FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0033712

Facility Name: Oakwood Estates

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

County: Tazewell

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

HFS ID Number:

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

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code: 501 (c)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2013 to 06/30/2014 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 # ( )

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: 07/01/2013 Ending: 06/30/2014

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	2,320			2,320	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,320			2,320	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.73%

D. How many bed-hold days during this year were paid by the Department?
11 (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: 06/30/14 Fiscal Year: 06/30/14

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

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	42,193	3,370	720	46,283	(8)	46,275	0	46,275			1
2	Food Purchase		20,552		20,552	0	20,552	0	20,552			2
3	Housekeeping	4,689	1,697	0	6,386	0	6,386	0	6,386			3
4	Laundry	0	2,939	1,300	4,239	0	4,239	0	4,239			4
5	Heat and Other Utilities			13,549	13,549	0	13,549	0	13,549			5
6	Maintenance	13,228	1,197	9,721	24,146	315	24,461	0	24,461			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	**TOTAL General Services**	60,110	29,755	25,290	115,155	307	115,462	0	115,462			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	9,170	12,002	782	21,954	(119)	21,835	0	21,835			10
10a	Therapy	197,220	0	924	198,144	(1,183)	196,961	0	196,961			10a
11	Activities	0	683	0	683	60	743	0	743			11
12	Social Services	50,968	4	5,016	55,988	(88)	55,900	0	55,900			12
13	CNA Training	0	0	0	0	265	265	0	265			13
14	Program Transportation	0	0	3,023	3,023	0	3,023	0	3,023			14
15	Other (specify):*	0	0	0	0	0	0	0	0			15
16	**TOTAL Health Care and Programs**	257,358	12,689	9,745	279,792	(1,065)	278,727	0	278,727			16
	C. General Administration											
17	Administrative	0	0	0	0	0	0	0	0			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			4,422	4,422	0	4,422	0	4,422			19
20	Dues, Fees, Subscriptions & Promotions			2,211	2,211	0	2,211	(448)	1,763			20
21	Clerical & General Office Expenses	36,266	2,522	0	38,788	0	38,788	0	38,788			21
22	Employee Benefits & Payroll Taxes			109,103	109,103	1,154	110,257	0	110,257			22
23	Inservice Training & Education			316	316	0	316	0	316			23
24	Travel and Seminar			354	354	0	354	(309)	45			24
25	Other Admin. Staff Transportation		0	124	124	0	124	0	124			25
26	Insurance-Prop.Liab.Malpractice			4,752	4,752	0	4,752	0	4,752			26
27	Other (specify):*	0	0	1,044	1,044	(1,403)	(359)	0	(359)			27
28	**TOTAL General Administration**	36,266	2,522	122,326	161,114	(249)	160,865	(757)	160,108			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	353,734	44,966	157,361	556,061	(1,007)	555,054	(757)	554,297			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 Estates #0033712 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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			56,876	56,876	0	56,876	0	56,876			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	0	0			32
33	Real Estate Taxes			0	0	0	0	0	0			33
34	Rent-Facility & Grounds			0	0	0	0	0	0			34
35	Rent-Equipment & Vehicles			0	0	0	0	0	0			35
36	Other (specify):*			0	0	0	0	0	0			36
37	**TOTAL Ownership**			56,876	56,876	0	56,876	0	56,876			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	0	0	0	0	1,007	1,007	0	1,007			39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0			40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0			41
42	Provider Participation Fee	0	0	31,140	31,140	0	31,140	0	31,140			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	31,140	31,140	1,007	32,147	0	32,147			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	353,734	44,966	245,377	644,077	0	644,077	(757)	643,320			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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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		15		24
25	Fund Raising, Advertising and Promotional	(448)	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)**	$ (448)		$ 0	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*	$ 396		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)**	$ 396		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52)		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	Dental	x				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

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Oakwood Estates

ID# 0033712

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

	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)	(62)	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)	(247)	24	7
8	Interest Expense		32	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**	(309)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estates # 0033712 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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	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	(448)	0	0	0	0	0	0	0	0	0	0	(448)	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	(309)	0	0	0	0	0	0	0	0	0	0	(309)	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**	(757)	0	0	0	0	0	0	0	0	0	0	(757)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(757)	0	0	0	0	0	0	0	0	0	0	(757)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakwood Estates **#** 0033712 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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

	Capital Expense D. Ownership	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)	
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)**	(757)	0	0	0	0	0	0	0	0	0	0	(757)	45

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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.		Timber Ridge	Morton	Community Residentia	Morton	CILA Services
		Linden Estate	Morton			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Virgil Metzger	BOD						1
2	Roger Aberle	BOD						2
3	Paul Kelson	BOD						3
4	Dennis Mott	BOD						4
5	Royce Schieler	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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	Vice-Chairman	Director	0.00	750	0.5		Travel	$ 67		1
2	Roger Aberle	Director	Director	0.00	1,617	0.5		Travel	144	line 24; col. 3	2
3	Paul Kelson	Director	Director	0.00	211	0.5		Travel	19		3
4	Dennis Mott	Chairman	Director	0.00	463	0.5		Travel	41	line 24; col. 3	4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		5
6	Bryan Stoller	Director	Director	0.00	242	0.5		Travel	22		6
7	Cleve Klopfenstein	Director	Director	0.00	0	0.5			0		7
8	Ed Leman	Director	Director	0.00	0	0.5			0		8
9	Tim Steffen	Director	Director	0.00	700	0.5		Travel	62	line 24; col. 3	9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	$ 354		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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 6/30/2014

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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$ 0	$ 0			$ 0	14
15	**TOTALS (line 9+line14)**						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 0 **Line #** _____

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

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

Facility Name & ID Number Oakwood Estates **#** 0033712 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ 0	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakwood Estates COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0033712

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,140 B. General Construction Type: Exterior Brick Frame Fireproof Constructio Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apostolic Christian Timber Ridge (IDPA #0016220) is located adjacent to this property.
Type of business: Nursing Home (ICF-ID/DD)
Square footage: Land - 1345699 sq ft; Building - 50,135 sq ft

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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$	$ 128,975	4
5					0	0		0		0	5
6											6
7											7
8											8
	Improvement Type**										
9	316--Vinyl Floor Covering			1988	3,509	0	10	0		3,509	9
10	343--Landscaping			1988	9,369	0	10	0		9,369	10
11	345--Driveways			1988	16,544	0	15	0		16,544	11
12	348--Parking Signs			1988	41	0	12	0		41	12
13	350--Sod			1988	3,790	0	10	0		3,790	13
14	354--Organization Costs			1988	26,269	0	5	0		26,269	14
15	352--Landscaping			1989	458	0	8	0		458	15
16	360--Lighting Fixtures			1989	3,764	0	10	0		3,764	16
17	859--Exit Ramps			2008	1,697	113	15	113		792	17
18	349--Underground Gas & Waterline			1988	621	21	30	21		549	18
19	358--Kitchen Serving Door			1988	1,747	0	20	0		1,747	19
20	344--Dainage/Sewer			1988	1,368	46	30	46		1,208	20
21	347--Concrete			1988	7,277	0	20	0		7,277	21
22	346--Irrigation System			1988	7,650	0	25	0		7,650	22
23	351--Drainage / Sewer			1989	4,287	143	30	143		3,644	23
24	361--New Facility Wiring			1989	23,166	0	20	0		23,166	24
25	300--Garage			1989	23,005	460	25	460		23,005	25
26	359--Fire Prevention Sprinkler System			1989	24,890	498	25	498		24,890	26
27	362--Water & Gas Plumbing			1989	36,140	723	25	723		36,140	27
28	364--Cabinets & Countertop			1991	2,010	0	20	0		2,010	28
29	305--Door for Porch Enclosure			1995	709	18	40	18		346	29
30	302--Door For Porch Enclosure			1995	733	18	40	18		358	30
31	303--Back Door For Porch			1995	775	19	40	19		378	31
32	306--Lighting for Porch			1995	1,249	31	40	31		609	32
33	304--Awning & Window for Porch			1995	4,136	103	40	103		2,017	33
34	307--Generator Wiring			1999	1,623	41	40	41		629	34
35	353--Resurface Driveway			1999	10,526	351	15	351		10,526	35
36	771--Fiber Optic Cable			2006	1,261	84	15	84		715	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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$	$ 105	37
38	308--Carpet	2000	4,866	0	10	0		4,866	38
39	565--Counter tops	2002	425	28	15	28		354	39
40	563--Counter tops	2002	900	60	15	60		750	40
41	780--Flooring	2007	7,109	474	15	474		3,555	41
42	857--Telephone System	2008	882	59	15	59		412	42
43	858--Roofing Project	2008	33,760	2,251	15	2,251		15,755	43
44	327--Vinyl Floor Coverings	1994	1,548	0	10	0		1,548	44
45	882--Laundry Utility Sinks	2009	1,404	94	15	94		562	45
46	883--Lighting Project	2009	2,500	167	15	167		1,000	46
47	939--Replace Sprinkler Main with Galvanized Pipe	2010	16,651	1,110	15	1,110		6,043	47
48	997--Misc repair to agree to TB	2011	39	0	1	0		39	48
49	1002--Carrier Furnace	2012	2,686	179	15	179		537	49
50	1012--Hallways Floorcoverings	2012	7,127	1,018	7	1,018		3,054	50
51	1013--Porch Remodeling (Storage Cabinets, Countertops, Handles)	2012	4,705	235	20	235		706	51
52	1015--Porch Remodeling (windows & Electrical)	2012	10,869	543	20	543		1,630	52
53	1027--Heat Pumps and Condensing Unit	2013	2,400	160	15	160		320	53
54	1028--Conversion to WC accessible facility (See Attachment A for	2014	898,241	29,941	30	29,941		29,941	54
55	1051--Reconciling item	2012	1,203	0	1	0		1,203	55
56			0	0		0		0	56
57	1071--Gutters	2014	1,600	80	20	80		80	57
58	1080--Window Tx	2014	5,115	341	15	341		341	58
59	1105--New Carrier Condenser and Coil	2014	4,700	313	15	313		313	59
60	1108--Patient Lift Systems	2014	79,236	5,282	15	5,282		5,282	60
61	1118--Final PJ Hoerr Pmt for Conversion (See Attachment A for d	2014	2,598	87	30	87		87	61
62			0	0		0		0	62
63			0	0		0		0	63
64			0	0		0		0	64
65			0	0		0		0	65
66			0	0		0		0	66
67			0	0		0		0	67
68			0	0		0		0	68
69			0	0		0		0	69
70	TOTAL (lines 4 thru 69)		$ 1,511,600	$ 50,156		$ 50,156	$ 0	$ 418,858	70

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

Oakwood Estates - - 0033712
FYE: 06/30/2014

Asset Descriptions

Page: 12A

Line	54	1028--Conversion to WC accessible facility (See Attachment A for descriptions)	898,241
Line	61	1118--Final PJ Hoerr Pmt for Conversion (See Attachment A for descriptions)	2,598
			900,839

Category Breakdown of PJ Hoerr Contractor Bills: (Rounded to nearest $)

Design Fees	66,098
General Contractor	106,797
Demolition	34,810
Concrete	9,546
Masonry	17,400
Handrails	4,670
Insulation	11,800
Rough Carpentry	12,310
Finish Carpentry	3,500
Cabinets & Millwork	37,633
Doors, Frames, Hardware	61,403
Windows	27,105
Drywall	49,100
Floor Coverings	92,880
Painting	31,698
Wall Coverings	29,596
Fire Protection	37,400
Plumbing	55,842
HVAC	37,720
Electrical	134,410
Nurse Call System	21,011
Phone System	6,600
Generator	11,510
	900,839

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 45,922	$ 1,047	$ 1,047	$ 0	13	$ 44,172	71
72	Current Year Purchases	64,413	5,672	5,672	0	10	5,672	72
73	Fully Depreciated Assets	104,506	0	0	0	10	104,506	73
74	Disposed Assets	0	0	0	0	5	0	74
75	TOTALS	$ 214,841	$ 6,719	$ 6,719	$ 0		$ 154,350	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				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,735,918	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,875	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 56,875	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 573,208	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	$ 0	$ 0	$ 0	86
87	Capitalized repairs	0	0	0	87
88	Vehicle Equipment	0	0	0	88
89	Vehicles	0	0	0	89
90	Disposed Assets	0	0	0	90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Conversion from Ambulatory t	$ 0	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies	0	94		94
3	Classroom Wages (a)	0	595		595
4	Clinical Wages (b)	0	140		140
5	In-House Trainer Wages (c)	0	51		51
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 880	$ 0	$ 880
10	SUM OF line 9, col. 1 and 2 (e)	$ 880			

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	1
2. From other facilities (f)	51
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	12
TOTAL TRAINED	64

(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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (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	$ 188,291	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	47,190	1,274,626	3
4	Supply Inventory (priced at)	646	20,456	4
5	Short-Term Investments	0	2,871,477	5
6	Prepaid Insurance	0	48,270	6
7	Other Prepaid Expenses	0	0	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify):	9	409,366	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 48,145	$ 4,812,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	9,477	572,033	13
14	Buildings, at Historical Cost	1,217,721	7,216,877	14
15	Leasehold Improvements, at Historical Cost	71,012	597,530	15
16	Equipment, at Historical Cost	335,372	2,665,971	16
17	Accumulated Depreciation (book methods)	(478,999)	(5,878,160)	17
18	Deferred Charges	0	0	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	0	11,736,008	21
22	Other Long-Term Assets (specify):	0	41,448	22
23	Other(specify): Investment in other facilities	0	9,573,788	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,154,583	$ 26,525,495	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,202,728	$ 31,337,981	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,017	$ 1,026,209	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	0	29
30	Accrued Salaries Payable	56,034	479,789	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,293	71,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	12,601	250,001	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	Rounding	(9)	245	36
37			0	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 82,936	$ 1,828,046	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	0	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43	Capital Lease	0	48,850	43
44			0	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 48,850	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 82,936	$ 1,876,896	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,119,792	$ 29,461,085	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,202,728	$ 31,337,981	48

*(See instructions.)

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (815,745)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (815,745)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(375,385)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (375,385)	17	
	B. Transfers (Itemize):			
18	**Investment from other facilities**	2,310,922	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,310,922	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,119,792	24	*

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 275,741	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 275,741	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	0	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	0	21
22	Laundry	0	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions	1,081	24
25	Interest and Other Investment Income***	0	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,081	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	See attached schedule	0	28
28a	Cost to Market Gain on Investments	0	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 276,822	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	115,155	31
32	Health Care	279,792	32
33	General Administration	161,114	33
	B. Capital Expense		
34	Ownership	56,876	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	31,140	36
	D. Other Expenses (specify):		
37			37
38	Cost to Market Loss on Investments	0	38
39	Loss on Sale of Assets	8,130	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 652,207	40
41	**Income before Income Taxes (line 30 minus line 40)****	(375,385)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (375,385)	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) ICFID/DD	275,741	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 275,741	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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	63	76	$ 2,173	$ 28.59	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	119	288	6,997	24.30	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	137	137	3,582	26.15	13
14	Head Cook	1,935	2,138	28,798	13.47	14
15	Cook Helpers/Assistants	1,080	1,080	11,580	10.72	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	920	920	14,918	16.22	17
18	Housekeepers	186	186	1,760	9.46	18
19	Laundry	0	0	0		19
20	Administrator	522	684	25,876	37.83	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	451	451	12,061	26.74	22
23	Office Manager	109	109	2,247	20.61	23
24	Clerical	95	95	1,382	14.55	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	1,870	2,079	51,191	24.62	29
30	Habilitation Aides (DD Homes)	15,850	16,937	187,567	11.07	30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	199	215	3,602	16.75	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	23,536	25,395	$ 353,734 *	$ 13.93	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	300	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	482	10-3	39
40	Physical Therapy Consultant	6	393	10-3	40
41	Occupational Therapy Consultant	8	531	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	33	2,394	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consult.	9	750	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	81	$ 5,569		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 Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Streitmatter	Administrator	0	$ 25,876
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 25,876

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	$ 511
Relias Learning Center	Data Processing	1,647
Margel Peddicord, CPA	Accounting	700
Koch Consultants, LTD	Accounting	992
Heinold-Banwart, LTD	Accounting	572
Other	Various non-legal	0
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 4,422

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,192
Unemployment Compensation Insurance	0
FICA Taxes	20,875
Employee Health Insurance	124,131
Employee Meals	202
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	540
Employee Promotional	1,119
Defined Contribution Pension Plan	12,601
Benefits Allocated to Day Program	0
Disability Insurance	1,154
Benefits for Transferred wages	(64,557)
Employee Scholarships	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 110,258

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	162
Health Care Worker Background Check	58
(Indicate # of checks performed)	
Patient Background Checks	
Participation Fees & Certificates	12
Dues (IHCA)	832
Subscriptions (journals, news, etc.)	71
Driving Records Verification	180
IDPH - Construction Review Fee	448
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,763

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
See Page 24 (XX-16)	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oakwood Estates **#** 0033712 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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. **IHCA - $832**

(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? **14.6 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,493** 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. $ **31,140**
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. $ **202** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No, they have been adjusted out.**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ ____

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Oakwood Estates
FYE 06/30/2014 **#0033712**
Sub schedules

Schedule V - Costs Center Expenses

Lines	Description	Amount
1	Day Program Costs	
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	
36	Interest Expense	
15	Bad Debt	
27	Dental costs	1,007
27	Charitable Contributions	-
27	Fines & Penalties	
27	Miscellaneous	(29)
	Other Expenses	978

Schedule V - Reclassifications

		Amount	
Lines	Description	Increase	Decrease
6	Communication equipment rental	-	
35	Communication equipment rental		-
32	Interest Expense	-	
36	Interest Expense		-
11	Donated labor	66	
1	Donated labor	-	
4	Donated labor	-	
6	Donated labor	330	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		396
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		1,154
22	Disability Pay to Benefits	1,154	
13	Nurse aid trainer wages	265	
1	Nurse aid trainer wages		8
6	Nurse aid trainer wages		15

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 396
Department	Time in Hours	Time in Dollars
Activities	8.75	66
Kitchen	-	-
Laundry	-	-
Maintenance	33.00	330
Nursing	-	-
PT/OT	-	-
Social Service Programs	-	-
Office	-	-
Totals	41.75	$ 396

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - $750.34 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Roger Aberle - $1,617.21 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Paul Kelson - $211.47 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Dennis Mott - $462.74 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Bryan Stoller - $242.45 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Tim Steffen - $700.33 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

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

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

Sch. XVIII - A. Staffin

Sch. V. Cost Center Expe
Sch. XVIII - A. Staffing a
Variance

Schedule XIX, D - Emp

Salaries, Sch V, Line 45,
Prior Year PTO Accrual
Current Year PTO Accrua
Prior Year Wage Accrual
Current Year Wage Accru
Section 125 Wages not a
Less: Wages over FICA ta
Add: Wages Allocated to
Add: ACCS Wages
Add: wages included in e
Cash basis salaries
FICA rate
Calculated FICA
FICA per Sch XIX
Variance

Sch. XX - General Info

12. Nurse Aide Trainer W

10	Nurse aid trainer wages		119
10a	Nurse aid trainer wages		29
11	Nurse aid trainer wages		6
12	Nurse aid trainer wages		88
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
39	Dental costs	1,007	
27	Dental costs		1,007
		2,822	2,822

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 10 visits	$ 1,007

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

Investment in Related Entities	-

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

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

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

Income before taxes per cost report	(375,385)
Income from related parties	1,248,344
Estimated excess for year, Form 990, p.1, line 18	872,959

14. A portion of office sp

16. Out of State Travel

g and Salary Costs

nses, Column 1, Row 45	353,734
nd Salary Costs, Column 3, Row 34	(353,734)
	-

ɔloyee Benefits and Payroll Taxes - FICA calculation

Col 1	353,734
	(30,154)
l	32,131
	11,951
ıal	(17,703)
pplicable to FICA taxes	(55,095)
axation limit of SS Wages ($0 x 6.2%/7.65%)	-
other facilites	(21,984)
mployee meal calculation	
	272,880
	7.650%
	20,875
	20,875
	0

ɾrmation

Vages:

Administrator	-
Therapy / PT / OT	29
Activities Director	6
Day Program	-
Head Cook	8
Maintenance	15
Nursing	119
Soc. Serv. / QMRP	88
	265

ɔace is allocated to related entities based on number of beds.

Administration	
Administrator	123
Assistant Administrator	-
	123
Board of Directors	
Virgil Metzger (Not out of State)	
Roger Aberle	144
Paul Kelson (Not out of State)	
Dennis Mott	41
Bryan Stoller (Not out of State)	
Tim Steffen	62
	247
Nursing	
None	-
	-

OAKWOOD ESTATES, IL #0033712

ATTACHMENT TO SCHEDUDLE VII A

Related Organizations:

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

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

Dennis Mott, Chairman
Virgil Metzger, Vice Chairman
Roger Beutel, Secretary/Treasurer
Bryan Stoller, Director
Ed Leman, Director
Roger Aberle, Director
Tim Steffen, Director
Virgil Metzger, Vice Chairman
Paul Kelson, Director
Cleve Klopfenstein, Chairman (term ended 5/20/2014)
Royce Scheiler, Director (term began 05/20/2014)

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

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

AIDE CLASSES OAKWOOD ESTATES, IL #0033712 From: 07/01/2013 to 06/30/2014

CLASS DATE	72	TR					OE					
		# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students	CLASS Hrs	CLASS Wages	OJT HRS	OJT Wages	# of Students
completed	52	33	1,320	$ 11,220.00	2640	$ 22,440.00	1	40	$ 340.00	80	$ 680.00	7
still enrolled, not complete	7	3	42	$ 357.00	84	$ 714.00	1	30	$ 255.00	60	$ 510.00	2
dropouts	12	11	48	$ 408.00	96	$ 816.00	0		$ -	0	$ -	0
				$ -	0	$ -			$ -	0	$ -	
Total	2242	47	1410	$ 11,985.00	2820	$ 23,970.00	2	70	$ 595.00	140	$ 1,190.00	9

TRAINER WAGES	Classification	Hours	Hourly Rate	Wages	WAGES TR	WAGES OE	WAGES LE	WAGES CILA	TR
Kristen Dancey	10			$ -	-	-	-	-	-
Cheryl Hays	10s	42.00		$ 672.00	422.62	20.98	87.52	140.87	26.41
Don Bowers	12q	36.00		$ 694.08	436.51	21.67	90.40	145.50	22.64
Evie Mogler	12r	2.00		$ 46.10	28.99	1.44	6.00	9.66	1.26
Gary Folkerts	6	18.00		$ 486.00	305.65	15.17	63.30	101.88	11.32
Crystal Streitmatter	17			$ -	-	-	-	-	-
Jenny Smith	10ot	12.00		$ 271.68	170.86	8.48	35.38	56.95	7.55
Kathy Kelch	10	142.00		$ 3,821.22	2,403.18	119.31	497.68	801.06	89.30
Leigh Wamsley	12q			$ -	-	-	-	-	-
Lori Brittain	1	10.00		$ 251.80	158.36	7.86	32.79	52.79	6.29
Sam Getz	10			$ -	-	-	-	-	-
Isaac Aberle	11			$ -	-	-	-	-	-
Randy Mogler	12r	45.00		$ 1,157.40	727.89	36.14	150.74	242.63	28.30
Rob Mooney	12r	4.00		$ 95.84	60.27	2.99	12.48	20.09	2.52
Sherrie Parnham	12r	2.00		$ 43.68	27.47	1.36	5.69	9.16	1.26
Tina Leman	12m	18.00		$ 405.00	254.71	12.64	52.75	84.90	11.32
Mark Baker	12q	24.00		$ 361.92	227.61	11.30	47.14	75.87	15.09
Isaac Aberle	11	10.00		$ 192.40	121.00	6.01	25.06	40.33	6.29
Gayle Fidler	10			$ -	-	-	-	-	-
Vikki Steele	15			$ -	-	-	-	-	-
Stephanie Barth	10a			$ -	-	-	-	-	-
Kathy Kelch	10			$ -	-	-	-	-	-
Gayle Fidler	10			$ -	-	-	-	-	-
OE					-	-	-	-	-
Jodi Fehr	17			$ -	-	-	-	-	-
Evie Mogler	12r			$ -	-	-	-	-	-

LE					-	-	-	-	-
Rob Mooney	12r		$	-	-	-	-	-	-
			$	-	-	-	-	-	-
CILA					-	-	-	-	-
Sherrie Parnham	12r		$	-	-	-	-	-	-
Leigh Wamsley	12q		$	-	-	-	-	-	-
					5,345.12	265.36	1,106.93	1,781.71	229.55

COMPLETED FOR 2014

LE				*CILA*				
CLASS		OJT		# of	CLASS		OJT	
Hrs	Wages	*HRS*	Wages	Students	*Hrs*	Wages	*HRS*	Wages
280	$ 2,380.00	*560*	$ 4,760.00	11	*440*	$ 3,740.00	*880*	$ 7,480.00
12	$ 102.00	*24*	$ 204.00	1	*30*	$ 255.00	*60*	$ 510.00
	$ -	*0*	$ -	1		$ -	*0*	$ -
	$ -	*0*	$ -			$ -	*0*	$ -
292	$ 2,482.00	584	$ 4,964.00	13	470	$ 3,995.00	940	$ 7,990.00

Hours		
OE	**LE**	**CILA**
-	-	-
1.31	5.47	8.80
1.12	4.69	7.55
0.06	0.26	0.42
0.56	2.34	3.77
-	-	-
0.37	1.56	2.52
4.43	18.49	29.77
-	-	-
0.31	1.30	2.10
-	-	-
-	-	-
1.40	5.86	9.43
0.12	0.52	0.84
0.06	0.26	0.42
0.56	2.34	3.77
0.75	3.13	5.03
0.31	1.30	2.10
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

8
7.25
22.936
20
5.734

-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
11.40	47.54	76.52

OAKWOOD ESTATES, IL #0033712

		Wages	Supplies	Other	Total	Reclass-ification	Total	Cost / Day Resident Days 2,320	Adjust-ments	Adjusted Total
	A. General Services									
1	Dietary	42,193	3,370	720	46,283	(8)	46,275	$19.95	-	46,275
2	Food Purchase	-	20,552	-	20,552	-	20,552	$8.86	-	20,552
3	Housekeeping	4,689	1,697	-	6,386	-	6,386	$2.75	-	6,386
4	Laundry	-	2,939	1,300	4,239	-	4,239	$1.83	-	4,239
5	Heat and Other Utilities	-	-	13,549	13,549	-	13,549	$5.84	-	13,549
6	Maintenance	13,228	1,197	9,721	24,146	315	24,461	$10.54	-	24,461
7	Other (specify):*	-	-	-	-	-	-	$0.00	-	-
8	**TOTAL General Services**	**60,110**	**29,755**	**25,290**	**115,155**	**307**	**115,462**	**$49.77**	**-**	**115,462**
	B. Health Care and Programs									
9	Medical Director	-	-	-	-	-	-	$0.00	-	-
10	Nursing and Medical Records	9,170	12,002	782	21,954	(119)	21,835	$9.41	-	21,835
10a	Therapy	197,220	-	924	198,144	(1,183)	196,961	$84.90	-	196,961
11	Activities	-	683	-	683	60	743	$0.32	-	743
12	Social Services	50,968	4	5,016	55,988	(88)	55,900	$24.09	-	55,900
13	CNA Training	-	-	-	-	265	265	$0.11	-	265
14	Program Transportation	-	-	3,023	3,023	-	3,023	$1.30	-	3,023
15	Other (specify):*	-	-	-	-	-	-	$0.00	-	-
16	**TOTAL Health Care and Programs**	**257,358**	**12,689**	**9,745**	**279,792**	**(1,065)**	**278,727**	**$120.14**	**-**	**278,727**
	C. General Administration									
17	Administrative	-	-	-	-	-	-	$0.00	-	-
18	Directors Fees	-	-	-	-	-	-	$0.00	-	-
19	Professional Services	-	-	4,422	4,422	-	4,422	$1.91	-	4,422
20	Dues, Fees, Subscriptions & Promotion	-	-	2,211	2,211	-	2,211	$0.95	(448)	1,763
21	Clerical & General Office Expenses	36,266	2,522	-	38,788	-	38,788	$16.72	-	38,788
22	Employee Benefits & Payroll Taxes	-	-	109,103	109,103	1,154	110,257	$47.52	-	110,257
23	Inservice Training & Education	-	-	316	316	-	316	$0.14	-	316
24	Travel and Seminar	-	-	354	354	-	354	$0.15	(309)	45
25	Other Admin. Staff Transportation	-	-	124	124	-	124	$0.05	-	124
26	Insurance-Prop.Liab.Malpractice	-	-	4,752	4,752	-	4,752	$2.05	-	4,752
27	Other (specify):*	-	-	1,044	1,044	(1,403)	(359)	($0.15)	-	(359)
28	**TOTAL General Administration**	**36,266**	**2,522**	**122,326**	**161,114**	**(249)**	**160,865**	**$69.34**	**(757)**	**160,108**
	TOTAL Operating Expense	**353,734**	**44,966**	**157,361**	**556,061**	**(1,007)**	**555,054**	**$239.25**	**(757)**	**554,297**

	D. Ownership								
30	Depreciation	-	-	56,876	56,876	-	56,876	$24.52	-	56,876
31	Amortization of Pre-Op. & Org.	-	-	-	-	-	-	$0.00	-	-
32	Interest	-	-	-	-	-	-	$0.00	-	-
33	Real Estate Taxes	-	-	-	-	-	-	$0.00	-	-
34	Rent-Facility & Grounds	-	-	-	-	-	-	$0.00	-	-
35	Rent-Equipment & Vehicles	-	-	-	-	-	-	$0.00	-	-
36	Other (specify):*	-	-	-	-	-	-	$0.00	-	-
37	**TOTAL Ownership**	**-**	**-**	**56,876**	**56,876**	**-**	**56,876**	**$24.52**	**-**	**56,876**
	Ancillary Expense									
	E. Special Cost Centers									
38	Medically Necessary Transportation	-	-	-	-	-	-	$0.00	-	-
39	Ancillary Service Centers	-	-	-	-	1,007	1,007	$0.43	-	1,007
40	Barber and Beauty Shops	-	-	-	-	-	-	$0.00	-	-
41	Coffee and Gift Shops	-	-	-	-	-	-	$0.00	-	-
42	Provider Participation Fee	-	-	31,140	31,140	-	31,140	$13.42	-	31,140
43	Other (specify):*	-	-	-	-	-	-	$0.00	-	-
44	**TOTAL Special Cost Centers**	**-**	**-**	**31,140**	**31,140**	**1,007**	**32,147**	**$13.86**	**-**	**32,147**
45	**GRAND TOTAL**	**353,734**	**44,966**	**245,377**	**644,077**	**-**	**644,077**	**$277.62**	**(757)**	**643,320**
	Current Reimbursement Rate							**$119.04**		
	Gain/(Loss) Per Resident / Day							**(158.58)**		
								-133.2%		
	% of Costs Per Area	**71.86%**	**6.98%**	**21.16%**	**100.00%**					

Cost / Day Resident Days 2,320	% of Total Costs	% of Daily Rate	Staff Hours/ Day
$19.95	7.2%	16.8%	1.36
$8.86	3.2%	7.4%	
$2.75	1.0%	2.3%	0.08
$1.83	0.7%	1.5%	-
$5.84	2.1%	4.9%	
$10.54	3.8%	8.9%	0.40
$0.00	0.0%	0.0%	
$49.77	**17.9%**	**41.8%**	**1.84**
$0.00	0.0%	0.0%	
$9.41	3.4%	7.9%	0.08
$84.90	30.6%	71.3%	6.92
$0.32	0.1%	0.3%	-
$24.09	8.7%	20.2%	0.81
$0.11	0.0%	0.1%	-
$1.30	0.5%	1.1%	
$0.00	0.0%	0.0%	
$120.14	**43.3%**	**100.9%**	**7.80**
$0.00	0.0%	0.0%	0.23
$0.00	0.0%	0.0%	
$1.91	0.7%	1.6%	
$0.76	0.3%	0.6%	
$16.72	6.0%	14.0%	0.28
$47.52	17.1%	39.9%	
$0.14	0.0%	0.1%	
$0.02	0.0%	0.0%	
$0.05	0.0%	0.0%	
$2.05	0.7%	1.7%	
($0.15)	-0.1%	-0.1%	
$69.01	**24.9%**	**58.0%**	**0.51**
$238.92	**86.2%**	**200.7%**	**10.14**

$24.52	8.8%	20.6%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$24.52	**8.8%**	**20.6%**	**-**
$0.00	0.0%	0.0%	
$0.43	0.2%	0.4%	
$0.00	0.0%	0.0%	
$0.00	0.0%	0.0%	
$13.42	4.8%	11.3%	
$0.00	0.0%	0.0%	
$13.86	**5.0%**	**11.6%**	**-**
$277.29	**100.0%**	**232.9%**	**10.14**
$119.04	**42.9%**	**100.0%**	
(158.25)	**-57.1%**	**-132.9%**	
-132.9%			