

Facility Name & ID Number Oakwood Estate

0033712 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,487			5,487	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,487			5,487	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.96%

D. How many bed-hold days during this year were paid by the Department?

135 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/15/1988

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	39,140	2,464	1,324	42,928	(19)	42,909	0	42,909		1
2	Food Purchase		28,673		28,673		28,673	0	28,673		2
3	Housekeeping		1,227		1,227		1,227	0	1,227		3
4	Laundry		656		656		656	0	656		4
5	Heat and Other Utilities			19,277	19,277		19,277	0	19,277		5
6	Maintenance	12,130	2,214	3,196	17,540	49	17,589	0	17,589		6
7	Other (specify):*				0		0	0	0		7
8	TOTAL General Services	51,270	35,234	23,797	110,301	30	110,331	0	110,331		8
	B. Health Care and Programs										
9	Medical Director			452	452		452	0	452		9
10	Nursing and Medical Records	42,745	6,902		49,647	(1,219)	48,428	0	48,428		10
10a	Therapy	212,387		1,174	213,561	(88)	213,473	0	213,473		10a
11	Activities		3,038		3,038	18	3,056	0	3,056		11
12	Social Services	42,231	16	2,865	45,112	(1,947)	43,165	0	43,165		12
13	CNA Training				0	3,319	3,319	0	3,319		13
14	Program Transportation		2,883		2,883	(5,143)	(2,260)	2,260	0		14
15	Other (specify):*				0	(4)	(4)	0	(4)		15
16	TOTAL Health Care and Programs	297,363	12,839	4,491	314,693	(5,064)	309,629	2,260	311,889		16
	C. General Administration										
17	Administrative	10,111			10,111	(16,739)	(6,628)	0	(6,628)		17
18	Directors Fees				0		0	0	0		18
19	Professional Services			3,272	3,272		3,272	0	3,272		19
20	Dues, Fees, Subscriptions & Promotions			1,732	1,732		1,732	(65)	1,667		20
21	Clerical & General Office Expenses	25,892	4,106		29,998		29,998	0	29,998		21
22	Employee Benefits & Payroll Taxes			129,277	129,277	16,729	146,006	0	146,006		22
23	Inservice Training & Education		653		653		653	0	653		23
24	Travel and Seminar			666	666		666	(449)	217		24
25	Other Admin. Staff Transportation				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice			8,134	8,134		8,134	0	8,134		26
27	Other (specify):* See Schedule			5,467	5,467	(5,436)	31	0	31		27
28	TOTAL General Administration	36,003	4,106	149,201	189,310	(5,446)	183,864	(514)	183,350		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	384,636	52,179	177,489	614,304	(10,480)	603,824	1,746	605,570		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Oakwood Estate

#0033712

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,444	16,444		16,444	0	16,444			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			0	0		0	0	0			32
33	Real Estate Taxes			0	0		0	0	0			33
34	Rent-Facility & Grounds			3,158	3,158		3,158	0	3,158			34
35	Rent-Equipment & Vehicles			0	0		0	0	0			35
36	Other (specify):*			0	0		0	0	0			36
37	TOTAL Ownership			19,602	19,602	0	19,602	0	19,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			0	0	5,143	5,143	(5,143)	0			38
39	Ancillary Service Centers			0	0	5,337	5,337	0	5,337			39
40	Barber and Beauty Shops			0	0	0	0	0	0			40
41	Coffee and Gift Shops			0	0	0	0	0	0			41
42	Provider Participation Fee			33,183	33,183	0	33,183	0	33,183			42
43	Other (specify):*			0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	0	33,183	33,183	10,480	43,663	(5,143)	38,520			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	384,636	52,179	230,274	667,089	0	667,089	(3,397)	663,692			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(65)	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	(3,332)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,397)		\$ 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,397)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x		\$ 5,143	14	38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 5,143		47

Oakwood Estate

ID# 0033712

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Offset day draining transportation income	\$ (5,143)	38	1
2	Offset day draining transportation income	2,260	14	2
3	Out-of-state Travel (Board of Directors)	(449)	24	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				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	(3,332)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estate# 0033712 Report Period Beginning:07/01/2005Ending: 06/30/2006**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	2,260	0	0	0	0	0	0	0	0	0	0	2,260	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	2,260	0	0	0	0	0	0	0	0	0	0	2,260	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	(65)	0	0	0	0	0	0	0	0	0	0	(65)	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	(449)	0	0	0	0	0	0	0	0	0	0	(449)	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	(514)	0	0	0	0	0	0	0	0	0	0	(514)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	1,746	0	0	0	0	0	0	0	0	0	0	1,746	29

Facility Name & ID Number **Oakwood Estate**

0033712

Report Period Beginning: **07/01/2005** Ending: **06/30/2006**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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.	100%	Apostolic Christian Timber Ridge	Morton	Community	Morton	Residential
		Linden Estate	Morton	Residential Services		Services for the Disabled

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Office Rent	\$ 3,158	Apostolic Christian Timber Ridge	100.00%	\$ 3,158	\$ *	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		\$ 3,158			\$ 3,158	\$ *	14

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	John Knobloch	Chairman	Director	0.00		0.5			\$	1
2	Roger Aberle	Director	Director	0.00	793	0.5		Travel	113	line 24; col.3
3	Dan Schumacher	Director	Director	0.00		0.5				3
4	Jerry Christensen	Vice-Chairman	Director	0.00		0.5				4
5	Ron Hodel	Director	Director	0.00		0.5				5
6	Jerry Kieser	Director	Director	0.00		0.5				6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	954	0.5		Travel	136	line 24; col.3
8	Cleve Klopfenstein	Director	Director	0.00		0.5				8
9	Stan Virkler	Director	Director	0.00	1,025	0.5		Travel	146	line 24; col.3
10	Warren Zahner	Director	Director	0.00	1,351	0.5		Travel	190	line 24; col.3
11										11
12										12
13								TOTAL	\$ 585	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	34	Office Rent	Number of Residents	146	146.48	\$ 30,062	\$ 0	15	\$ 3,158	1
2										2
3	6,10a,17,21	Wages	Direct Cost/# of Hours	2,149	2,149	44,333	44,333	2,149	44,333	3
4										4
5	22	Benefits	Direct Cost/# of Hours	2,149	2,149	9,667	9,667	2,149	9,667	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					\$ 84,062	\$ 54,000		\$ 57,158	25

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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 Estate**# **0033712** Report Period Beginning: **07/01/2005** Ending: **06/30/2006****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2005 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 2006 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:					
	2001		8		
	2002		9		
	2003		10		
	2004		11		
	2005		12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2005 \$ 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakwood Estate COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0033712

CONTACT PERSON REGARDING THIS REPORT Matthew D. Steffen

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

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 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 2005.

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

B. Real Estate Tax Cost Allocation:

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

Facility Name & ID Number Oakwood Estate

0033712 Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,140 B. General Construction Type: Exterior Brick Veneer Frame Wood Frame Number of Stories 1C. Does the Operating Entity? (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? (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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

Apostolic Christian Timber Ridge (IDPA #0016220) is located adjacent to this property.Type of business: Nursing Home (ICF/DD)Square footage: Land - 1,345,699 sq ft; Building - 50,135 sq ft# of Licensed Beds: 98F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>91,781</u>	<u>1988</u>	<u>\$ 9,477</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	91,781		\$ 9,477	3

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1988	\$ 202,314	\$ 5,058	40	\$ 5,058		\$ 88,512	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Vinyl Floor Covering		1987	3,509	0	10	0		3,509	9
10	Landscaping		1987	9,369	0	10	0		9,369	10
11	Driveways		1987	16,544	0	15	0		16,544	11
12	Parking Signs		1987	41	0	12	0		41	12
13	Sod		1987	3,790	0	10	0		3,790	13
14	Organization Costs		1987	26,269	0	5	0		26,269	14
15	Landscaping		1988	458	0	8	0		458	15
16	Lighting Fixtures		1988	3,764	0	10	0		3,764	16
17	Vinyl Floor Coverings		1993	1,548	0	10	0		1,548	17
18	Underground Gas & Waterline		1987	621	21	30	21		383	18
19	Kitchen Serving Door		1987	1,747	87	20	87		1,616	19
20	Dainage/Sewer		1987	1,368	46	30	46		843	20
21	Concrete		1987	7,277	364	20	364		6,731	21
22	Irrigation System		1987	7,650	306	25	306		5,661	22
23	Drainage / Sewer		1988	4,287	143	30	143		2,500	23
24	New Facility Wiring		1988	23,166	1,158	20	1,158		20,270	24
25	Garage		1988	23,005	920	25	920		16,103	25
26	Fire Prevention Sprinkler System		1988	24,890	996	25	996		17,423	26
27	Water & Gas Plumbing		1988	36,140	1,446	25	1,446		25,298	27
28	Cabinets & Countertop		1990	2,010	101	20	101		1,558	28
29	Door for Porch Enclosure		1994	709	18	40	18		204	29
30	Door For Porch Enclosure		1994	733	18	40	18		211	30
31	Back Door For Porch		1994	775	19	40	19		223	31
32	Lighting for Porch		1994	1,249	31	40	31		359	32
33	Awning & Window for Porch		1994	4,136	103	40	103		1,189	33
34	Generator Wiring		1998	1,623	41	40	41		304	34
35	Resurface Driveway		1998	10,526	702	15	702		5,263	35
36	Fiber Optic Cable		2005	1,261	42	15	42		42	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Generator Circuits	1999	\$ 108	\$ 7	15	\$ 7	\$	\$ 47	37
38	Carpet	1999	4,866	487	10	487		3,163	38
39	Counter tops	2001	425	28	15	28		127	39
40	Counter tops	2001	900	60	15	60		270	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 427,078	\$ 12,202		\$ 12,202	\$ 0	\$ 263,592	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 54,618	\$ 3,898	\$ 3,898	\$ 0	13	\$ 38,617	71
72	Current Year Purchases	4,145	342	342	0	6	342	72
73	Fully Depreciated Assets	88,840	0	0	0	10	88,840	73
74			0	0	0	0	0	74
75	TOTALS	\$ 147,603	\$ 4,240	\$ 4,240	\$ 0		\$ 127,799	75

D. Vehicle Depreciation (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)	\$ 584,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,442	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,442	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)	\$ 391,391	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES 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: _____ *

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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	_____/2007	\$ _____
13.	_____/2008	\$ _____
14.	_____/2009	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1 Drop-outs	2 Completed	3 Contract	4 Total
1 Community College Tuition	\$	\$	\$	\$ 0
2 Books and Supplies	0	0		0
3 Classroom Wages (a)	22	1,335		1,357
4 Clinical Wages (b)	94	314		408
5 In-House Trainer Wages (c)	177	591		768
6 Transportation				0
7 Contractual Payments				0
8 CNA Competency Tests				0
9 TOTALS	\$ 293	\$ 2,240	\$ 0	\$ 2,533
10 SUM OF line 9, col. 1 and 2 (e)	\$ 2,533			

- (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.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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 prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													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

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Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 338,379	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	80,051	1,060,315	3
4	Supply Inventory (priced at)	3,519	32,600	4
5	Short-Term Investments		4,098,760	5
6	Prepaid Insurance	3,657	37,277	6
7	Other Prepaid Expenses		5,172	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employees & other related parti	577	30,366	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 88,304	\$ 5,602,869	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	262,033	13
14	Buildings, at Historical Cost	240,780	3,691,272	14
15	Leasehold Improvements, at Historical Cost	61,931	520,895	15
16	Equipment, at Historical Cost	245,702	2,098,292	16
17	Accumulated Depreciation (book methods)	(365,125)	(3,797,886)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,269	46,122	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,269)	(46,122)	20
21	Restricted Funds		4,322,538	21
22	Other Long-Term Assets (spec Restricted Assets)		22,030	22
23	Other(specify): Investment in other facilities			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 192,765	\$ 7,119,174	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 281,069	\$ 12,722,043	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 8,253	\$ 169,383	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,079	465,292	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	33,994	205,053	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 83,326	\$ 839,728	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Lease		29,009	43
44	Investments from Other Facilities	(3,345)	0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (3,345)	\$ 29,009	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 79,981	\$ 868,737	46
47	TOTAL EQUITY (page 18, line 24)	\$ 201,088	\$ 11,853,306	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 281,069	\$ 12,722,043	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 273,310	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 273,310	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(72,222)	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) Cost to Market Adjustment on Investments		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (72,222)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 201,088	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2005

Ending:

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06/30/2006

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 588,779	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 588,779	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	5,143	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,143	23
D. Non-Operating Revenue			
24	Contributions	945	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 945	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 594,867	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	110,301	31
32	Health Care	314,693	32
33	General Administration	189,310	33
B. Capital Expense			
34	Ownership	19,602	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	33,183	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 667,089	40
41	Income before Income Taxes (line 30 minus line 40)**	(72,222)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (72,222)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	679	27,527	19.40	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	2,531	37,728	12.16	15
16	Dishwashers				16
17	Maintenance Workers	956	15,460	16.17	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	253	22,473	18.05	20
21	Assistant Administrator				21
22	Other Administrative	217	6,823	31.44	22
23	Office Manager	218	4,613	21.16	23
24	Clerical	688	14,843	21.57	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,808	42,379	20.37	29
30	Habilitation Aides (DD Homes)	19,008	212,586	10.34	30
31	Medical Records				31
32	Other Health Care OT/PT, Speech	13	204	15.69	32
33	Other(specify) Day Program				33
34	TOTAL (lines 1 - 33)	26,371	384,636 *	\$ 12.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	22	\$ 1,324	1-3	35
36	Medical Director	flat fee	234	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	218	10-3	39
40	Physical Therapy Consultant	10	590	10a-3	40
41	Occupational Therapy Consultant	10	585	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	18	1,316	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	7	549	12-3	46
47				12-3	47
48					48
49	TOTAL (lines 35 - 48)	67	\$ 4,816		49

C. CONTRACT NURSES

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

Facility Name & ID Number Oakwood Estate# 0033712Report Period Beginning: 07/01/2005Ending: 06/30/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$839
- (3) Did the nursing home make political contributions or payments to a political 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? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39 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 n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,183
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 benefit: on Schedule V. \$ 15,286 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. \$ 5,143
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: Heinold-Banwart, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Oakwood Estate
 FYE 06/30/2006 #0033712
 Sub schedules

Schedule V - Costs Center Expenses		
Lines	Description	Amount
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
27	Dental costs	5,337
27	Donated Labor	99
27	Fines & Penalties	-
27	Miscellaneous	31
	Other Expenses	5,467

Schedule V - Reclassifications			
Lines	Description	Increase	Decrease
6	Communication equipment rental	-	-
35	Communication equipment rental	-	-
11	Donated labor	22	-
1	Donated labor	-	-
4	Donated labor	-	-
6	Donated labor	77	-
21	Donated labor	-	-
10	Donated labor	-	-
10a	Donated labor	-	-
12	Donated labor	-	-
27	Donated labor	-	99
38	Medically necessary transportation	5,143	-
14	Medically necessary transportation	-	5,143
13	Nurse aid trainer wages	3,319	-
1	Nurse aid trainer wages	-	19
6	Nurse aid trainer wages	-	28
10	Nurse aid trainer wages	-	1,219
10a	Nurse aid trainer wages	-	88
11	Nurse aid trainer wages	-	4
12	Nurse aid trainer wages	-	1,947
15	Nurse aid trainer wages	-	4
17	Nurse aid trainer wages	-	10
17	Reclassify Disability Pay	-	16,729
22	Reclassify Disability Pay	16,729	-
39	Dental costs	5,337	-
27	Dental costs	-	5,337
		30,627	30,627

Schedule V, Line 39 - Ancillary Service Centers	
Dental costs for 32 visits	\$ 5,337

Schedule VI B - Non-paid workers			
Lines	Description	Amount	
31	Donated Labor	\$	99
	Department	Time in Hours	Time in Dollars
	Activities	4.00	22
	Kitchen		
	Laundry		
	Maintenance	14.00	77
	Nursing		
	PT/OT		
	Social Service Programs		
	Office		
	Totals	18.00	\$ 99

Schedule VII - Compensation Received From Other Nursing Homes	
Roger Aberle - \$793.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Stan Virkler - \$1,025.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Keith Pflum - \$954.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Warren Zahner - \$1,351.00 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	

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 on Sale of Assets	-
Insurance Income	-
Miscellaneous	-
Employee Meals	-

Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	(72,222)
Income from related parties	264,315
Estimated excess for year, Form 990, p.1, line 18	192,093

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Column 1, Row 45	384,636
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(384,636)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	384,636
Add Prior Year PTO Accrual at 06/30/05	21,977
Less Current Year PTO Accrual at 06/30/06	(24,403)
Less: Section 125 Wages not applicable to FICA taxes	(15,425)
Less: Wages over FICA taxation limit of \$90k SS Wages (\$0 x 6.2%/7.65%)	-
Less: Miscellaneous Wages	(12,880)
Add ACCS Wages	
Add wages included in employee meal benefits calculation	9,158
Cash basis salaries	363,063
FICA rate	7.650%
Calculated FICA	27,774
FICA per Sch XIX	27,774
Unknown variance	0

Sch. XX - General Information		
12. Nurse Aide Trainer Wages:		
	Administrator	10
	Therapy / PT / OT	88
	Activities Director	4
	Day Program	4
	Head Cook	19
	Maintenance	28
	Nursing	1,219
	Soc. Serv. / QMRP	1,947
		3,319

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

16. Out of State Travel

Administration	
	-
	-
Board of Directors	
Stan Virkler	146
Roger Aberle	113
Warren Zahner	190
	449
Nursing	
	-

Cell: A5
Comment: Done
2004

Cell: F5
Comment: Done
2004

Cell: F7
Comment: Done
2004

Cell: G9
Comment: ACHH:
6.5 - LE

Cell: J11
Comment: Done
2004

Cell: F19
Comment: Done
2004

Cell: F33
Comment: Done
2004

Cell: J41
Comment: Done
2004

Cell: A47
Comment: Done
2004

Cell: B49
Comment: ACHH:
31 - LE

OAKWOOD ESTATE, #0033712

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Apostolic Christian Timber Ridge, Morton, IL	#0033712
Linden Estate, Morton, IL	#0039305

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

John Knobloch, Chairman
Jerry Christensen, Vice Chairman
Keith Pflum, Secretary/ Treasurer
Ron Hodel, Director
Jerry Kieser, Director (term ended 03/18/2006)
Cleve Klopfenstein, Director
Daniel Schumacher, Director
Roger Aberle, Director (term began 03/18/2006)
Stan Virkler, Director
Warren Zahner, Director

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 ESTATE, #0033712

From: 07/01/2005 to 06/30/2006

CLASS DATE

	# of Students	TR				OE				LE				CILA							
		CLASS	Hrs	Wages	OJT	CLASS	Hrs	Wages	OJT	CLASS	Hrs	Wages	OJT	CLASS	Hrs	Wages	OJT				
completed	47	39	1,560	\$ 13,260.00	3120	\$ 26,520.00	3	120	\$ 1,020.00	240	\$ 2,040.00	2	80	\$ 680.00	160	\$ 1,360.00	3	120	\$ 1,020.00	240	\$ 2,040.00
still enrolled, not complete	24	18	289	\$ 2,456.50	578	\$ 4,913.00	2	37	\$ 314.50	74	\$ 629.00	1	3	\$ 25.50	6	\$ 51.00	3	27	\$ 229.50	54	\$ 459.00
dropouts	20	17	262	\$ 2,227.00	524	\$ 4,454.00	1	11	\$ 93.50	22	\$ 187.00	0	0	\$ -	0	\$ -	2	6	\$ 51.00	12	\$ 102.00
			\$ -	\$ -	0	\$ -		\$ -	0	\$ -		\$ -	0	\$ -	0	\$ -		\$ -	0	\$ -	
Total	2515	74	2111	\$ 17,943.50	4222	\$ 35,887.00	6	168	\$ 1,428.00	336	\$ 2,856.00	3	83	\$ 705.50	166	\$ 1,411.00	8	153	\$ 1,300.50	306	\$ 2,601.00

TRAINER WAGES

Classification	Hours	Hourly Rate	Wages	Hours/Class	# of Classes	WAGES				Hours				
						TR	OE	LE	CILA	TR	OE	LE	CILA	
Aggression Management - 1,2,3	12q	30	\$ 16.80	\$ 504.00	6	5	423.04	33.67	16.63	30.66	25.18	2.00	0.99	1.83
Nutrition	1	15	\$ 19.14	\$ 287.10	3	5	240.98	19.18	9.47	17.47	12.59	1.00	0.50	0.91
Nursing 1 class	10	20	\$ 22.98	\$ 459.60	4	5	385.77	30.70	15.17	27.96	16.79	1.34	0.66	1.22
ISP Development	12q	16	\$ 17.01	\$ 272.16	4	4	228.44	18.18	8.98	16.56	13.43	1.07	0.53	0.97
On the Job Trainer - RN	10	894	\$ 19.49	\$ 17,419.19			14,621.04	1,163.59	574.87	1,059.70	750.18	59.70	29.50	54.37
Maintenance - Gary Folkerts	6	18	\$ 23.69	\$ 426.42	3	6	357.92	28.48	14.07	25.94	15.11	1.20	0.59	1.10
Environmental Safety	15	4	\$ 18.09	\$ 65.12	0.6	6	54.66	4.35	2.15	3.96	3.02	0.24	0.12	0.22
Community Integration	11	4	\$ 18.08	\$ 65.02	0.6	6	54.57	4.34	2.15	3.96	3.02	0.24	0.12	0.22
Community Integration	12r	4	\$ 20.45	\$ 73.62	0.6	6	61.79	4.92	2.43	4.48	3.02	0.24	0.12	0.22
Community Integration	12r	4	\$ 12.34	\$ 44.42	0.6	6	37.29	2.97	1.47	2.70	3.02	0.24	0.12	0.22
Community Integration	12r	4	\$ 16.96	\$ 61.06	0.6	6	51.25	4.08	2.01	3.71	3.02	0.24	0.12	0.22
CPR	10a	48	\$ 10.15	\$ 487.20	3	16	408.94	32.54	16.08	29.64	40.29	3.21	1.58	2.92
First Aide	10a	18	\$ 10.15	\$ 182.70	2	9	153.35	12.20	6.03	11.11	15.11	1.20	0.59	1.10
Body Mechanics / Eating & Food Safety	10ot	15	\$ 19.34	\$ 275.10	3	5	230.01	18.38	9.08	16.74	12.59	1.00	0.50	0.91
Introduction to DD / Human Rights	12r	40	\$ 23.68	\$ 947.20	8	5	795.05	63.27	31.26	57.62	33.57	2.67	1.32	2.43
Great Counseling	12r	5	\$ 23.68	\$ 118.40	1	5	99.38	7.91	3.91	7.20				
Nursing 2 class	10	12	\$ 31.33	\$ 375.96	3	4	315.57	25.11	12.41	22.87	10.07	0.80	0.40	0.73
Sign Language	10s	10	\$ 15.64	\$ 156.40	2	5	131.28	10.45	5.16	9.51	8.39	0.67	0.33	0.61
Human Interaction	10s	14	\$ 15.64	\$ 218.96	3.5	4	183.79	14.63	7.23	13.32	11.75	0.94	0.46	0.85
Mission & Social Serv. Dir. - Jodi Anlik	12m	14	\$ 16.15	\$ 226.10	3.5	4	189.78	15.10	7.46	13.75	11.75	0.94	0.46	0.85
Abuse/Neglect/Etc.	17	6	\$ 24.27	\$ 145.62	3	2	122.23	9.73	4.81	8.86	5.04	0.40	0.20	0.37
Abuse/Neglect/Etc.	12ojt	1933	\$ 13.91	\$ 26,881.08			22,563.00	1,795.63	887.13	1,635.31	1,622.07	129.09	63.78	117.56
On the Job Trainer - Aide														
OE														
RSD - Evie Mogler	12r	0	\$ 20.45	\$ -	6									
Administrator - Helen Schuon	17	0	\$ 24.27	\$ -	2									
LE														
RSD - Rob Mooney	12r	0	\$ 16.96	\$ -	6									
CILA														
RSD - Sherry Parnham	12r	0	\$ 12.34	\$ -	6									
Total trainer wages		3125.25		\$ 49,692.42			41,710.02	3,319.41	1,639.95	3,023.04	2,619.02	208.43	102.97	189.82

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	17	1	0	2
Clinical Wages	\$ 4,454.00	\$ 22.00	\$ -	\$ 102.00
Classroom Wages	\$ 2,227.00	\$ 94.00	\$ -	\$ 51.00
In-House Trainer Wages	\$ 1,726.00	\$ 177.00	\$ -	\$ 40.00
Completed				
Number from this Facility	57	5	3	6
Clinical Wages	\$ 15,717.00	\$ 1,335.00	\$ 706.00	\$ 1,250.00
Classroom Wages	\$ 31,433.00	\$ 314.00	\$ 1,411.00	\$ 2,499.00
In-House Trainer Wages	\$ 24,356.00	\$ 591.00	\$ 1,093.00	\$ 1,936.00

Schedule V	Line	TR	OE	LE	CILA
		Change	Change	Change	Change
Dietary	1	(241.00)	(19.00)	(9.00)	(17.00)
Maintenance	6	(358.00)	(28.00)	(14.00)	(26.00)
Nursing	10	(15,322.00)	(1,219.00)	(602.00)	(1,111.00)
Therapy	10a	(562.00)	(45.00)	(22.00)	(41.00)
OT/PT	10ot	(231.00)	(18.00)	(9.00)	(17.00)
Activities	11	(55.00)	(4.00)	(2.00)	(4.00)
RSD	12r	(1,045.00)	(83.00)	(41.00)	(78.00)
QMRP's	12q	(651.00)	(52.00)	(26.00)	(47.00)
MSSD	12m	(190.00)	(15.00)	(7.00)	(14.00)
Training Wages	13	41,710.00	3,319.00	1,640.00	3,023.00
Day Program	15	(55.00)	(4.00)	(2.00)	(4.00)
Administrator	17	(122.00)	(10.00)	(5.00)	(9.00)
OJT	12ojt	(22,563.00)	(1,796.00)	(887.00)	(1,635.00)
Speech	10s	(315.00)	(25.00)	(12.00)	(23.00)
Adjustment	12	-	(1.00)	(2.00)	1.00

