

Facility Name & ID Number Oakwood Estate

0033712 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	16	Intermediate (ICF)	16	5,856	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	5,679			5,679
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	5,679			5,679

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.98%

D. How many bed-hold days during this year were paid by the Department? 157 (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 08/15/1998

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: 06/30/2008 Fiscal Year: 06/30/2008

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	42,686	2,295	1,355	46,336	(11)	46,325	0	46,325		1
2	Food Purchase		33,052		33,052	0	33,052	0	33,052		2
3	Housekeeping	5,060	1,271		6,331	0	6,331	0	6,331		3
4	Laundry	0	733		733	0	733	0	733		4
5	Heat and Other Utilities			17,649	17,649	0	17,649	0	17,649		5
6	Maintenance	17,034	1,216	4,790	23,040	(15)	23,025	0	23,025		6
7	Other (specify):*				0	0	0	0	0		7
8	TOTAL General Services	64,780	38,567	23,794	127,141	(26)	127,115	0	127,115		8
	B. Health Care and Programs										
9	Medical Director			442	442	0	442	0	442		9
10	Nursing and Medical Records	31,689	6,480	0	38,169	(809)	37,360	0	37,360		10
10a	Therapy	220,983	0	714	221,697	(23)	221,674	0	221,674		10a
11	Activities	0	2,403		2,403	120	2,523	0	2,523		11
12	Social Services	47,464	78	1,941	49,483	(131)	49,352	0	49,352		12
13	CNA Training		0		0	993	993	0	993		13
14	Program Transportation		4,901		4,901	(2,880)	2,021	0	2,021		14
15	Other (specify):* Day Programming	0	0		0	0	0	0	0		15
16	TOTAL Health Care and Programs	300,136	13,862	3,097	317,095	(2,730)	314,365	0	314,365		16
	C. General Administration										
17	Administrative	21,506			21,506	(3)	21,503	0	21,503		17
18	Directors Fees				0	0	0	0	0		18
19	Professional Services			3,898	3,898	0	3,898	0	3,898		19
20	Dues, Fees, Subscriptions & Promotions			1,682	1,682	0	1,682	0	1,682		20
21	Clerical & General Office Expenses	21,698	5,319		27,017	0	27,017	0	27,017		21
22	Employee Benefits & Payroll Taxes			99,760	99,760	0	99,760	0	99,760		22
23	Inservice Training & Education			929	929	0	929	0	929		23
24	Travel and Seminar			1,024	1,024	0	1,024	(790)	234		24
25	Other Admin. Staff Transportation				0	0	0	0	0		25
26	Insurance-Prop.Liab.Malpractice			10,762	10,762	0	10,762	0	10,762		26
27	Other (specify):* See Schedule			2,895	2,895	(2,828)	67	0	67		27
28	TOTAL General Administration	43,204	5,319	120,950	169,473	(2,831)	166,642	(790)	165,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	408,120	57,748	147,841	613,709	(5,587)	608,122	(790)	607,332		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: 07/01/2007 Ending: 06/30/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			19,045	19,045		19,045	0	19,045		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			2,400	2,400		2,400	0	2,400		34
35	Rent-Equipment & Vehicles			0	0		0	0	0		35
36	Other (specify):*			0	0		0	0	0		36
37	TOTAL Ownership			21,445	21,445	0	21,445	0	21,445		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			0	0	2,880	2,880	(2,880)	0		38
39	Ancillary Service Centers			0	0	2,707	2,707	0	2,707		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			35,186	35,186	0	35,186	0	35,186		42
43	Other (specify):*			0	0	0	0	0	0		43
44	TOTAL Special Cost Centers	0	0	35,186	35,186	5,587	40,773	(2,880)	37,893		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	408,120	57,748	204,472	670,340	0	670,340	(3,670)	666,670		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: 07/01/2007

Ending: 06/30/2008

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				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				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	(3,670)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,670)		\$ 0	30

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))	\$ (3,670)		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		\$ 2,880	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			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 2,880		47

BHF USE ONLY					
48		49		50	51
					52

Oakwood Estate

ID# 0033712
 Report Period Beginning: 07/01/2007
 Ending: 06/30/2008

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Offset Medical Transportation income	\$ (2,880)	38	1
2	Out-of-state Travel (Board of Directors)	(790)	24	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				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	(3,670)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	0	0	0	0	0	0	0	0	0	0	0	0	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	(790)	0	0	0	0	0	0	0	0	0	0	(790)	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	(790)	0	0	0	0	0	0	0	0	0	0	(790)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(790)	0	0	0	0	0	0	0	0	0	0	(790)	29

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2007 Ending:

Summary B

06/30/2008

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	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	(2,880)	0	0	0	0	0	0	0	0	0	0	(2,880)	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	(2,880)	0	(2,880)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,670)	0	(3,670)	45									

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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 Linden Estate	Morton Morton	Community Residential Services	Morton Morton	Residential Services for the Developmentally 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	34 Office Rent	\$ 2,400			\$ 2,400	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 2,400			\$ 2,400	\$ *

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

Facility Name & ID Number

Oakwood Estate

#

0033712

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	Director	Director	0.00		0.5			\$	1
2	Roger Aberle	Director	Director	0.00	2,470	0.5		Travel	353	line 24; col.3
3	Dan Schumacher	Chairman	Director	0.00		0.5				3
4	Dennis Mott	Director	Director	0.00	191	0.5		Travel	27	line 24; col.3
5	Ron Hodel	Director	Director	0.00		0.5				5
6	Roger Beutel	Director	Director	0.00		0.5				6
7	Keith Pflum	Sec/ Treasurer	Director	0.00	782	0.5		Travel	112	line 24; col.3
8	Cleve Klopfenstein	Director	Director	0.00		0.5				8
9	Stan Virkler	Vice-Chairman	Director	0.00	638	0.5		Travel	91	line 24; col.3
10	Warren Zahner	Director	Director	0.00	1,450	0.5		Travel	207	line 24; col.3
11										11
12										12
13								TOTAL	\$ 790	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: 07/01/2007

Ending: 6/30/2008

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	148.99	148.99	\$ 23,467	\$ 0	15	\$ 2,400	1
2										2
3	6,10a,17,21	Wages	Direct Cost/# of Hours	1,798	1,798	(54,292)	(54,292)	1,798	(54,292)	3
4										4
5	22	Benefits	Direct Cost/# of Hours	1,798	1,798	(16,494)	0	1,798	(16,494)	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number

Oakwood Estate

0033712

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 0	\$ 0			\$ 0						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0						
15	TOTALS (line 9+line14)						\$ 0	\$ 0			\$ 0						

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

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

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

Facility Name & ID Number Oakwood Estate# 0033712 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 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 2008 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:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakwood Estate 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 2007 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 2007.

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

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. 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 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/DD)

Square footage: Land - 1,345,699 sq ft; Building - 50,135 sq ft

of Licensed Beds: 98

F. 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:

07/01/2007

Ending:

06/30/2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$	\$ 98,628	4
5											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		113	17
18		349--Underground Gas & Waterline		1988	621	21	30	21		425	18
19		358--Kitchen Serving Door		1988	1,747	44	20	44		1,747	19
20		344--Dainage/Sewer		1988	1,368	46	30	46		935	20
21		347--Concrete		1988	7,277	182	20	182		7,277	21
22		346--Irrigation System		1988	7,650	306	25	306		6,273	22
23		351--Drainage / Sewer		1989	4,287	143	30	143		2,786	23
24		361--New Facility Wiring		1989	23,166	1,158	20	1,158		22,586	24
25		300--Garage		1989	23,005	920	25	920		17,944	25
26		359--Fire Prevention Sprinkler System		1989	24,890	996	25	996		19,414	26
27		362--Water & Gas Plumbing		1989	36,140	1,446	25	1,446		28,189	27
28		364--Cabinets & Countertop		1991	2,010	101	20	101		1,759	28
29		305--Door for Porch Enclosure		1995	709	18	40	18		240	29
30		302--Door For Porch Enclosure		1995	733	18	40	18		248	30
31		303-- Back Door For Porch		1995	775	19	40	19		262	31
32		306--Lighting for Porch		1995	1,249	31	40	31		422	32
33		304--Awning & Window for Porch		1995	4,136	103	40	103		1,396	33
34		307--Generator Wiring		1999	1,623	41	40	41		386	34
35		353--Resurface Driveway		1999	10,526	702	15	702		6,667	35
36		771--Fiber Optic Cable		2006	1,261	84	15	84		210	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:

07/01/2007

Ending:

06/30/2008

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	309--Generator Circuits	2000	\$ 108	\$ 7	15	\$ 7	\$	\$ 62	37
38	308--Carpet	2000	4,866	487	10	487		4,136	38
39	565--Counter tops	2002	425	28	15	28		184	39
40	563--Counter tops	2002	900	60	15	60		390	40
41	780--Flooring	2007	7,109	474	15	474		711	41
42	857--Telephone System	2008	882	59	15	59		59	42
43	858--Roofing Project	2008	33,760	2,251	15	2,251		2,251	43
44	327--Vinyl Floor Coverings	1994	1,548	0	10	0		1,548	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)		\$ 470,526	\$ 14,916		\$ 14,916	\$ 0	\$ 290,992	70

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

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

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	\$ 54,278	\$ 3,948	\$ 3,948	\$ 0	11	\$ 40,282	71
72	Current Year Purchases	0	0	0	0	0	0	72
73	Fully Depreciated Assets	96,252	183	183	0	10	96,252	73
74	Disposed Assets	0	0	0	0	0	0	74
75	TOTALS	\$ 150,530	\$ 4,131	\$ 4,131	\$ 0		\$ 136,534	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)	\$ 630,533	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,047	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,047	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)	\$ 427,526	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.

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: n/a *

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	<u>n/a</u>		\$	\$	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.

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.)

<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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)	0	731		731
4	Clinical Wages (b)	0	172		172
5	In-House Trainer Wages (c)	0	177		177
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 1,080	\$ 0	\$ 1,080
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,080			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	28
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	26
TOTAL TRAINED	56

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

Facility Name & ID Number Oakwood Estate# 0033712 Report Period Beginning:07/01/2007 Ending: 06/30/2008

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	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.

Facility Name & ID Number Oakwood Estate# 0033712Report Period Beginning: 07/01/2007

Ending:

06/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(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	\$ 500	\$ 362,741	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	128,668	1,633,865	3
4	Supply Inventory (priced at)	3,519	25,600	4
5	Short-Term Investments		4,170,651	5
6	Prepaid Insurance	(807)		6
7	Other Prepaid Expenses		2,018	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employees & other related partik</u>	1,841	21,176	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 133,721	\$ 6,216,051	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	308,840	4,215,861	14
15	Leasehold Improvements, at Historical Cost	71,012	547,401	15
16	Equipment, at Historical Cost	222,320	2,095,319	16
17	Accumulated Depreciation (book methods)	(401,254)	(4,297,528)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,269	46,122	19
	Accumulated Amortization - Organization & Pre-Operating Costs	(26,269)	(46,122)	20
21	Restricted Funds		4,466,049	21
22	Other Long-Term Assets (spe <u>Cash Value of Life Insurance Policies</u>)		36,270	22
23	Other(specify): <u>Investment in other facilities</u>		3,738,284	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 210,395	\$ 11,063,689	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 344,116	\$ 17,279,741	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 11,054	\$ 196,786	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,543	333,917	30
	Accrued Taxes Payable (excluding real estate taxes)	0	31,366	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	18,467	146,720	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 85,064	\$ 708,789	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	<u>Capital Lease</u>		23,547	43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 23,547	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 85,064	\$ 732,336	46
47	TOTAL EQUITY (page 18, line 24)	\$ 259,052	\$ 16,547,405	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 344,116	\$ 17,279,741	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 213,244	1
2	Restatements (describe):		2
3	<u>Auditor adjustment for prior year</u>		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 213,244	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(26,923)	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)	\$ (26,923)	17
B. Transfers (Itemize):			
18	<u>Investment from other facilities</u>	72,731	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 72,731	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 259,052	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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	\$ 625,079	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 625,079	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	2,880	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)	\$ 2,880	23
D. Non-Operating Revenue			
24	Contributions	15,458	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,458	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)	\$ 643,417	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	127,141	31
32	Health Care	317,095	32
33	General Administration	169,473	33
B. Capital Expense			
34	Ownership	21,445	34
C. Ancillary Expense			
35	Special Cost Centers	0	35
36	Provider Participation Fee	35,186	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 670,340	40
41	Income before Income Taxes (line 30 minus line 40)**	(26,923)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (26,923)	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: 07/01/2007

Ending:

06/30/2008

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	0	0	\$ 0	\$	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,113	1,330	34,210	25.72	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	79	79	748	9.47	10
11	Social Service Workers	190	117	2,122	18.14	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	2,907	3,250	43,832	13.49	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	985	985	17,034	17.29	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	764	924	21,506	23.27	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	1,167	1,167	20,897	17.91	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	1,959	2,154	46,324	21.51	29
30	Habilitation Aides (DD Homes)	19,042	19,070	221,391	11.61	30
31	Medical Records	0	0	0		31
32	Other Health Care OT/PT	3	3	56	18.67	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	28,209	29,079	\$ 408,120 *	\$ 14.03	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	24	\$ 1,355	1-3	35
36	Medical Director	Flat Fee	208	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Flat Fee	234	10-3	39
40	Physical Therapy Consultant	5	258	10-3	40
41	Occupational Therapy Consultant	8	455	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,393	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	7	549	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	63	\$ 4,452		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

Oakwood Estate
 FYE 06/30/2008 #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	2,707
27	Charitable Contributions	
27	Fines & Penalties	
27	Miscellaneous	67
	Other Expenses	2,774

Schedule V - Reclassifications Amount

Lines	Description	Increase	Decrease
6	Communication equipment rental		
35	Communication equipment rental		-
11	Donated labor	121	
1	Donated labor	-	
4	Donated labor	-	
6	Donated labor	-	
21	Donated labor	-	
10	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		121
38	Medically necessary transportation	2,880	
14	Medically necessary transportation		2,880
10a	Disability Pay to Benefits		-
22	Disability Pay to Benefits	-	
13	Nurse aid trainer wages	993	
1	Nurse aid trainer wages		11
6	Nurse aid trainer wages		15
10	Nurse aid trainer wages		809
10a	Nurse aid trainer wages		23
11	Nurse aid trainer wages		1
12	Nurse aid trainer wages		131
15	Nurse aid trainer wages		-
17	Nurse aid trainer wages		3
39	Dental costs	2,707	
27	Dental costs		2,707
		6,701	6,701

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 28 visits	\$ 2,707
----------------------------	----------

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	\$ 121
	Department	Time in Hours Time in Dollars
	Activities	16.25 121
	Kitchen	- -
	Laundry	- -
	Maintenance	- -
	Nursing	- -
	PT/OT	- -
	Social Service Programs	- -
	Office	- -
	Totals	16.25 \$ 121

Schedule VII - Compensation Received From Other Nursing Homes

Roger Aberle - \$2470 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Stan Virkler - \$638 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Keith Pflum - \$782 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Dennis Mott - \$191 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	
Warren Zahner - \$1450 - reimbursement of travel expenses received from Oakwood Estate & Timber Ridge	

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	-
Increase in Cash Value of Life Insurance	-
Miscellaneous	-
Cost to Market Adjustment	-

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

Income before taxes per cost report	(26,923)
Income from related parties	213,401
Estimated excess for year, Form 990, p.1, line 18	186,478

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	408,120
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(408,120)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	408,120
Add Prior Year PTO Accrual at 06/30/07	14,598
Less Current Year PTO Accrual at 06/30/08	(17,379)
Add Prior Year Wage Accrual at 06/30/07	12,328
Less Current Year Wage Accrual at 06/30/08	(16,513)
Less: Section 125 Wages not applicable to FICA taxes	(17,509)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$0 x 6.2%/7.65%)	-
Less: Wages Allocated to Linden from other facilities	96,792
Add: ACCS Wages	-
Add: wages included in employee meal calculation	5,866
Cash basis salaries	486,303
FICA rate	7.650%
Calculated FICA	37,202
FICA per Sch XIX	37,202
Variance	-

Sch. XX - General Information

12. Nurse Aide Trainer Wages:		
	Administrator	3
	Therapy / PT / OT	23
	Activities Director	1
	Day Program	-
	Head Cook	11
	Maintenance	15
	Nursing	809
	Soc. Serv. / QMRP	131
		993

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

16. Out of State Travel

Administration

Administrator	-
	-

Board of Directors

Stan Virkler	91
Roger Aberle	353
Keith Pflum	112
Dennis Mott	27
Warren Zahner	207
	790

Nursing

None	-
	-

Cell: A5
Comment: Done
2007

Cell: F5
Comment: Done
2004

Cell: F7
Comment: Done
2004

Cell: J11
Comment: Done
2004

Cell: F19
Comment: Done
2004

Cell: F36
Comment: Done
2004

Cell: J44
Comment: Done
2004

Cell: A47
Comment: Done
2007

OAKWOOD ESTATE #0033712

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

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

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

Daniel Schumacher, Chairman
Stan Virkler, Vice Chairman
Keith Pflum, Secretary/ Treasurer
John Knobloch, Director (term ended 03/15/2008)
Warren Zahner, Director
Ron Hodel, Director
Cleve Klopfenstein, Director
Roger Aberle, Director
Roger Beutel, Director
Dennis Mott, Director (term began 03/15/2008)

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: 07/01/2007 to 06/30/2008

CLASS DATE	TR				OJT				OE				LE				CILA				
	# of Students	CLASS		WAGES	HRS	WAGES	HRS	WAGES	HRS	WAGES	HRS	WAGES	HRS	WAGES	HRS	WAGES	HRS	WAGES			
		Hrs	Wages																Hrs	Wages	Hrs
completed	30	25	1,000	\$ 8,500.00	2000	\$ 17,000.00	2	80	\$ 680.00	160	\$ 1,360.00	1	40	\$ 340.00	80	\$ 680.00	2	80	\$ 680.00	160	\$ 1,360.00
still enrolled, not complete	19	15	757	\$ 1,334.50	314	\$ 2,669.00	2	6	\$ 51.00	12	\$ 102.00	1	23	\$ 195.50	46	\$ 391.00	11	11	\$ 93.50	22	\$ 187.00
dropouts	26	25	371	\$ 3,153.50	742	\$ 6,307.00	0	0	\$ -	0	\$ -	1	29	\$ 246.50	58	\$ 493.00	0	0	\$ -	0	\$ -
Total	1797	65	1528	\$ 12,988.00	3056	\$ 25,976.00	4	86	\$ 731.00	172	\$ 1,462.00	3	92	\$ 782.00	184	\$ 1,564.00	3	91	\$ 773.50	182	\$ 1,547.00

TRAINER WAGES

Classification	Hours	Hourly Rate	Wages	Hours/Class	# of Classes	WAGES				Hours					
						TR	OE	LE	CILA	TR	OE	LE	CILA		
Abuse/Neglect/Etc.	17m	7	\$ 18.71	\$ 137.97	3.5	2	117.32	6.60	7.06	6.99	5.95	0.34	0.36	0.35	\$19.71
Abuse/Neglect/Etc.	17	3	\$ 22.44	\$ 67.32	3	1	57.24	3.22	3.45	3.41	2.55	0.14	0.15	0.15	\$22.44
Aggression Management - 1,2,3	12a	30	\$ 17.65	\$ 528.00	6	5	448.96	25.27	27.03	26.74	25.51	1.44	1.54	1.52	\$17.65
Body Mechanics / Eating & Food Sa	10a	9	\$ 20.85	\$ 187.65	3	3	159.56	8.98	9.81	9.50	7.65	0.43	0.46	0.46	\$20.85
Community Integration	10a	2	\$ 18.90	\$ 27.75	0.5	3	23.60	1.33	1.42	1.41	1.28	0.07	0.08	0.08	\$18.90
Community Integration	11	2	\$ 18.51	\$ 27.77	0.5	3	23.61	1.33	1.42	1.41	1.28	0.07	0.08	0.08	\$18.51
Community Integration	12r	2	\$ 21.35	\$ 32.03	0.5	3	27.23	1.53	1.64	1.62	1.28	0.07	0.08	0.08	\$21.35
Community Integration	12r	2	\$ 17.98	\$ 26.25	0.5	3	22.32	1.26	1.34	1.33	1.28	0.07	0.08	0.08	\$17.98
Community Integration	12r	2	\$ 22.44	\$ 33.66	0.5	3	28.62	1.61	1.72	1.70	1.28	0.07	0.08	0.08	\$22.44
CPR	12r	15	\$ 22.44	\$ 336.60	3	5	286.21	16.11	17.23	17.05	12.75	0.72	0.77	0.76	\$22.44
CPR	10	81	\$ 24.50	\$ 1,984.50	3	27	1,687.43	94.97	101.60	100.49	68.87	3.88	4.15	4.10	\$24.50
Environmental Safety	6	12	\$ 24.93	\$ 299.16	3	4	254.38	14.32	15.32	15.15	10.20	0.57	0.61	0.61	\$24.93
First Aid	12r	4	\$ 22.44	\$ 89.76	3	2	76.32	4.30	4.60	4.55	3.40	0.19	0.20	0.20	\$22.44
First Aid	10	36	\$ 24.50	\$ 882.00	2	18	749.97	42.21	45.16	44.68	30.61	1.72	1.84	1.82	\$24.50
Grief Counseling	12r	4	\$ 24.92	\$ 99.68	1	4	84.76	4.77	5.10	5.05	3.40	0.19	0.20	0.20	\$24.92
Human Interaction	10a	11	\$ 14.42	\$ 151.41	3.5	3	128.74	7.25	7.75	7.67	8.93	0.50	0.54	0.53	\$14.42
Introduction to DD / Human Rights	12r	40	\$ 24.92	\$ 996.80	8	5	847.69	47.70	51.03	50.48	34.01	1.91	2.05	2.03	\$24.92
ISP Development	12a	16	\$ 14.90	\$ 238.40	4	4	202.71	11.41	12.21	12.07	13.60	0.77	0.82	0.81	\$14.90
Nursing 1 class	10	12	\$ 24.12	\$ 289.44	4	3	246.11	13.85	14.82	14.66	10.20	0.57	0.61	0.61	\$24.12
Nursing 2 class	10	12	\$ 33.16	\$ 397.92	3	4	338.35	19.04	20.37	20.15	10.20	0.57	0.61	0.61	\$33.16
Nutrition	1	6	\$ 20.67	\$ 124.02	3	2	105.45	5.94	6.35	6.28	5.10	0.29	0.31	0.30	\$20.67
Nutrition	1	8	\$ 14.90	\$ 89.40	3	2	76.02	4.28	4.58	4.53	5.10	0.29	0.31	0.30	\$14.90
On the Job Trainer - RN	10	500	\$ 24.50	\$ 12,250.13	-	-	10,421.46	596.55	627.47	620.65	425.37	23.94	25.61	25.33	\$24.50
Sign Language	10a	6	\$ 14.42	\$ 86.52	2	3	73.57	4.14	4.43	4.38	5.10	0.29	0.31	0.30	\$14.42
On the Job Trainer - Aide	12ojt	0	\$ -	\$ -	-	-	-	-	-	-	-	-	-	-	-
RCD - Rob Mowbray	12r	0	\$ 22.44	\$ -	-	-	-	-	-	-	-	-	-	-	-
Speech - Cheryl Hays	10a	0	\$ 14.42	\$ -	-	-	-	-	-	-	-	-	-	-	-
Maintenance - Gary Folkerts	6	0	\$ 24.93	\$ -	-	-	-	-	-	-	-	-	-	-	-
Nurse - Kathy Kolch RN	10	0	\$ 24.50	\$ -	-	-	-	-	-	-	-	-	-	-	-
						16,487.54	927.96	992.71	981.92	694.91	39.11	41.84	41.39		

Total trainer wages 817.25 \$ 19,390.13

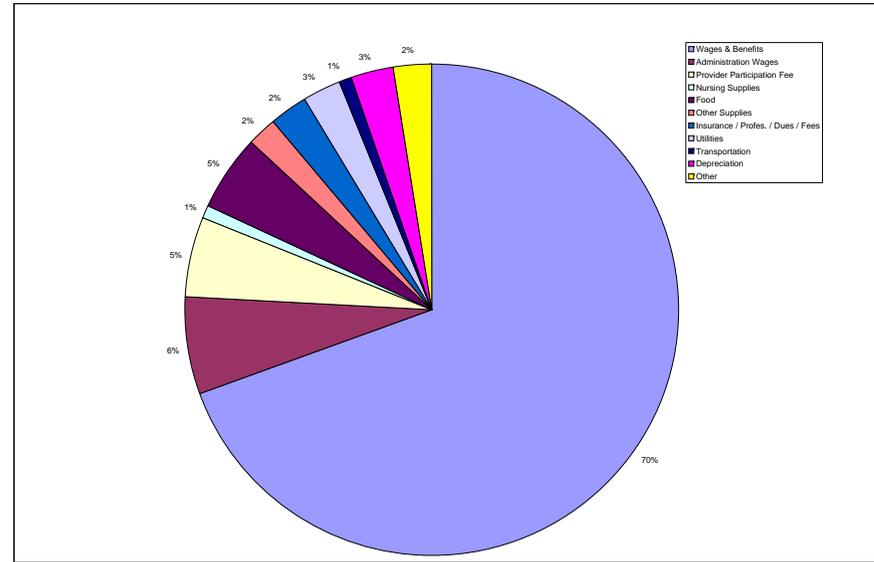
	TR	OE	LE	CILA
Drop-Outs	25	0	1	0
Number from this Facility				
Clinical Wages	\$ 6,307.00	\$ -	\$ 493.00	\$ -
Classroom Wages	\$ 3,154.00	\$ -	\$ 247.00	\$ -
In-House Trainer Wages	\$ 1,335.00	\$ -	\$ 105.00	\$ -
Completed	40	4	2	3
Number from this Facility				
Clinical Wages	\$ 9,835.00	\$ 731.00	\$ 536.00	\$ 774.00
Classroom Wages	\$ 19,669.00	\$ 172.00	\$ 1,071.00	\$ 1,547.00
In-House Trainer Wages	\$ 8,323.00	\$ 177.00	\$ 453.00	\$ 655.00

Schedule V	Line	TR	OE	LE	CILA
Dietary	1	1	(181.00)	(10.00)	(11.00)
Maintenance	6	6	(254.00)	(14.00)	(15.00)
Nursing	10	10	(13,443.00)	(757.00)	(809.00)
Therapy	10a	10a	(24.00)	(1.00)	(1.00)
OT/PT	10ot	10a	(160.00)	(9.00)	(10.00)
Activities	11	11	(24.00)	(1.00)	(1.00)
RSD	12r	12	(1,373.00)	(77.00)	(83.00)
QMRP's	12q	12	(652.00)	(37.00)	(39.00)
MSSD	12m	12	(117.00)	(7.00)	(7.00)
Training Wages	13	13	16,488.00	928.00	993.00
Day Program	15	15	-	-	-
Administrator	17	17	(57.00)	(3.00)	(3.00)
OJT	12ojt	12	-	-	-
Speech	10s	10a	(202.00)	(11.00)	(12.00)
Adjustment	12		(1.00)	(1.00)	(2.00)

\$ 17,000.00	160	\$ 680.00	\$ 1,360.00
\$ 2,669.00	12	\$ 391.00	\$ 187.00
\$ 6,307.00	0	\$ 493.00	\$ -
\$ 8,500.00	\$ 680.00	\$ 340.00	\$ 680.00
\$ 1,334.50	\$ 51.00	\$ 195.50	\$ 93.50
\$ 3,153.50	\$ -	\$ 246.50	\$ -

Oakwood Estate -- 0033712

	Wages	Supplies	Other	Total	Reclass- ification	Total	Cost / Day Resident Days 5,679	Adjust- ments	Adjusted Total	Cost / Day Resident Days 5,679	% of Total Costs	% of Daily Rate	Staff Hours/ Day
A. General Services													
1 Dietary	42,686	2,295	1,355	46,336	(11)	46,325	\$8.16	-	46,325	\$8.16	6.9%	5.7%	0.51
2 Food Purchase	-	33,052	-	33,052	-	33,052	\$5.82	-	33,052	\$5.82	5.0%	4.1%	-
3 Housekeeping	5,060	1,271	-	6,331	-	6,331	\$1.11	-	6,331	\$1.11	0.9%	0.8%	-
4 Laundry	-	733	-	733	-	733	\$0.13	-	733	\$0.13	0.1%	0.1%	-
5 Heat and Other Utilities	-	-	17,649	17,649	-	17,649	\$3.11	-	17,649	\$3.11	2.6%	2.2%	-
6 Maintenance	17,034	1,216	4,790	23,040	(15)	23,025	\$4.05	-	23,025	\$4.05	3.5%	2.8%	0.17
7 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
8 TOTAL General Services	64,780	38,567	23,794	127,141	(26)	127,115	\$22.38	-	127,115	\$22.38	19.1%	15.7%	0.69
B. Health Care and Programs													
9 Medical Director	-	-	442	442	-	442	\$0.08	-	442	\$0.08	0.1%	0.1%	-
10 Nursing and Medical Records	31,689	6,480	-	38,169	(809)	37,360	\$6.58	-	37,360	\$6.58	5.6%	4.6%	0.20
10a Therapy	220,983	-	714	221,697	(23)	221,674	\$39.03	-	221,674	\$39.03	33.3%	27.3%	3.35
11 Activities	-	2,403	-	2,403	120	2,523	\$0.44	-	2,523	\$0.44	0.4%	0.3%	0.01
12 Social Services	47,464	78	1,941	49,483	(131)	49,352	\$8.69	-	49,352	\$8.69	7.4%	6.1%	0.38
13 CNA Training	-	-	-	993	-	993	\$0.17	-	993	\$0.17	0.1%	0.1%	-
14 Program Transportation	-	4,901	-	4,901	(2,880)	2,021	\$0.36	-	2,021	\$0.36	0.3%	0.2%	-
15 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
16 TOTAL Health Care and Programs	300,136	13,862	3,097	317,095	(2,730)	314,365	\$55.36	-	314,365	\$55.36	47.2%	38.8%	3.94
C. General Administration													
17 Administrative	21,506	-	-	21,506	(3)	21,503	\$3.79	-	21,503	\$3.79	3.2%	2.7%	0.13
18 Director Fees	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
19 Professional Services	-	-	3,898	3,898	-	3,898	\$0.69	-	3,898	\$0.69	0.6%	0.5%	-
20 Dues, Fees, Subscriptions & Promotion	-	-	1,682	1,682	-	1,682	\$0.30	-	1,682	\$0.30	0.3%	0.2%	-
21 Clerical & General Office Expenses	21,698	5,319	-	27,017	-	27,017	\$4.76	-	27,017	\$4.76	4.1%	3.3%	0.21
22 Employee Benefits & Payroll Taxes	-	-	99,760	99,760	-	99,760	\$17.57	-	99,760	\$17.57	15.0%	12.3%	-
23 Inservice Training & Education	-	-	929	929	-	929	\$0.16	-	929	\$0.16	0.1%	0.1%	-
24 Travel and Seminar	-	-	1,024	1,024	-	1,024	\$0.18	(790)	234	\$0.04	0.0%	0.0%	-
25 Other Admin. Staff Transportation	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
26 Insurance-Prop.Liab.Malpractice	-	-	10,762	10,762	-	10,762	\$1.90	-	10,762	\$1.90	1.6%	1.3%	-
27 Other (specify):*	-	-	2,895	2,895	(2,828)	67	\$0.01	-	67	\$0.01	0.0%	0.0%	-
28 TOTAL General Administration	43,204	5,319	120,950	169,473	(2,831)	166,642	\$29.34	(790)	165,852	\$29.20	24.9%	20.5%	0.34
TOTAL Operating Expense	408,120	57,748	147,841	613,709	(5,587)	608,122	\$107.08	(790)	607,332	\$106.94	91.1%	74.9%	4.97
D. Ownership													
30 Depreciation	-	-	19,045	19,045	-	19,045	\$3.35	-	19,045	\$3.35	2.9%	2.3%	-
31 Amortization of Pre-Op. & Org.	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
32 Interest	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
33 Real Estate Taxes	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
34 Rent-Facility & Grounds	-	-	2,400	2,400	-	2,400	\$0.42	-	2,400	\$0.42	0.4%	0.3%	-
35 Rent-Equipment & Vehicles	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
36 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
37 TOTAL Ownership	-	-	21,445	21,445	-	21,445	\$3.78	-	21,445	\$3.78	3.2%	2.6%	-
E. Special Cost Centers													
38 Medically Necessary Transportation	-	-	-	-	2,880	2,880	\$0.51	(2,880)	-	\$0.00	0.0%	0.0%	-
39 Ancillary Service Centers	-	-	-	-	2,707	2,707	\$0.48	-	2,707	\$0.48	0.4%	0.3%	-
40 Barber and Beauty Shops	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
41 Coffee and Gift Shops	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
42 Provider Participation Fee	-	-	35,186	35,186	-	35,186	\$6.20	-	35,186	\$6.20	5.3%	4.3%	-
43 Other (specify):*	-	-	-	-	-	-	\$0.00	-	-	\$0.00	0.0%	0.0%	-
44 TOTAL Special Cost Centers	-	-	35,186	35,186	5,587	40,773	\$7.18	(2,880)	37,893	\$6.67	5.7%	4.7%	-
45 GRAND TOTAL	408,120	57,748	204,472	670,340	-	670,340	\$118.04	(3,670)	666,670	\$117.39	100.0%	82.2%	4.97
Current Reimbursement Rate							\$142.75			\$142.75	121.6%	100.0%	
Gain/(Loss) Per Resident / Day							24.71			25.36	21.6%	17.8%	
% of Costs Per Area	75.76%	8.61%	15.62%	100.00%			17.3%			17.8%			



Wages & Benefi	Administration	Provider Participa	Nursing Supplies	Food	Other	Suppl	Insurance / Pr	Utilities	Transportation	Depreciation	Other
\$ 464,676	\$ 43,204	\$ 35,186	\$ 6,480	\$ 33,052	\$ 13,315	\$ 16,342	\$ 17,649	\$ 4,901	\$ 19,045	\$ 16,490	