

		FOR BHF USE			

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: <u>1000139</u></p> <p>Facility Name: <u>Oak Hill SLF</u></p> <p>Address: <u>76 East Rollins Road</u> <u>Round Lake Beach</u> <u>60073</u> <small>Number City Zip Code</small></p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>(847) 201-1100</u> Fax # _____</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>7/30/2012</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other <u>Limited Partnership</u></td> <td>_____</td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2014</u> to <u>12/31/2014</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u> Email Address: _____</p>																													
<p>MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																													

Facility Name Oak Hill SLF

Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	94	Single Unit Apartment	94	34,310	1
2		Double Unit Apartment			2
3		Other			3
4	94	TOTALS	94	34,310	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	18,225	12,150		30,375	5
6	Double Unit					6
7	Other					7
8	TOTALS	18,225	12,150		30,375	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.53%

D. Indicate the number of paid bed-hold days the SLF had during this year 467 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 14 (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

Facility Name: Oak Hill SLF

Report Period Beginning:

1/1/2014

Ending: 12/31/2014

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	223,280	183,886	11,703	418,869	806	419,675	1
2	Housekeeping, Laundry and Maintenance	89,699	27,839	104,423	221,961	8,488	230,449	2
3	Heat and Other Utilities			122,451	122,451	182	122,633	3
4	Other (specify):							4
5	TOTAL General Services	312,979	211,725	238,577	763,281	9,476	772,757	5
B. Health Care and Programs								
6	Health Care/ Personal Care	448,489	3,887	23,450	475,826	10,564	486,390	6
7	Activities and Social Services	54,106	3,196	8,250	65,552	8,409	73,961	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	502,595	7,083	31,700	541,378	18,973	560,351	9
C. General Administration								
10	Administrative and Clerical	208,549	18,802	493,441	720,792	(129,074)	591,718	10
11	Marketing Materials, Promotions and Advertising	91,055	1,542	61,550	154,147	35,966	190,113	11
12	Employee Benefits and Payroll Taxes			169,377	169,377		169,377	12
13	Insurance-Property, Liability and Malpractice			31,324	31,324	1,105	32,429	13
14	Other (specify):					21,119	21,119	14
15	TOTAL General Administration	299,604	20,344	755,692	1,075,640	(70,884)	1,004,756	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,115,178	239,152	1,025,969	2,380,299	(42,435)	2,337,864	16
Capital Expenses								
D. Ownership								
17	Depreciation			1,216,384	1,216,384	(822,551)	393,833	17
18	Interest			308,542	308,542	(731)	307,811	18
19	Real Estate Taxes			109,156	109,156		109,156	19
20	Rent -- Facility and Grounds					11,468	11,468	20
21	Rent -- Equipment			4,632	4,632	98	4,730	21
22	Other (specify): MIP & Amortization			104,265	104,265		104,265	22
23	TOTAL Ownership			1,742,979	1,742,979	(811,716)	931,263	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,115,178	239,152	2,768,948	4,123,278	(854,152)	3,269,126	24

Oak Hill SLF

Report Period Beginning: 1/1/2014
Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	\$ (822,551)	17	1
2	Guest Meals	(6,729)	01	2
3	Employee Meals	(1,259)	01	3
4	Maintenance Fees	(187)	02	4
5	Damage Recovery	(1,038)	10	5
6	Pet Fee	(750)	07	6
7	NSF Fee	(150)	10	7
8	Termination Fee	(13)	10	8
9	Other Income	(2,174)	10	9
10	Meals & Entertainment	(511)	11	10
11	Bank Service Charges	(1,309)	10	11
12	Resident Gifts	(111)	10	12
13	Resident Reimbursables	(67)	10	13
14	Bad Debt - Tenant	(9,171)	10	14
15	Bad Debt - Medicaid	(48,805)	10	15
16	Cable TV	(710)	02	16
17	Management Fees	(42,117)	10	17
18	Service Provider Fee	(172,749)	10	18
19	Asset Management Fee	(15,145)	10	19
20	Partnership Mgmt Fee	(15,145)	10	20
21	Interest Income-Escrows	(72)	18	21
22	Interest Income	(659)	18	22
23	Additional R&M	4,906	02	23
24	Studio Furniture	(549)	02	24
25				25
26	PATHWAY MANAGEMENT LLC:			26
27	Maintenance	3,941	02	27
28	Utilities	182	03	28

29	Health Care / Personal Care	5,139	06	29
30	Community Life	1,802	07	30
31	Administrative	92,510	10	31
32	Marketing	15,463	11	32
33	Insurance	62	13	33
34	Employee Benefits	9,436	14	34
35	Rent - Building	10,605	20	35
36	Rent - Equipment	48	21	36
37				37
38	PATHWAY SENIOR LIVING LLC:			38
39	Dietary	8,793	01	39
40	Maintenance	1,087	02	40
41	Health Care / Personal Care	5,425	06	41
42	Community Life	7,357	07	42
43	Administrative	86,412	10	43
44	Marketing	21,014	11	44
45	Insurance	1,043	13	45
46	Employee Benefits	11,683	14	46
47	Rent - Building	863	20	47
48	Rent - Equipment	50	21	48
49				49
50				50
51				51
52				52
53				53
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99			99
100			100

101	Total	(854,152)	101
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Facility Name: Oak Hill SLF

Report Period Beginning 1/1/2014 Ending: 12/31/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.03	\$ 25.98	1
2	Licensed Practical Nurses	2.00	24.03	2
3	Certified Nurse Assistants	10.85	10.59	3
4	Activity Director & Assistants	1.37	18.95	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8.97	11.96	7
8	Dishwashers			8
9	Maintenance Workers	1.42	17.79	9
10	Housekeepers	1.87	9.56	10
11	Laundry			11
12	Managers			12
13	Other Administrative	4.21	23.83	13
14	Clerical			14
15	Marketing	1.28	34.33	15
16	Other			16
17	Total (lines 1 thru 16)	33.99	\$ 15.77	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
				Total	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 1
2		2
		Total
		\$ 3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached					

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: N/A If yes, what is the value of those services? \$ N/A

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Oak Hill SLF

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 615,000 Year land was acquired 2012

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	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	
1	94		2012		\$ 13,516,738	\$ 1,216,384	35	\$ 386,193	\$ (830,191)	\$ 772,386	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Supplemental Page 5's				10,690			535	535	869	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 13,527,428	\$ 1,216,384		\$ 386,728	\$ (829,656)	\$ 773,255	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 71,054	\$	\$ 7,105	7,105	10	\$ 9,930	18
19	Vehicles					5	-	19
20	TOTAL (lines 18 and 19)	\$ 71,054	\$	\$ 7,105	7,105		\$ 9,930	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

STATE OF ILLINOIS

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	Ac
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
1							
2	Civil Engineering	2013	6,694	20	335	335	
3	Smoking Shelter	2014	3,996	20	200	200	
4							
5							
6							
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33							
34	TOTAL (lines 1 thru 33)		\$ 10,690	\$	\$ 535	\$ 535	\$

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

9	
Accumulated	
depreciation	
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869	34

STATE OF ILLINOIS

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	Ac
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
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34	TOTAL (lines 1 thru 33)		\$	\$	\$	\$	\$

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

9 Accumulated Depreciation	
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STATE OF ILLINOIS

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	Ac
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
1							
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33							
34	TOTAL (lines 1 thru 33)		\$	\$	\$	\$	\$

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

9 Accumulated Depreciation	
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Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2014

Ending: 2/31/2014

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6	Allocated from Pathway			/ /	11,468			6
7	TOTAL				\$ 11,468			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ 4,730

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	Centennial Mortgage		X	Mortgage	9/1/11	\$ 7,200,000	\$ 7,060,407	12/1/52	4.3500	\$ 308,522
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	Security Deposit Interest		X		/ /			/ /		20
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 7,200,000	\$ 7,060,407			\$ 308,542
	B. Non-Facility Related									
8	Interest Income		X		/ /			/ /		(659)
9	Interest Income - Escrows		X		/ /			/ /		(72)
10	TOTALS (lines 7, 8 and 9)					\$ 7,200,000	\$ 7,060,407			\$ 307,811

* If there is an option to buy the building, please provide complete details on an attached schedule.

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 865,758	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	651,305		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,309		6
7	Other Prepaid Expenses	4,230		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,161,507		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,704,109	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	615,000		13
14	Buildings, at Historical Cost	13,516,738		14
15	Leasehold Improvements, at Historical Cost	2,078,977		15
16	Equipment, at Historical Cost	2,364,934		16
17	Accumulated Depreciation (book methods)	(3,345,143)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	978,015		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,208,521	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,912,630	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,605	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,652		30
31	Accrued Taxes Payable	130,232		31
32	Accrued Interest Payable	25,594		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	1,399,643		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,651,726	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,060,407		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 7,060,407	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,712,133	\$	45
46	TOTAL EQUITY	\$ 10,200,497	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 18,912,630	\$	47

*(See instructions.)

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,572,681	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,572,681	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	525	8
9	Non-Resident Meals	7,988	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 8,513	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	731	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 731	14
D. Other Revenue (specify):			
15	See Attached	4,861	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,861	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,586,786	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	763,281	19
20	Health Care/ Personal Care	541,378	20
21	General Administration	1,075,640	21
B. Capital Expense			
22	Ownership	1,742,979	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 4,123,278	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (536,492)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (536,492)	31