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: 0033712

Facility Name: Oakwood Estate

Address: 2213 Veterans Rd (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)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/12 to 6/30/13 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) Crystal Streitmatter

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Matthew D. Steffen Telephone Number: (309) 266-9781
Email Address:

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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	16	Intermediate/DD	16	5,840	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?
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 [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: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	44,070	2,943	720	47,733	(18)	47,715		47,715			1
2	Food Purchase		36,465		36,465		36,465		36,465			2
3	Housekeeping	1,339	855		2,194		2,194		2,194			3
4	Laundry		331	1,983	2,314		2,314		2,314			4
5	Heat and Other Utilities			16,811	16,811		16,811		16,811			5
6	Maintenance	13,972	528	5,941	20,441	(16)	20,425		20,425			6
7	Other (specify):*											7
8	**TOTAL General Services**	59,381	41,122	25,455	125,958	(34)	125,924		125,924			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	38,753	7,036	1,214	47,003	(3,155)	43,848		43,848			10
10a	Therapy	209,110		1,004	210,114	(6,787)	203,327		203,327			10a
11	Activities		1,811		1,811	173	1,984		1,984			11
12	Social Services	49,751	11	5,696	55,458	(152)	55,306		55,306			12
13	CNA Training	680			680	3,378	4,058		4,058			13
14	Program Transportation			6,265	6,265		6,265		6,265			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	298,294	8,858	14,179	321,331	(6,543)	314,788		314,788			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			6,454	6,454		6,454		6,454			19
20	Dues, Fees, Subscriptions & Promotions			1,856	1,856		1,856	(597)	1,259			20
21	Clerical & General Office Expenses	49,971	2,821		52,792		52,792		52,792			21
22	Employee Benefits & Payroll Taxes			162,948	162,948	6,750	169,698		169,698			22
23	Inservice Training & Education			598	598		598		598			23
24	Travel and Seminar			661	661		661	(556)	105			24
25	Other Admin. Staff Transportation			217	217		217		217			25
26	Insurance-Prop.Liab.Malpractice			10,977	10,977		10,977		10,977			26
27	Other (specify):* See Pg 24			3,386	3,386	(3,042)	344		344			27
28	**TOTAL General Administration**	49,971	2,821	187,097	239,889	3,708	243,597	(1,153)	242,444			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	407,646	52,801	226,731	687,178	(2,869)	684,309	(1,153)	683,156			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: 7/1/2012 Ending: 6/30/2013

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			18,778	18,778		18,778		18,778			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):* Investment Expenses											36
37	**TOTAL Ownership**			18,778	18,778		18,778		18,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					2,869	2,869		2,869			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,056	39,056		39,056		39,056			42
43	Other (specify):* Facility Bulletin											43
44	**TOTAL Special Cost Centers**			39,056	39,056	2,869	41,925		41,925			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	407,646	52,801	284,565	745,012		745,012	(1,153)	743,859			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 # 0033712 Report Period Beginning: 7/1/2012 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	(597)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (597)		$	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))**	$ (597)		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# 0033712

Report Period Beginning: 7/1/2012

Ending: 6/30/2013

	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)		24	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)	(556)	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**	(556)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estate # 0033712 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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	(597)	0	0	0	0	0	0	0	0	0	0	(597)	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	(556)	0	0	0	0	0	0	0	0	0	0	(556)	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**	(1,153)	0	0	0	0	0	0	0	0	0	0	(1,153)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,153)	0	0	0	0	0	0	0	0	0	0	(1,153)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakwood Estate # 0033712 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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	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)**	(1,153)	0	0	0	0	0	0	0	0	0	0	(1,153)	45

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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
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 ☐ 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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 Abelre	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	Ed Leman	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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	Virgil Metzger	Director	Director	0.00	653	0.5		Travel	$ 117	line 24; col.3	1
2	Roger Aberle	Director	Director	0.00	1,618	0.5		Travel	289	line 24; col.3	2
3	Paul Kelson	Director	Director	0.00	253	0.5		Travel	45	line 24; col.3	3
4	Dennis Mott	Vice-Chairman	Director	0.00	484	0.5		Travel	86	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	162	0.5		Travel	29	line 24; col.3	7
8	Cleve Klopfenstein	Director	Director	0.00		0.5					8
9	Ed Leman	Director	Director	0.00		0.5					9
10	Tim Steffen	Director	Director	0.00	533	0.5		Travel	96	line 24; col.3	10
11											11
12											12
13								TOTAL	$ 661		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 # 0033712 Report Period Beginning: 7/1/2012 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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,140 B. General Construction Type: Exterior Brick Frame Fireproof construction 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).

Aposltolic 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	LTC Facility	91,781	1988	$ 9,477	1
2					2
3	TOTALS	91,781		$ 9,477	3

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	16			1989	$ 202,314	$ 5,058	40	$ 5,058	$	$ 123,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	316--Vinyl Floor Covering			1988	3,790		10			3,790	9
10	343--Landscaping			1988	26,269		5			26,269	10
11	345--Driveways			1989	458		8			458	11
12	348--Parking Signs			1989	3,764		10			3,764	12
13	350--Sod			2008	1,697	113	15	113		679	13
14	354--Organization Costs			1988	621	21	30	21		528	14
15	352--Landscaping			1988	1,747		20			1,747	15
16	360--Lighting Fixtures			1988	1,368	46	30	46		1,163	16
17	859--Exit Ramps			1988	7,277		20			7,277	17
18	349--Underground Gas & Waterline			1988	7,650	153	25	153		7,650	18
19	358--Kitchen Serving Door			1989	4,287	143	30	143		3,501	19
20	344--Dainage/Sewer			1989	23,166		20			23,166	20
21	347--Concrete			1989	23,005	920	25	920		22,544	21
22	346--Irrigation System			1989	24,890	996	25	996		24,392	22
23	351--Drainage / Sewer			1989	36,140	1,446	25	1,446		35,417	23
24	361--New Facility Wiring			1991	2,010		20			2,010	24
25	300--Garage			1995	709	18	40	18		329	25
26	359--Fire Prevention Sprinkler System			1995	733	18	40	18		339	26
27	362--Water & Gas Plumbing			1995	775	19	40	19		359	27
28	364--Cabinets & Countertop			1995	1,249	31	40	31		578	28
29	305--Door for Porch Enclosure			1995	4,136	103	40	103		1,913	29
30	302--Door For Porch Enclosure			1999	1,623	41	40	41		588	30
31	303--Back Door For Porch			1999	10,526	702	15	702		10,176	31
32	306--Lighting for Porch			2006	1,261	84	15	84		631	32
33	304--Awning & Window for Porch			2000	108	7	15	7		98	33
34	307--Generator Wiring			2000	4,866		10			4,866	34
35	353--Resurface Driveway			2002	425	28	15	28		326	35
36	771--Fiber Optic Cable			2002	900	60	15	60		690	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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	309--Generator Circuits	2000	$ 108	$ 7	15	$ 7	$	$ 98	37
38	308--Carpet	2000	4,866		10			4,866	38
39	565--Counter tops	2002	425	28	15	28		326	39
40	563--Counter tops	2002	900	60	15	60		690	40
41	780--Flooring	2007	7,109	474	15	474		3,081	41
42	857--Telephone System	2008	882	59	15	59		353	42
43	858--Roofing Project	2008	33,760	2,251	15	2,251		13,504	43
44	327--Vinyl Floor Coverings	1994	1,548		10			1,548	44
45	882--Laundry Utility Sinks	2009	1,404	94	15	94		468	45
46	883--Lighting Project	2009	2,500	167	15	167		833	46
47	939--Replace Sprinkler Main with Galvanized Pipe	2010	9,267	618	15	618		2,471	47
48	997--Misc repair to agree to TB	2011	39		1			39	48
49	1002--Carrier Furnace	2012	2,686	179	15	179		358	49
50	1012--Hallways Floorcoverings	2012	7,127	1,018	7	1,018		2,036	50
51	1013--Cabinets, Countertops, Handles	2012	4,705	235	20	235		471	51
52	1015--Porch	2012	10,869	543	20	543		1,087	52
53	1027--Heat Pump	2013	2,400	160	15	160		160	53
54	929--Ramp Railings	2008	7,384	492	15	492		2,461	54
55	1051--Porch	2012	1,203	1,203	1	1,203		1,203	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)		$ 496,946	$ 17,595		$ 17,595	$	$ 345,218	70

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 37,968	$ 1,097	$ 1,097	$	14	$ 35,171	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	99,375	182	182		10	99,375	73
74	Disposed Assets							74
75	TOTALS	$ 137,343	$ 1,279	$ 1,279	$		$ 134,546	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)	$ 643,766	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,874	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 18,874	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)	$ 479,764	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	$	$	$	86
87	Capitalized repairs				87
88	Vehicle Equipment				88
89	Vehicles				89
90	Disposed Assets				90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Conversion to Wheelchair Faci	$ 64,045	92
93			93
94			94
95		$ 64,045	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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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? [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)		680		680
4	Clinical Wages (b)		160		160
5	In-House Trainer Wages (c)		643		643
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,483	$	$ 1,483
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,483			

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
2. From other facilities (f)	42
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	9
TOTAL TRAINED	53

(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 **#** 0033712 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2013 **(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	$ 300	$ 192,899	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	119,141	1,855,742	3
4	Supply Inventory (priced at)	646	20,456	4
5	Short-Term Investments		2,570,622	5
6	Prepaid Insurance		31,000	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		413,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 120,087	$ 5,083,924	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	543,233	13
14	Buildings, at Historical Cost	388,775	6,067,299	14
15	Leasehold Improvements, at Historical Cost	71,012	582,977	15
16	Equipment, at Historical Cost	235,441	2,512,092	16
17	Accumulated Depreciation (book methods)	(476,975)	(5,755,647)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,269	46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,269)	(46,121)	20
21	Restricted Funds		10,642,015	21
22	Other Long-Term Assets (spe **Cash Value of Life Insurance**		36,270	22
23	Other(specify): **Investment in other facilities**		7,523,109	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 227,730	$ 22,151,348	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 347,817	$ 27,235,272	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,936	$ 281,505	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,038	414,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,383	50,241	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	17,976	225,000	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Rounding**	2	(3)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 79,335	$ 971,154	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**		15,351	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,351	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 79,335	$ 986,505	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 268,482	$ 26,248,767	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 347,817	$ 27,235,272	48

***(See instructions.)**

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: ###### Ending: 6/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (706,677)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (706,677)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(185,521)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(1,431)	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)**	$ (186,952)	17
	B. Transfers (Itemize):		
18	**Investment from other facilities**	1,162,111	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,162,111	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 268,482	24 *

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 558,060	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 558,060	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	1,431	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,431	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule		28
28a	Cost to Market Gain on Investments		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 559,491	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	125,958	31
32	Health Care	321,331	32
33	General Administration	239,889	33
	B. Capital Expense		
34	Ownership	18,778	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,056	36
	D. Other Expenses (specify):		
37	Rounding Errors		37
38	Cost to Market Loss on Investements		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 745,012	40
41	**Income before Income Taxes (line 30 minus line 40)****	(185,521)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (185,521)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 558,060	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)	$ 558,060	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 # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	402	462	$ 12,474	$ 27.00	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	562	635	14,579	22.96	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	0	0	0		5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	144	144	3,594	24.96	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	3,131	3,637	46,202	12.70	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	808	808	13,997	17.32	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	886	995	31,460	31.62	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	315	315	8,610	27.33	22
23	Office Manager	0	0	0		23
24	Clerical	1,355	1,355	22,791	16.82	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	1,838	2,087	49,770	23.85	29
30	Habilitation Aides (DD Homes)	17,294	18,726	204,169	10.90	30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	26,735	29,164	$ 407,646 *	$ 13.98	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	914	10-3	39
40	Physical Therapy Consultant	6	386	10-3	40
41	Occupational Therapy Consultant	9	618	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	29	1,968	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consulta	8	627	12-3	46
47	Dental Consultant	0	0		47
48	Psychiatrist Consultant	5	1,064	12-3	48
49	TOTAL (lines 35 - 48)	81	$ 6,657		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 Oakwood Estate # 0033712 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Steitmatter	Administrator	0	$ 31,460
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,460

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	$ 751
Silverchair Learning Center	Data Processing	1,199
Koch Consultants, LTD.	Accounting	1,901
Heinold-Banwart LTD.	Accounting	1,288
Farnsworth	Various	1,236
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,376

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,872
Unemployment Compensation Insurance	0
FICA Taxes	41,021
Employee Health Insurance	132,570
Employee Meals	676
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	389
Employee Promotional	1,585
Defined Contribution Pension Plan	17,976
Benefits Allocated to Day Program	0
Disability Insurance	6,750
Benefits for Transferred wages	(43,141)
Employee Scholarships	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,698

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	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	
Participation Fees & Certificates	155
Dues (Employers Assn, IHCA)	1,056
Subscriptions (journals, news, etc.)	
Driving Records Verification	48
Secretary of State	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,259

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
See Ppage 24 (XX-16)	
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 # 0033712 Report Period Beginning: 7/1/2012 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 Health Care 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? **20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **649** 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. $ **39,056**
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. $ **676** 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? **80%**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees