

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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
Apostolic Christian Home for the Handicapped, Inc.		Apostolic Christian Timber Ridge	Morton	Community Residential Services	Morton	Residential Services for the Developmentally Disabled
		Linden Estate	Morton			

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 [x] 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			$			$	$	1
2	V								2
3	V								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			$			$	$ *	14

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

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	Virgil Metzger	BOD						1
2	Roger Aberle	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Ron Hodel	BOD						5
6	Roger Beutel	BOD						6
7	Bryan Stoller	BOD						7
8	Cleve Klopfenstein	BOD						8
9	Stan Virkler	BOD						9
10	Tim Steffen	BOD						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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	Virgil Metzger	Director	Director	0.00	611	0.5		Travel	$ 109	line 24; col.3	1
2	Roger Aberle	Director	Director	0.00	1,151	0.5		Travel	205	line 24; col.3	2
3	Paul Kelson	Director	Director	0.00		0.5					3
4	Dennis Mott	Vice-Chairman	Director	0.00	406	0.5		Travel	72	line 24; col.3	4
5	Ron Hodel	Chairman	Director	0.00		0.5					5
6	Roger Beutel	Sec/ Treasurer	Director	0.00		0.5					6
7	Bryan Stoller	Director	Director	0.00	229	0.5		Travel	127	line 24; col.3	7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Stan Virkler	Director	Director	0.00	402	0.5		Travel	71	line 24; col.3	9
10	Tim Steffen	Director	Director	0.00	418	0.5		Travel	74	line 24; col.3	10
11											11
12											12
13								TOTAL	$ 658		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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: ######

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 [x]

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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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**		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				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** 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 Oakwood Estate # 33712 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	**8**
	2008	**9**
	2009	**10**
	2010	**11**
	2011	**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	**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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakwood Estate COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0033712

CONTACT PERSON REGARDING THIS REPORT Matthew D. Steffen

TELEPHONE (309) 266-9781 FAX #: (309) 266-9468

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,135 B. General Construction Type: Exterior Brick Frame Fireproof Building 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).

Apostolic Christian Timber Ridge (IDPA #0016220) is located adjacent to this property.
Type of business: Nursing Home (ICF/DD)
Square footage: Land - 1,345,699 sq ft; Building - 50,135 sq ft
Licensed Beds: 74

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	Nursing Home	91,781	1988	$ 9,477	1
2					2
3	TOTALS	91,781		$ 9,477	3

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	16			1989	$ 202,314	$ 5,058	40	$ 5,058	$	$ 118,859	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	316--Vinyl Floor Covering			1988	3,509		10			3,509	9
10	343--Landscaping			1988	9,369		10			9,369	10
11	345--Driveways			1988	16,544		15			16,544	11
12	348--Parking Signs			1988	41		12			41	12
13	350--Sod			1988	3,790		10			3,790	13
14	354--Organization Costs			1988	26,269		5			26,269	14
15	352--Landscaping			1989	458		8			458	15
16	360--Lighting Fixtures			1989	3,764		10			3,764	16
17	859--Exit Ramps			2008	1,697	113	15	113		566	17
18	349--Underground Gas & Waterline			1988	621	21	30	21		507	18
19	358--Kitchen Serving Door			1988	1,747		20			1,747	19
20	344--Dainage/Sewer			1988	1,368	46	30	46		1,117	20
21	347--Concrete			1988	7,277		20			7,277	21
22	346--Irrigation System			1988	7,650	306	25	306		7,497	22
23	351--Drainage / Sewer			1989	4,287	143	30	143		3,358	23
24	361--New Facility Wiring			1989	23,166		20			23,166	24
25	300--Garage			1989	23,005	920	25	920		21,624	25
26	359--Fire Prevention Sprinkler System			1989	24,890	996	25	996		23,396	26
27	362--Water & Gas Plumbing			1989	36,140	1,446	25	1,446		33,971	27
28	364--Cabinets & Countertop			1991	2,010		20			2,010	28
29	305--Door for Porch Enclosure			1995	709	18	40	18		311	29
30	302--Door For Porch Enclosure			1995	733	18	40	18		321	30
31	303--Back Door For Porch			1995	775	19	40	19		340	31
32	306--Lighting for Porch			1995	1,249	31	40	31		547	32
33	304--Awning & Window for Porch			1995	4,136	103	40	103		1,810	33
34	307--Generator Wiring			1999	1,623	41	40	41		548	34
35	353--Resurface Driveway			1999	10,526	702	15	702		9,474	35
36	771--Fiber Optic Cable			2006	1,261	84	15	84		546	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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	309--Generator Circuits	2000	$ 108	$ 7	15	$ #REF!	$	$ 90	37
38	308--Carpet	2000	4,866		10			4,866	38
39	565--Counter tops	2002	425	28	15	28		297	39
40	563--Counter tops	2002	900	60	15	60		630	40
41	780--Flooring	2007	7,109	474	15	474		2,607	41
42	857--Telephone System	2008	882	59	15	59		294	42
43	858--Roofing Project	2008	33,760	2,251	15	2,251		11,253	43
44	327--Vinyl Floor Coverings	1994	1,548		10			1,548	44
45	882--Laundry Utility Sinks	2009	1,404	94	15	94		374	45
46	883--Lighting Project	2009	2,500	167	15	167		667	46
47	939--Replace Sprinkler Main with Galvanized Pipe	2009	16,651	1,110	15	1,110		3,822	47
48	997--Misc repair to agree to TB	2011	39		15			39	48
49	1002--Carrier Furnace	2012	2,686	179	15	179		179	49
50	1012--Hallways Floorcoverings	2012	7,127	1,018	7	1,018		1,018	50
51	1013--Cabinets, Countertops, Handles	2012	4,705	235	20	235		235	51
52	1015--Porch Enclosure Remodel Project	2012	10,869	543	20	543		543	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)		$ 516,507	$ 16,290		$ 16,290	$	$ 351,198	70

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

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 45,922	$ 1,847	$ 1,847	$	13	$ 41,846	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	78,196	170	170		10	78,196	73
74	Disposed Assets							74
75	TOTALS	$ 124,118	$ 2,017	$ 2,017	$		$ 120,042	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)	$ 650,102	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,307	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,307	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 471,240	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	Fully depreciated vehicles	$ 26,309	$	$ 26,309	86
87	Capitalized repairs				87
88	Vehicle Equipment				88
89	Vehicles				89
90	Disposed Assets				90
91	TOTALS	$ 26,309	$	$ 26,309	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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	n/a		$	$	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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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? [X] YES [ ] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

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)		1,267		1,267
4	Clinical Wages (b)		298		298
5	In-House Trainer Wages (c)		993		993
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,558	$	$ 2,558
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,558			

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	3
2. From other facilities (f)	45
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	4
TOTAL TRAINED	52

(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 Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 Oakwood Estate **#** 33712 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2012 **(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	$ 400	$ 30,093	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	195,156	1,792,183	3
4	Supply Inventory (priced at)	646	20,456	4
5	Short-Term Investments		3,770,791	5
6	Prepaid Insurance	(10,063)	(4,108)	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	17	928,052	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 186,156	$ 6,537,467	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	422,033	13
14	Buildings, at Historical Cost	322,330	5,094,693	14
15	Leasehold Improvements, at Historical Cost	71,012	568,803	15
16	Equipment, at Historical Cost	235,441	2,417,995	16
17	Accumulated Depreciation (book methods)	(458,197)	(5,405,103)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,121)	20
21	Restricted Funds		9,505,010	21
22	Other Long-Term Assets (spe Cash Value of Life Insurance Policies		36,270	22
23	Other(specify): Investment in other facilities		5,706,680	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 180,063	$ 18,346,381	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 366,219	$ 24,883,848	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,468	$ 670,140	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,567	373,421	30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,867)	28,466	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	19,010	208,909	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rounding	3	5	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 68,181	$ 1,280,941	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Lease		24,647	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 24,647	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 68,181	$ 1,305,588	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 298,038	$ 23,578,260	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 366,219	$ 24,883,848	48

***(See instructions.)**

Facility Name & ID Number Oakwood Estate # 33712 **Report Period Beginning:** ###### **Ending:** 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (644,828)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (644,828)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(48,957)	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	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (48,957)	17
	B. Transfers (Itemize):		
18	**Investment from other facilities**	991,823	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 991,823	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 298,038	24 *

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

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 690,691	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 690,691	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule		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)**	$ 690,691	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	107,170	31
32	Health Care	328,085	32
33	General Administration	247,967	33
	B. Capital Expense		
34	Ownership	18,306	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,120	36
	D. Other Expenses (specify):		
37	Rounding Errors		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 739,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	(48,957)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (48,957)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 690,691	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 690,691	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Oakwood Estate # ### Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	652	826	$ 23,873	$ 28.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	189	817	13,551	16.59	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants		81	852	10.52	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	168	168	4,073	24.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,287	2,396	27,175	11.34	15
16	Dishwashers					16
17	Maintenance Workers	747	747	15,086	20.20	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	227	227	9,701	42.74	20
21	Assistant Administrator	269	616	18,216	29.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	655	655	5,935	9.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,845	2,129	48,834	22.94	29
30	Habilitation Aides (DD Homes)	17,837	20,107	218,911	10.89	30
31	Medical Records					31
32	Other Health C: OT/PT & Speech Therapies					32
33	Other(specify) Day Program					33
34	TOTAL (lines 1 - 33)	24,876	28,769	$ 386,207 *	$ 13.42	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	24	$ 720	1-3	35
36	Medical Director	Flat Fee	360	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	831	10-3	39
40	Physical Therapy Consultant	6	350	10-3	40
41	Occupational Therapy Consultant	9	611	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	25	1,782	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consulta	10	792	12-3	46
47	Dental Consultant	0	0		47
48	Podiatrist Consultant	0	0		48
49	TOTAL (lines 35 - 48)	74	$ 5,446		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			10-3	51
52	Certified Nurse Assistants/Aides			10a-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matthew Steffen	Administrator	0	$ 9,701
Crystal Streitmatter	Assistant Administrator	0	18,216
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,917

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Quantum Solutions Inc	Data Processing	$ 927
Silverchair Learning Center	Data Processing	1,158
Koch Consultants, LTD	Accounting	1,863
Heinold-Banwart, LTD	Accounting	1,362
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,310

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 10,230
Unemployment Compensation Insurance	0
FICA Taxes	26,082
Employee Health Insurance	125,255
Employee Meals	18,218
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	825
Employee Promotional	1,619
Defined Contribution Pension Plan	19,010
Benefits Allocated to Day Program	0
Disability Insurance	2,834
Benefits for Transferred wages	(12,062)
Employee Scholarships	800
TOTAL (agree to Schedule V, line 22, col.8)	$ 192,811

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	62
(Indicate # of checks performed 5)	
Patient Background Checks	
Participation Fees & Certificates	18
Dues (Employers Assn, IHCA)	897
Subscriptions (journals, news, etc.)	60
Driving Records Verification	36
Secretary of State	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,073

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakwood Estate # 33712 Report Period Beginning: 7/1/2011 Ending: #######

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 Oakwood Estate # 33712 **Report Period Beginning:** 7/1/2011 **Ending:** #

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? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association - $839**

(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? **15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,161** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **226,007**
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? **Yes** 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? **Yes** 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. $ **18,218** 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, they have been adjusted out.**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Koch Consultants, LTD.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

Oakwood Estate
FYE 6/30/2012 #0033712
Sub schedules

Schedule V - Costs Center Expenses

Lines	Description	Amount
43	Facility Bulletin / Newsletter	
36	Investment Management Fees	
36	Interest Expense	
27	Dental costs	2,137
27	Charitable Contributions	
27	Fines & Penalties	
27	Miscellaneous	116
	Other Expenses	2,253

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
6	Communication equipment rental		
35	Communication equipment rental		-
32	Interest Expense	-	
36	Interest Expense		-
11	Donated labor	528	
1	Donated labor	-	
4	Donated labor	-	
3	Donated labor	165	
6	Donated labor	-	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		693
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		2,834
22	Disability Pay to Benefits	2,834	
13	Nurse aid trainer wages	5,215	
1	Nurse aid trainer wages		22
6	Nurse aid trainer wages		35
10	Nurse aid trainer wages		4,945
10a	Nurse aid trainer wages		44
11	Nurse aid trainer wages		10
12	Nurse aid trainer wages		159
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
39	Dental costs	2,137	
27	Dental costs		2,137
		10,879	10,879

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 23 visits	$ 2,137

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 693
Department	Time in Hours	Time in Dollars
Activities	70.50	528
Kitchen	-	-
Laundry	-	-
Housekeeping	22.00	165
Maintenance	-	-
Nursing	-	-
PT/OT	-	-
Social Service Programs	-	-
Office	-	-
Totals	92.50	$ 693

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - $611.36 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Roger Aberle - $1,150.53 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Stan Virkler - $401.96 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Dennis Mott - $406.31 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Bryan Stoller - $228.92 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate
Tim Steffen - $417.69 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 9; Other Current Assets

A/R - N.A. Training	-
A/R - Bequests	-
A/R - Health Insurance	-
A/R - Employees	17
	17

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	-

Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	
Farm Income	
Gain/(Loss) on Sale of Assets	
Increase in Cash Value of Life Insurance	-
Miscellaneous	
Cost to Market Adjustment on Investments	
	-

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	(48,957)
Income from related parties	1,401,039
Estimated excess for year, Form 990, p.1, line 18	1,352,082

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	386,207
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(386,207)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	386,207
Prior Year PTO Accrual	(28,979)
Current Year PTO Accrual	25,804
Prior Year Wage Accrual	8,451
Current Year Wage Accrual	(10,927)
Section 125 Wages not applicable to FICA taxes	(39,634)
Less: Wages over FICA taxation limit of $94.2k SS Wages ($0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilites	(12,062)
Add: Disability Wages	2,834
Add: wages included in employee meal calculation	9,248
Cash basis salaries	340,943
FICA rate	7.650%
Calculated FICA	26,082
FICA per Sch XIX	26,082
Variance	0

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	-
Therapy / PT / OT	44
Activities Director	10
Day Program	-
Head Cook	22
Maintenance	35
Nursing	4,945
Soc. Serv. / QMRP	159
	5,215

14. A portion of office space is allocated to related entities based on number of beds.

16. Out of State Travel

Administration

Administrator	178
Assistant Administrator	83
	261

Board of Directors

Virgil Metzger (Not out of State)	
Stan Virkler	71
Roger Aberle	205
Bryan Stoller (Not out of State)	
Dennis Mott	72
Tim Steffen	74
	422

Nursing

None	-
	-

OAKWOOD ESTATE - - #0033712

ATTACHMENT TO SCHEDUDLE VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, IL #0016220
Linden Estate, Morton, IL #0039305

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Ron Hodel, Chairman
Dennis Mott, Vice Chairman
Roger Beutel, Secretary/Treasurer
Bryan Stoller, Director
Cleve Klopfenstein, Director
Roger Aberle, Director
Tim Steffen, Director
Virgil Metzger, Director
Paul Kelson, Director (term began 5/17/2012)
Stan Virkler, Chairman (term ended 05/17/2012)

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

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AIDE CLASSES **From: 7/1/2011 to 6/30/2012**

CLASS DATE		TR					OE					LE					CILA				
		# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages
completed	48	26	1,040	$ 8,840.00	2080	$ 17,680.00	3	120	$ 1,020.00	240	$ 2,040.00	5	200	$ 1,700.00	400	$ 3,400.00	14	560	$ 4,760.00	1,120	$ 9,520.00
still enrolled, not complete	16	15	174	$ 1,479.00	348	$ 2,958.00	0	29	$ 246.50	58	$ 493.00	1	26	$ 221.00	52	$ 442.00	0	16	$ 136.00	32	$ 272.00
dropouts	4	4	22	$ 187.00	44	$ 374.00	0		$ -	0	$ -	0		$ -	0	$ -	0	4	$ 34.00	8	$ 68.00
				$ -	0	$ -			$ -	0	$ -			$ -	0	$ -			$ -	0	$ -
Total	2191	45	1236	$ 10,506.00	2472	$ 21,012.00	3	149	$ 1,266.50	298	$ 2,533.00	6	226	$ 1,921.00	452	$ 3,842.00	14	580	$ 4,930.00	1160	$ 9,860.00

TRAINER WAGES	Classification	Hours	Hourly Rate	Wages	WAGES TR	WAGES OE	WAGES LE	WAGES CILA	Hours TR	Hours OE	Hours LE	Hours CILA	
Anna Liza Raboza	10			$ -	-	-	-	-	-	-	-	-	8
Cheryl Hays	10s	32.00		$ 499.20	281.61	33.95	51.49	132.15	18.05	2.18	3.30	8.47	7.25
Don Bowers	12q	18.00		$ 339.84	191.71	23.11	35.05	89.96	10.15	1.22	1.86	4.76	
Evie Mogler	12r	1.00		$ 23.05	13.00	1.57	2.38	6.10	0.56	0.07	0.10	0.26	22.936
Gary Folkerts	6	19.00		$ 510.91	288.22	34.74	52.70	135.25	10.72	1.29	1.96	5.03	
Jodi Fehr	17	-		$ -	-	-	-	-	-	-	-	-	
Jenny Smith	10ot	6.00		$ 131.04	73.92	8.91	13.52	34.69	3.38	0.41	0.62	1.59	20
Kathy Kelch	10	47.75		$ 1,258.69	710.06	85.60	129.83	333.20	26.94	3.25	4.93	12.64	5.734
Leigh Wamsley	12q	-		$ -	-	-	-	-	-	-	-	-	
Lori Brittain	1	13.00		$ 316.94	178.79	21.55	32.69	83.90	7.33	0.88	1.34	3.44	
Marcella Chapman	10	-		$ -	-	-	-	-	-	-	-	-	
Mary Beth Garza	11	-		$ -	-	-	-	-	-	-	-	-	
Randy Mogler	12r	53.00		$ 1,363.16	768.99	92.70	140.61	360.85	29.90	3.60	5.47	14.03	
Rob Mooney	12r	4.00		$ 84.80	47.84	5.77	8.75	22.45	2.26	0.27	0.41	1.06	
Sherrie Parnham	12r	2.00		$ 43.68	24.64	2.97	4.51	11.56	1.13	0.14	0.21	0.53	
Tina Leman	12m	15.00		$ 325.50	183.62	22.14	33.58	86.17	8.46	1.02	1.55	3.97	
Mark Baker	12q	11.00		$ 159.28	89.85	10.83	16.43	42.16	6.21	0.75	1.13	2.91	
Isaac Aberle	11	8.00		$ 153.92	86.83	10.47	15.88	40.75	4.51	0.54	0.83	2.12	
Gayle Fidler	10	-		$ -	-	-	-	-	-	-	-	-	
Vikki Steele	15	-		$ -	-	-	-	-	-	-	-	-	
Stephanie Barth	10a	2.00		$ 18.90	10.66	1.29	1.95	5.00	1.13	0.14	0.21	0.53	
Kathy Kelch	10	1,741.50		$ 45,905.94	25,896.73	3,121.86	4,735.16	12,152.19	982.43	118.43	179.63	461.01	
Gayle Fidler	10	1,135.25		$ 25,543.13	14,409.54	1,737.07	2,634.75	6,761.76	640.42	77.20	117.10	300.52	
OE					-	-	-	-	-	-	-	-	
Jodi Fehr	17			$ -	-	-	-	-	-	-	-	-	
Evie Mogler	12r			$ -	-	-	-	-	-	-	-	-	
LE					-	-	-	-	-	-	-	-	
Rob Mooney	12r			$ -	-	-	-	-	-	-	-	-	
				$ -	-	-	-	-	-	-	-	-	
CILA					-	-	-	-	-	-	-	-	
Sherrie Parnham	12r			$ -	-	-	-	-	-	-	-	-	
Leigh Wamsley	12q			$ -	-	-	-	-	-	-	-	-	
					43,256.04	5,214.52	7,909.28	20,298.14	1,753.59	211.40	320.64	822.88	

Total trainer wages 3108.5 $ 76,677.98 $ 2,170.00 Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	4	0	0	0
Clinical Wages	$ 374.00	$ -	$ -	$ 68.00
Classroom Wages	$ 187.00	$ -	$ -	$ 34.00
In-House Trainer Wages	$ 257.00	$ -	$ -	$ 47.00
Completed				
Number from this Facility	26	3	5	14
Clinical Wages	$ 10,319.00	$ 1,267.00	$ 1,921.00	$ 4,896.00
Classroom Wages	$ 20,638.00	$ 298.00	$ 3,842.00	$ 9,792.00
In-House Trainer Wages	$ 28,324.00	$ 993.00	$ 5,273.00	$ 13,439.00

Supplies 4654.38

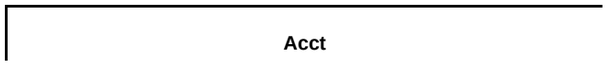
Schedule V

		Line	TR Change	OE Change	LE Change	CILA Change
Dietary	1	1	(179.00)	(22.00)	(33.00)	(84.00)
Maintenance	6	6	(288.00)	(35.00)	(53.00)	(135.00)
Nursing	10	10	(41,016.00)	(4,945.00)	(7,500.00)	(19,247.00)
Therapy	10a	10a	(11.00)	(1.00)	(2.00)	(5.00)
OT/PT	10ot	10a	(74.00)	(9.00)	(14.00)	(35.00)
Activities	11	11	(87.00)	(10.00)	(16.00)	(41.00)
RSD	12r	12	(854.00)	(103.00)	(156.00)	(401.00)
QMRP's	12q	12	(282.00)	(34.00)	(51.00)	(132.00)
MSSD	12m	12	(184.00)	(22.00)	(34.00)	(86.00)
Training Wages	13	13	43,256.00	5,215.00	7,909.00	20,298.00
Day Program	15	15	-	-	-	-
Administrator	17	17	-	-	-	-
OJT	12ojt	12	-	-	-	-
Speech	10s	10a	(282.00)	(34.00)	(51.00)	(132.00)
Adjustment		12	1.00	-	1.00	-
			-	-	-	-

$ 17,680.00	240	$ 3,400.00	$	9,520.00
$ 2,958.00	58	$ 442.00	$	272.00
$ 374.00	0	$ -	$	68.00
$ 8,840.00	$ 1,020.00	$ 1,700.00	$	4,760.00
$ 1,479.00	$ 246.50	$ 221.00	$	136.00
$ 187.00	$ -	$ -	$	34.00

Oakwood Estate -- 0033712

		Wages	Supplies	Other	Total	Reclass-ification	Total	Cost / Day Resident Days 5,595	Adjust-ments	Adjusted Total	Cost / Day Resident Days 5,595	% of Total Costs	% of Daily Rate	Staff Hours/ Day
	A. General Services													
1	Dietary	34,885	1,612	720	37,217	(22)	37,195	$6.65	-	37,195	$6.65	5.0%	5.6%	0.44
2	Food Purchase	-	30,582	-	30,582	-	30,582	$5.47	-	30,582	$5.47	4.1%	4.6%	
3	Housekeeping	-	633	165	798	165	963	$0.17	-	963	$0.17	0.1%	0.1%	-
4	Laundry	-	1,949	-	1,949	-	1,949	$0.35	-	1,949	$0.35	0.3%	0.3%	-
5	Heat and Other Utilities	-	-	14,849	14,849	-	14,849	$2.65	-	14,849	$2.65	2.0%	2.2%	
6	Maintenance	15,086	736	5,953	21,775	(35)	21,740	$3.89	-	21,740	$3.89	2.9%	3.3%	0.13
7	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
8	**TOTAL General Services**	**49,971**	**35,512**	**21,687**	**107,170**	**108**	**107,278**	**$19.17**	**-**	**107,278**	**$19.17**	**14.5%**	**16.1%**	**0.57**
	B. Health Care and Programs													
9	Medical Director	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
10	Nursing and Medical Records	36,372	10,947	1,131	48,450	(4,945)	43,505	$7.78	-	43,505	$7.78	5.9%	6.5%	0.15
10a	Therapy	219,537	-	962	220,499	(2,878)	217,621	$38.90	-	217,621	$38.90	29.5%	32.7%	3.19
11	Activities	-	1,295	-	1,295	518	1,813	$0.32	-	1,813	$0.32	0.2%	0.3%	-
12	Social Services	48,539	37	2,794	51,370	(159)	51,211	$9.15	-	51,211	$9.15	6.9%	7.7%	0.33
13	CNA Training	-	-	-	-	5,215	5,215	$0.93	-	5,215	$0.93	0.7%	0.8%	-
14	Program Transportation	-	-	6,471	6,471	-	6,471	$1.16	-	6,471	$1.16	0.9%	1.0%	
15	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
16	**TOTAL Health Care and Programs**	**304,448**	**12,279**	**11,358**	**328,085**	**(2,249)**	**325,836**	**$58.24**	**-**	**325,836**	**$58.24**	**44.1%**	**48.9%**	**3.67**
	C. General Administration													
17	Administrative	16,152	-	-	16,152	-	16,152	$2.89	-	16,152	$2.89	2.2%	2.4%	0.09
18	Directors Fees	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
19	Professional Services	-	-	5,309	5,309	-	5,309	$0.95	-	5,309	$0.95	0.7%	0.8%	
20	Dues, Fees, Subscriptions & Promotion	-	-	1,302	1,302	-	1,302	$0.23	(229)	1,073	$0.19	0.1%	0.2%	
21	Clerical & General Office Expenses	15,636	2,334	-	17,970	-	17,970	$3.21	-	17,970	$3.21	2.4%	2.7%	0.12
22	Employee Benefits & Payroll Taxes	-	-	192,811	192,811	2,834	195,645	$34.97	-	195,645	$34.97	26.5%	29.4%	
23	Inservice Training & Education	-	-	816	816	-	816	$0.15	-	816	$0.15	0.1%	0.1%	
24	Travel and Seminar	-	-	776	776	-	776	$0.14	(422)	354	$0.06	0.0%	0.1%	
25	Other Admin. Staff Transportation	-	-	349	349	-	349	$0.06	(261)	88	$0.02	0.0%	0.0%	
26	Insurance-Prop.Liab.Malpractice	-	-	9,701	9,701	-	9,701	$1.73	-	9,701	$1.73	1.3%	1.5%	
27	Other (specify):*	-	-	2,781	2,781	(2,830)	(49)	($0.01)	-	(49)	($0.01)	0.0%	0.0%	
28	**TOTAL General Administration**	**31,788**	**2,334**	**213,845**	**247,967**	**4**	**247,971**	**$44.32**	**(912)**	**247,059**	**$44.16**	**33.4%**	**37.1%**	**0.21**
	TOTAL Operating Expense	**386,207**	**50,125**	**246,890**	**683,222**	**(2,137)**	**681,085**	**$121.73**	**(912)**	**680,173**	**$121.57**	**92.1%**	**102.1%**	**4.45**
	D. Ownership													
30	Depreciation	-	-	18,306	18,306	-	18,306	$3.27	-	18,306	$3.27	2.5%	2.7%	
31	Amortization of Pre-Op. & Org.	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
32	Interest	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
33	Real Estate Taxes	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
34	Rent-Facility & Grounds	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
35	Rent-Equipment & Vehicles	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
36	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
37	**TOTAL Ownership**	**-**	**-**	**18,306**	**18,306**	**-**	**18,306**	**$3.27**	**-**	**18,306**	**$3.27**	**2.5%**	**2.7%**	**-**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
39	Ancillary Service Centers	-	-	-	-	2,137	2,137	$0.38	-	2,137	$0.38	0.3%	0.3%	
40	Barber and Beauty Shops	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
41	Coffee and Gift Shops	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
42	Provider Participation Fee	-	-	38,120	38,120	-	38,120	$6.81	-	38,120	$6.81	5.2%	5.7%	
43	Other (specify):*	-	-	-	-	-	-	$0.00	-	-	$0.00	0.0%	0.0%	
44	**TOTAL Special Cost Centers**	**-**	**-**	**38,120**	**38,120**	**2,137**	**40,257**	**$7.20**	**-**	**40,257**	**$7.20**	**5.4%**	**6.0%**	**-**
45	**GRAND TOTAL**	**386,207**	**50,125**	**303,316**	**739,648**	**-**	**739,648**	**$132.20**	**(912)**	**738,736**	**$132.04**	**100.0%**	**110.9%**	**4.45**
	Current Reimbursement Rate							**$119.04**			**$119.04**	**90.2%**	**100.0%**	
	Gain/(Loss) Per Resident / Day							**(13.16)**			**(13.00)**	**-9.8%**	**-10.9%**	
								-11.1%			-10.9%			
	% of Costs Per Area	**78.28%**	**6.78%**	**14.94%**	**100.00%**									
								(4,803)			(4,743.19)			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