FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0047019

Facility Name: OAK HILL

Address: 623 HAMACHER STREET (Number) WATERLOO (City) 62298 (Zip Code)

County: MONROE

Telephone Number: (618) 939-3488 **Fax #** (618) 989-5030

HFS ID Number:

Date of Initial License for Current Owners: 02/01/1952

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: KEVIN WELLEN **Telephone Number:** (314) 231-5544
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 12/01/2012 to 11/30/2013 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) KEVIN WELLEN, DIRECTOR
(Firm Name & Address) BKD, LLP, 211 NORTH BROADWAY SUITE 600
(Telephone) (314) 231-5544 Fax # (314) 231-9731

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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	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	18,259	21,063	5,087	44,409	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,259	21,063	5,087	44,409	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.88%

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)

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 02/01/1952

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 [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 4,585

Medicare Intermediary WISCONSIN PHYSICIAN SERVICES, INC

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/2013 Fiscal Year: 11/30/2013

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

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	388,381	17,542		405,923		405,923		405,923			1
2	Food Purchase		235,540		235,540		235,540		235,540			2
3	Housekeeping	166,548	33,917		200,465		200,465		200,465			3
4	Laundry	114,634	13,149		127,783		127,783		127,783			4
5	Heat and Other Utilities			263,909	263,909		263,909		263,909			5
6	Maintenance	148,069	124,016		272,085		272,085		272,085			6
7	Other (specify):*											7
8	TOTAL General Services	817,632	424,164	263,909	1,505,705		1,505,705		1,505,705			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,805,571	117,071	28,274	2,950,916		2,950,916		2,950,916			10
10a	Therapy		3,792	567,904	571,696		571,696		571,696			10a
11	Activities	217,577	7,454	8,866	233,897		233,897		233,897			11
12	Social Services	46,573			46,573		46,573		46,573			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,069,721	128,317	614,644	3,812,682		3,812,682		3,812,682			16
	C. General Administration											
17	Administrative	70,813		65,692	136,505		136,505	49,299	185,804			17
18	Directors Fees											18
19	Professional Services			69,134	69,134		69,134		69,134			19
20	Dues, Fees, Subscriptions & Promotions			20,097	20,097		20,097	(1,324)	18,773			20
21	Clerical & General Office Expenses	247,814	19,937	90,335	358,086		358,086		358,086			21
22	Employee Benefits & Payroll Taxes			1,684,726	1,684,726		1,684,726		1,684,726			22
23	Inservice Training & Education			1,239	1,239		1,239		1,239			23
24	Travel and Seminar			13,337	13,337		13,337		13,337			24
25	Other Admin. Staff Transportation			811	811		811		811			25
26	Insurance-Prop.Liab.Malpractice			126,005	126,005		126,005		126,005			26
27	Other (specify):*											27
28	TOTAL General Administration	318,627	19,937	2,071,376	2,409,940		2,409,940	47,975	2,457,915			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,205,980	572,418	2,949,929	7,728,327		7,728,327	47,975	7,776,302			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 OAK HILL #0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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			65,093	65,093		65,093	333,131	398,224			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					299,493	299,493	(19,880)	279,613			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			65,093	65,093	299,493	364,586	313,251	677,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,892	23,276	141,168		141,168		141,168			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			315,306	315,306		315,306		315,306			42
43	Other (specify):* **NONALLOWABLE**			1,304,207	1,304,207	(299,493)	1,004,714	(1,004,714)				43
44	**TOTAL Special Cost Centers**		117,892	1,642,789	1,760,681	(299,493)	1,461,188	(1,004,714)	456,474			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,205,980	690,310	4,657,811	9,554,101		9,554,101	(643,488)	8,910,613			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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	$		$	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	(7,741)	17		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	(19,880)	32		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,135)	17		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,324)	20		28
29	Other-Attach Schedule	(1,004,714)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,047,794)		$	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))**	$ (1,047,794)		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

OAK HILL

ID# 0047019

Report Period Beginning: 12/01/2012

Ending: 11/30/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PUBLIC RELATION	$ (10,941)	43	1
2	ADVERTISING	(4,254)	43	2
3	PET MAINTENANCE	(1,037)	43	3
4	SPIRIT COMMITTEE ACTIVITY	960	43	4
5	BIRD AVIRY	(2,532)	43	5
6	SALES TAX	(193)	43	6
7	SPECIAL PROJECTS	(1,297)	43	7
8	ALZHEIMERS ACCOUNTS	2,054	43	8
9	RESIDENT COUNCIL ACCOUNT	2,540	43	9
10	WESSEL-PISTOR EXP	(1,500)	43	10
11	ENDOWNMENT ASSOC	(130,526)	43	11
12	SENIOR JUBILEE EXPENSE	(3,303)	43	12
13	MONROE COUNTY LABOR SHARE	(30,000)	43	13
14	DEBT SERVICE COVERAGE PRINCIPAL	(803,658)	43	14
15	WALKING TRIAL	17,635	43	15
16	DONATION EXPENSE PURCHASES	(38,662)	43	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**	(1,004,714)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK HILL # 0047019 **Report Period Beginning:** 12/01/2012 **Ending:** 11/30/2013

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	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	(21,876)	71,175	0	0	0	0	0	0	0	0	0	49,299	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	(1,324)	0	0	0	0	0	0	0	0	0	0	(1,324)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	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**	(23,200)	71,175	0	0	0	0	0	0	0	0	0	47,975	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,200)	71,175	0	0	0	0	0	0	0	0	0	47,975	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK HILL **#** 0047019 **Report Period Beginning:** 12/01/2012 **Ending:** 11/30/2013

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	333,131	0	0	0	0	0	0	0	0	0	333,131	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,880)	0	0	0	0	0	0	0	0	0	0	(19,880)	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**	(19,880)	333,131	0	0	0	0	0	0	0	0	0	313,251	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):*	(1,004,714)	0	0	0	0	0	0	0	0	0	0	(1,004,714)	43
44	**TOTAL Special Cost Centers**	(1,004,714)	0	0	0	0	0	0	0	0	0	0	(1,004,714)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,047,794)	404,306	0	0	0	0	0	0	0	0	0	(643,488)	45

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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
N/A						

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	30	DEPRECIATION	$	MONROE COUNTY		$ 333,131	$ 333,131	1
2	V	17	GENERAL ADMINISTRATION		MONROE COUNTY		71,175	71,175	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			$			$ 404,306	$ * 404,306	14

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

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 1/30/2013

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	N/A					$	$		$	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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	N/A	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.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	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.)**	$	N/A	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.)**	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008	N/A	8
2009	N/A	9
2010	N/A	10
2011	N/A	11
2012	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK HILL COUNTY MONROE

FACILITY IDPH LICENSE NUMBER 0001628

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,560 B. General Construction Type: Exterior BRICK Frame BRICK & CONCRET Number of Stories 2

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).

Supportive Living Facility - Magnolia Terrace 57 beds

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	54,477	2007	$ 13,325,251	1
2					2
3	TOTALS	54,477		$ 13,325,251	3

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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			2006	2006	$ 13,325,251	$ 333,121	40	$ 333,121	$	$ 2,331,897	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEGAL FEELS FOR SLF BUILDING			2006	1,425	201	7	201		1,425	9
10	WASHER(2), DRYER(2), MICROWAVE & RANGE			2006	3,490	496	7	496		3,490	10
11	FIRE EXTINGUISHERS (56)			2006	3,160	454	7	454		3,160	11
12	GENERATOR			2006	3,238	460	7	460		3,239	12
13	NEW CONSTRUCTION- CLEAN			2006	3,385	169	20	169		1,183	13
14	NEW CONSTRUCTION- CLEAN			2006	19,500	975	20	975		6,825	14
15	ARTWORK, FRAMES, TIE BACKS & SIGNS PERMIT			2006	1,222	172	7	172		1,222	15
16	CHAPEL FURNISHINGS			2006	3,300	474	7	474		3,300	16
17	PAYROLL FILE CABINETS			2006	1,100	158	7	158		1,100	17
18	SINGLE DECK CONVECTION OVEN			2006	2,682		5			2,682	18
19	ELECTRIC LOCK, CONTROLS & MONITOR SPRUCE GATE			2006	3,477	232	15	232		1,624	19
20	NEW CONSTRUCTION- CLEAN			2006	6,511	326	20	326		5,282	20
21	ELECTRIC FOR FOUNTAIN			2007	2,277	327	7	327		2,277	21
22	SLING			2007	1,105	157	7	157		1,105	22
23	LOCK & KEYS			2007	4,557	651	7	651		4,557	23
24	PARALLEL BARS FOR THERAPY			2007	1,424		5			1,424	24
25	DIRECT SUPPLY- FURNITURE			2007	8,622	1,229	7	1,229		8,622	25
26	ELECTRICAL & SYSTEM DAMAGE FROM STORM			2007	804	114	7	114		804	26
27	HANDICAP RAMP			2008	2,505	125	20	125		750	27
28	6"TALL WHITE LAKELAND PRIVACY FENCE			2008	8,490	566	15	566		3,255	28
29	FINNERTY CONSTRUCTION- FENCE RESTOCK			2008	3,078	205	15	205		1,025	29
30	FIRE SPRINKLER UPDATES			2009	4,317	617	7	617		3,085	30
31	GENERATOR			2009	9,528	1,361	7	1,361		6,805	31
32	GENERATOR REFUND			2010	(1,048)	(175)	6	(175)		(700)	32
33	AIR GRILLS AND SMOKE DAMPER			2010	2,543	363	7	363		1,452	33
34	NEW SPRINKLER INSTALLATION			2010	11,365	568	20	568		2,272	34
35	BEL-O PSI UPGRADE			2011	3,872	553	7	553		1,659	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	H&G SALES- FRONT DOOR PANIC HARDWARE	2011	$ 6,337	$ 905	7	$ 905	$	$ 2,715	37
38	NEW SPRINKLER UPDATES	2011	5,785	826	7	826		2,478	38
39	GAZEBO PROJECT	2011	26,694	1,780	15	1,780		5,340	39
40	GAZEBO PROJECT - SLF Allocation	2011	(10,851)	(724)	15	(724)		(2,171)	40
41	MAIN KITCHEN BACKUP POWER	2012	2,400	343	7	343		686	41
42	NEW LIGHTSWITCHES FOR BUILDING	2012	7,281	364	20	364		728	42
43	MAIN KITCHEN ENTRY SUPPLY	2012	4,200	210	20	210		420	43
44	STORAGE BUILDING	2012	11,195	560	20	560		1,120	44
45	SELF TIMER SYSTEM	2012	6,615	945	7	945		1,890	45
46	GRACIE GARDEN	2012	45,454	3,030	15	3,030		6,060	46
47	KITCHEN CABINETS - SPRUCE	2013	5,849	836	7	836		836	47
48	KITCHEN CABINETS - CEDAR	2013	6,712	959	7	959		959	48
49	NEW FIRE PANEL	2013	1,597	228	7	228		28	49
50	TILE FLOOR	2013	2,000	286	7	286		286	50
51	AUTOMATIC FIRE SPRINKLER UPGRADE	2013	69,433	3,472	20	3,472		3,472	51
52	TURF	2013	19,120	1,275	15	1,275		1,275	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)		$ 13,651,001	$ 359,194		$ 359,194	$	$ 2,430,943	70

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

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	$ 213,909	$ 49,670	$ 49,670	$	various	$ 175,855	71
72	Current Year Purchases	33,961	6,003	6,003		various	6,003	72
73	Fully Depreciated Assets	273,660				various	273,660	73
74								74
75	TOTALS	$ 521,530	$ 55,673	$ 55,673	$		$ 455,518	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	RESIDENT CARE	1996 FORD BUS	1996	$ 42,892	$	$	$	7	$ 42,892	76
77										77
78										78
79										79
80	TOTALS			$ 42,892	$	$	$		$ 42,892	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)	$ 27,540,674	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 414,867	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 414,867	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)	$ 2,929,353	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	GAZEBO - SLF Portion	$ 10,851	$ 724	$ 2,171	86
87	SLF Assets	19,504	2,187	13,654	87
88					88
89					89
90					90
91	TOTALS	$ 30,355	$ 2,911	$ 15,825	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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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 [X] 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: N/A *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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.

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.

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	$	2,247	$ 153,249	$	2,247	$ 153,249	1
2	Licensed Speech and Language Development Therapist		hrs		2,121	199,406		2,121	199,406	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,725	183,348		2,725	183,348	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): Respiratory Therapy				580	31,900		580	31,900	12
13	Other (specify):									13
14	TOTAL			$	7,673	$ 567,903	$	7,673	$ 567,903	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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2013 (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	$	$ 3,239,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,743,262	3
4	Supply Inventory (priced at)		55,714	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		11,134	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		860,194	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 5,909,836	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		356,105	14
15	Leasehold Improvements, at Historical Cost		(125,807)	15
16	Equipment, at Historical Cost		564,422	16
17	Accumulated Depreciation (book methods)		(444,582)	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)**	$	$ 350,138	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 6,259,974	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 453,769	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)		315,480	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER LIABILITIES		40,781	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 810,030	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	OTHER L-T LIABILITIES		614,527	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 614,527	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 1,424,557	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,835,417	$ 4,835,417	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,835,417	$ 6,259,974	48

*(See instructions.)

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,981,097	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,981,097	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(130,710)	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)	(1,014,970)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,145,680)	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)**	$ 4,835,417	24 *

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

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	$ 7,436,874	1
2	Discounts and Allowances for all Levels	(1,032,026)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,404,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	115,504	5
6	Therapy	1,156,666	6
7	Oxygen	87,821	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,359,991	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	7,741	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	103,590	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,225	19
20	Radiology and X-Ray	15,858	20
21	Other Medical Services	166,072	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 302,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,880	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,880	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SUPPORTIVE LIVING REVENUE	1,634,961	28
28a	MISCELLANEOUS OTHER	1,345,508	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,980,469	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,067,674	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,505,705	31
32	Health Care	3,812,682	32
33	General Administration	2,409,940	33
	B. Capital Expense		
34	Ownership	65,093	34
	C. Ancillary Expense		
35	Special Cost Centers	1,445,375	35
36	Provider Participation Fee	315,306	36
	D. Other Expenses (specify):		
37	SUPPORTIVE LIVING EXPENSES	1,644,283	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,198,384	40
41	**Income before Income Taxes (line 30 minus line 40)****	(130,710)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (130,710)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	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)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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	2,080	2,080	$ 66,888	$ 32.16	1
2	Assistant Director of Nursing	2,080	2,080	58,548	28.15	2
3	Registered Nurses	8,449	8,449	221,852	26.26	3
4	Licensed Practical Nurses	33,864	33,864	712,054	21.03	4
5	CNAs & Orderlies	106,208	106,208	1,352,491	12.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,122	4,122	58,797	14.26	8
9	Activity Director					9
10	Activity Assistants	20,139	20,139	217,577	10.80	10
11	Social Service Workers	2,080	2,080	46,573	22.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,862	37,862	388,381	10.26	15
16	Dishwashers					16
17	Maintenance Workers	8,935	8,935	148,069	16.57	17
18	Housekeepers	16,699	16,699	166,548	9.97	18
19	Laundry	11,119	11,119	114,634	10.31	19
20	Administrator	1,498	1,498	70,813	47.27	20
21	Assistant Administrator	2,080	2,080	40,359	19.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,607	11,607	207,455	17.87	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	4,160	4,160	68,695	16.51	31
32	Other Health C: MDS Coord/Care	10,400	10,400	266,246	25.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	283,382	283,382	$ 4,205,980 *	$ 14.84	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KECKRITZ	ADMINISTRATOR		$ 70,813
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,813

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 51,513
BAD DEBT EXPENSE	14,135
BOND ISSUANCE COSTS	44
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 65,692

C. Professional Services

Vendor/Payee	Type	Amount
ACCOUNTING FEES	ACCOUNTING	$ 13,154
PAYROLL PROCESSING	ACCOUNTING	681
LEGAL FEES	LEGAL	55,299
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 69,134

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 625,022
Unemployment Compensation Insurance	3,465
FICA Taxes	295,935
Employee Health Insurance	313,509
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	408,195
PRE-EMPLOYMENT TESTING	10,604
EMPLOYEE RELATIONS	13,375
EMPLOYEE VACCINES	4,073
UNIFORM EXPENSE	175
WORK COMP DRUG SCREEN	290
ADMINISTRATOR RETIREMENT ACCT	10,083
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,684,726

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,768
Advertising: Employee Recruitment	3,693
Health Care Worker Background Check	2,230
(Indicate # of checks performed 244)	
Yellow Page Advertising	1,324
DUES	9,620
SUBSCRIPTIONS	462
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,324)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,773

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE REIMBURSEMENT	1,642
LODGING MEALS	1,232
Seminar Expense	
SEMINAR FEES	10,463
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,337

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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 OAK HILL # 0047019 Report Period Beginning: 12/01/2012 Ending: 11/30/2013

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **IDPH/LSN**
If YES, give association name and amount. **IDPH $2767; Life Svs Network $9621**

(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? **No** 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? **7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **63,139** 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.

(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. $ **315,306**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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? **0**
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FICK, EGGEMEYER & WILLIAMSON**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.