

Facility Name & ID Number Oakwood Estate

0033712 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	5,840	3
4		Intermediate/DD			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 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,550			5,550	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,550			5,550	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.03%

D. How many bed-hold days during this year were paid by the Department? 199 (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 05/15/1998

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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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



STATE OF ILLINOIS

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF
		Salary/Wage	Supplies	Other	Total					
	A. General Services	1	2	3	4	5	6	7	8	9
1	Dietary	48,078	2,860	987	51,925	42	51,967		51,967	
2	Food Purchase		31,774		31,774		31,774		31,774	
3	Housekeeping		410		410		410		410	
4	Laundry		1,055		1,055		1,055		1,055	
5	Heat and Other Utilities			18,689	18,689		18,689		18,689	
6	Maintenance	21,727	2,557	5,605	29,889	40	29,929		29,929	
7	Other (specify):*									
8	TOTAL General Services	69,805	38,656	25,281	133,742	82	133,824		133,824	
	B. Health Care and Programs									
9	Medical Director									
10	Nursing and Medical Records	76,219	7,407	348	83,974	(2,087)	81,887		81,887	
10a	Therapy	235,335		850	236,185	(2,498)	233,687		233,687	
11	Activities		1,235		1,235	168	1,403		1,403	
12	Social Services	46,313	22	2,538	48,873	(134)	48,739		48,739	
13	CNA Training					2,273	2,273		2,273	
14	Program Transportation		5,673		5,673		5,673		5,673	
15	Other (specify):*									
16	TOTAL Health Care and Programs	357,867	14,337	3,736	375,940	(2,278)	373,662		373,662	
	C. General Administration									
17	Administrative	27,371			27,371	(3)	27,368		27,368	
18	Directors Fees									
19	Professional Services			5,150	5,150		5,150		5,150	
20	Dues, Fees, Subscriptions & Promotions			1,974	1,974		1,974	(294)	1,680	
21	Clerical & General Office Expenses	28,302	3,912		32,214		32,214		32,214	
22	Employee Benefits & Payroll Taxes			116,716	116,716	2,482	119,198		119,198	
23	Inservice Training & Education			379	379		379		379	
24	Travel and Seminar			795	795		795	(102)	693	
25	Other Admin. Staff Transportation									
26	Insurance-Prop.Liab.Malpractice			9,116	9,116		9,116		9,116	
27	Other (specify):*			(1,781)	(1,781)	(2,991)	(4,772)		(4,772)	
28	TOTAL General Administration	55,673	3,912	132,349	191,934	(512)	191,422	(396)	191,026	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	483,345	56,905	161,366	701,616	(2,708)	698,908	(396)	698,512	

*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.

USE ONLY	
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STATE OF ILLINOIS

Facility Name & ID Number

Oakwood Estate

#0033712

Report Period Beginning:

07/01/2008

Ending:

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 9
		Salary/Wage 1	Supplies 2	Other 3	Total 4					
	D. Ownership									
30	Depreciation			18,153	18,153		18,153		18,153	
31	Amortization of Pre-Op. & Org.									
32	Interest									
33	Real Estate Taxes									
34	Rent-Facility & Grounds									
35	Rent-Equipment & Vehicles									
36	Other (specify):*									
37	TOTAL Ownership			18,153	18,153		18,153		18,153	
	Ancillary Expense									
	E. Special Cost Centers									
38	Medically Necessary Transportation									
39	Ancillary Service Centers					2,708	2,708		2,708	
40	Barber and Beauty Shops									
41	Coffee and Gift Shops									
42	Provider Participation Fee			32,444	32,444		32,444		32,444	
43	Other (specify):*									
44	TOTAL Special Cost Centers			32,444	32,444	2,708	35,152		35,152	
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	483,345	56,905	211,963	752,213		752,213	(396)	751,817	

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

USE ONLY	
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FOR LINES 1 THRU 28 AND 31 THRU 33, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINES 29 OR 35 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Oakwood Estate**

0033712

Report Period Beginning: **07/01/2008**

Ending: **06/30/2009**

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	(294)	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	(102)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (396)		\$	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)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (396)		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	\$		38
39						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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The amounts in column F will transfer to the Adj. Summary column automatically.
 The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS

Oakwood Estate

ID# 0033712
 Report Period Beginning: 07/01/2008
 Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Out-of-state Travel (Administrative Staff)	\$ 0	24	1
2	Offset medically necessary transportation income	0	38	2
3	Out-of-state Travel (Board of Directors)	(102)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48

49	Total	(102)	49
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Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	(294)
Line 21	0
Line 22	0
Line 23	0
Line 24	(102)
Line 25	0
Line 26	0
Line 27	0
Line 28	(396)
Line 29	(396)
Line 30	0
Line 31	0
Line 32	0
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	0
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(396)

Summary A
06/30/2009

SUMMARY TOTALS (to Sch V, col.7)	
0	1
0	2
0	3
0	4
0	5
0	6
0	7
0	8
0	9
0	10
0	10a
0	11
0	12
0	13
0	14
0	15
0	16
0	17
0	18
0	19
(294)	20
0	21
0	22
0	23
(102)	24
0	25
0	26
0	27
(396)	28
(396)	29

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

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

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

	Capital Expense	PAGES	PAGE									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0
32	Interest	0	0	0	0	0	0	0	0	0	0	0
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(396)	0	0	0	0	0	0	0	0	0	0

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Summary B
06/30/2009

SUMMARY	
TOTALS	
(to Sch V, col.7)	
0	30
0	31
0	32
0	33
0	34
0	35
0	36
0	37
0	38
0	39
0	40
0	41
0	42
0	43
0	44
(396)	45

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

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

STATE OF ILLINOIS

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

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**	
						Hours	Percent	Description	Amount
1	Virgil Metzger	Director	Director	0.00	423	0.5		Travel	\$ 61
2	Roger Aberle	Director	Director	0.00	2,081	0.5		Travel	297
3	Dan Schumacher	Chairman	Director	0.00		0.5			
4	Dennis Mott	Director	Director	0.00	218	0.5		Travel	31
5	Ron Hodel	Director	Director	0.00		0.5			
6	Roger Beutel	Director	Director	0.00		0.5			
7	Keith Pflum	Sec/ Treasurer	Director	0.00	887	0.5		Travel	127
8	Cleve Klopfenstein	Director	Director	0.00		0.5			
9	Stan Virkler	Vice-Chairman	Director	0.00	715	0.5		Travel	102
10	Warren Zahner	Director	Director	0.00	936	0.5		Travel	134
11									
12									
13								TOTAL	\$ 752

* 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 that 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 REPO

** 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

8	
Schedule V. Line & Column Reference	
	1
line 24; col.3	2
	3
line 24; col.3	4
	5
	6
	7
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line 24; col.3	9
line 24; col.3	10
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ie name(s)

IRTS

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning: 07/01/2008

Ending: 6/30/2009

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

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

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

1	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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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: **07/01/2008** Ending: **06/30/2009**

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

1. Real Estate Tax accrual used on 2008 report.	\$
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.)	\$
3. Under or (over) accrual (line 2 minus line 1).	\$
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$
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.)	\$
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.)	\$
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	8
	2005	9
	2006	10
	2007	11
	2008	12

	FOR BHF USE ONLY
13	FROM R. E. TAX STATEMENT FOR 2008 \$
14	PLUS APPEAL COST FROM LINE 5 \$
15	LESS REFUND FROM LINE 6 \$
16	AMOUNT TO USE FOR RATE CALCULATION \$

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.

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STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2008 Ending:

X. BUILDING AND GENERAL INFORMATION:

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

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

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:

	1	2	3	4	
A. Land.	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

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Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate

0033712

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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			1989	\$ 202,314	\$ 5,058	40	\$ 5,058		\$ 103,686	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	316-- Vinyl Floor Covering		1988	3,509			10			3,509	9
10	343--Landscaping		1988	9,369			10			9,369	10
11	345--Driveways		1988	16,544			15			16,544	11
12	348--Parking Signs		1988	41			12			41	12
13	350--Sod		1988	3,790			10			3,790	13
14	354--Organization Costs		1988	26,269			5			26,269	14
15	352--Landscaping		1989	458			8			458	15
16	360--Lighting Fixtures		1989	3,764			10			3,764	16
17	859--Exit Ramps		2008	1,697	113		15	113		226	17
18	349--Underground Gas & Waterline		1988	621	21		30	21		445	18
19	358--Kitchen Serving Door		1988	1,747			20			1,747	19
20	344--Dainage/Sewer		1988	1,368	46		30	46		980	20
21	347--Concrete		1988	7,277			20			7,277	21
22	346--Irrigation System		1988	7,650	306		25	306		6,579	22
23	351--Drainage / Sewer		1989	4,287	143		30	143		2,929	23
24	361--New Facility Wiring		1989	23,166	580		20	580		23,166	24
25	300--Garage		1989	23,005	920		25	920		18,864	25
26	359--Fire Prevention Sprinkler System		1989	24,890	996		25	996		20,409	26
27	362--Water & Gas Plumbing		1989	36,140	1,446		25	1,446		29,634	27
28	364--Cabinets & Countertop		1991	2,010	101		20	101		1,860	28
29	305--Door for Porch Enclosure		1995	709	18		40	18		258	29
30	302--Door For Porch Enclosure		1995	733	18		40	18		266	30
31	303-- Back Door For Porch		1995	775	19		40	19		281	31
32	306--Lighting for Porch		1995	1,249	31		40	31		453	32
33	304--Awning & Window for Porch		1995	4,136	103		40	103		1,500	33
34	307--Generator Wiring		1999	1,623	41		40	41		426	34
35	353--Resurface Driveway		1999	10,526	702		15	702		7,369	35
36	771--Fiber Optic Cable		2006	1,261	84		15	84		294	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

- 481814 Page 12A
- Page 12B
- Page 12C
- Page 12D
- Page 12E
- Page 12F
- Page 12G
- Page 12H
- Page 12I

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Oakwood Estate # 0033712 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	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	\$ 69	37
38	308--Carpet	2000	4,866	487	10	487	4,623	38
39	565--Counter tops	2002	425	28	15	28	212	39
40	563--Counter tops	2002	900	60	15	60	450	40
41	780--Flooring	2007	7,109	474	15	474	1,185	41
42	857--Telephone System	2008	882	59	15	59	118	42
43	858--Roofing Project	2008	33,760	2,251	15	2,251	4,501	43
44	327--Vinyl Floor Coverings	1994	1,548		10		1,548	44
45	882--Laundry Utility Sinks	2009	1,404	94	15	94	94	45
46	883--Lighting Project	2009	2,500	167	15	167	167	46
47	929--Ramp Railings	2008	7,384	492	15	492	492	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)		\$ 481,814	\$ 14,865		\$ 14,865	\$ 305,852	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:

07/01/2008

Ending:

06/30/2009

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	\$ 52,281	\$ 3,240	\$ 3,240		11	\$ 41,575
72	Current Year Purchases						
73	Fully Depreciated Assets	98,249	50	50		11	98,249
74	Disposed Assets					5	
75	TOTALS	\$ 150,530	\$ 3,290	\$ 3,290			\$ 139,824

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				\$	\$	\$			\$
77									
78									
79									
80	TOTALS			\$	\$	\$			\$

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)	\$ 641,821
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,155
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,155
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 445,676

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Fully depreciated vehicles	\$	\$	\$	86
87	Capitalized repairs				87
88	Vehicle Equipment				88
89	Vehicles				89
90	Disposed Assets				90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost
92		\$
93		
94		
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.

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STATE OF ILLINOIS

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

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	N/A		\$ _____	\$ _____	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 rental agreement:

	Fiscal Year Ending	Annual Rent
12.	_____ /2010	\$ _____
13.	_____ /2011	\$ _____
14.	_____ /2012	\$ _____

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

** This amount plus any amortization of expense must agree with page 4, line 7.

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STATE OF ILLINOIS

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

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. 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>40</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>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		151		151
3	Classroom Wages (a)		1,020		1,020
4	Clinical Wages (b)		240		240
5	In-House Trainer Wages (c)		433		433
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,844	\$	\$ 1,844
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,844		

C. CONTRACTUAL INCOME

In the box below record the amount of income received from other facilities for training CNAs

\$

D. NUMBER OF CNAs TRAINED

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

- (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.

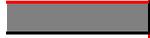


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Facility Name & ID Number Oakwood Estate

STATE OF ILLINOIS

0033712 Report Period Beginning:

07/01/2008 Ending:

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)	To (Col.
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$	
2	Licensed Speech and Language Development Therapist		hrs									
3	Licensed Recreational Therapist		hrs									
4	Licensed Physical Therapist		hrs									
5	Physician Care		visits									
6	Dental Care		visits									
7	Work Related Program		hrs									
8	Habilitation		hrs									
9	Pharmacy		# of prescripts									
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									
11	Academic Education		hrs									
12	Other (specify):											
13	Other (specify):											
14	TOTAL			\$		\$		\$			\$	

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.

8

tal Cost (3 + 5 + 6)	
	1
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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(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	\$ 290,895	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	129,898	1,895,529	3
4	Supply Inventory (priced at)	3,519	25,600	4
5	Short-Term Investments		2,296,577	5
6	Prepaid Insurance	2,405	(2,870)	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employees</u>	480	33,972	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 136,802	\$ 4,539,703	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	382,033	13
14	Buildings, at Historical Cost	286,435	4,715,767	14
15	Leasehold Improvements, at Historical Cost	71,012	572,892	15
16	Equipment, at Historical Cost	248,629	2,567,807	16
17	Accumulated Depreciation (book methods)	(419,407)	(4,660,407)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,269	46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,269)	(46,121)	20
21	Restricted Funds		5,649,405	21
22	Other Long-Term Assets (spe Cash Value of Life Ins)		36,270	22
23	Other(specify): <u>Investment in other facilities</u>		5,544,263	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,146	\$ 14,808,030	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 332,948	\$ 19,347,733	25

		1	2
		Operating	After Consolidation*
	C. Current Liabilities		
26	Accounts Payable	\$ 5,680	\$ 1,369,863
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		
30	Accrued Salaries Payable	66,117	579,307
31	Accrued Taxes Payable (excluding real estate taxes)		(6,786)
32	Accrued Real Estate Taxes(Sch.IX-B)		
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
36			
37			
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 71,797	\$ 1,942,384
	D. Long-Term Liabilities		
39	Long-Term Notes Payable		
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
	Other Long-Term Liabilities(specify):		
43	<u>Capital Lease</u>		17,566
44	<u>Rounding Errors</u>	(2)	1
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2)	\$ 17,567
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 71,795	\$ 1,959,951
47	TOTAL EQUITY(page 18, line 24)	\$ 261,153	\$ 17,387,782
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 332,948	\$ 19,347,733

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 386,428	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 386,428	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(125,275)	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (125,275)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 261,153	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oakwood Estate# 0033712Report Period Beginning: 07/01/2008Ending: 06/30/2009

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	\$ 619,046	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 619,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	3,174	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,174	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	4,717	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,717	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 626,937	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	133,742	31
32	Health Care	375,940	32
33	General Administration	191,934	33
	B. Capital Expense		
34	Ownership	18,153	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,444	36
	D. Other Expenses (specify):		
37	<u>Rounding Errors</u>	(1)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 752,212	40
41	Income before Income Taxes (line 30 minus line 40)**	(125,275)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (125,275)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

STATE OF ILLINOIS

Facility Name & ID Number **Oakwood Estate**

0033712

Report Period Beginning: **07/01/2008**

Ending:

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	2,048	2,048	53,466	26.11	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	106	106	2,430	22.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,455	2,971	45,409	15.28	15
16	Dishwashers					16
17	Maintenance Workers	1,254	1,254	22,464	17.91	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	395	605	18,097	29.91	20
21	Assistant Administrator	262	262	9,274	35.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,426	1,426	28,302	19.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,846	2,063	45,447	22.03	29
30	Habilitation Aides (DD Homes)	17,628	19,241	258,456	13.43	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,420	29,976	\$ 483,345 *	\$ 16.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period
35	Dietary Consultant	24	\$ 987
36	Medical Director	Flat Fee	114
37	Medical Records Consultant		
38	Nurse Consultant		
39	Pharmacist Consultant	Flat Fee	234
40	Physical Therapy Consultant	5	314
41	Occupational Therapy Consultant	9	536
42	Respiratory Therapy Consultant		
43	Speech Therapy Consultant	28	1,953
44	Activity Consultant		
45	Social Service Consultant		
46	Other(specify) <u>Psychologist</u>	7	585
47			
48			
49	TOTAL (lines 35 - 48)	73	\$ 4,723

C. CONTRACT NURSES

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

3

Schedule V Line & Column Reference	
1-3	35
9-3	36
	37
	38
10-3	39
10-3	40
10a-3	41
	42
10a-3	43
	44
	45
12-3	46
	47
	48
	49

3

Schedule V Line & Column Reference	
	50
	51
	52
	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jodi Anliker	Administrator	0	\$ 18,097	Workers' Compensation Insurance	\$ 12,550	IDPH License Fee		\$	
Matthew Steffen	Assistant Administrator	0	9,274	Unemployment Compensation Insurance	0	Advertising: Employee Recruitment			
				FICA Taxes	31,470	Health Care Worker Background Check			
				Employee Health Insurance	50,387	(Indicate # of checks performed <u>22</u>)			
				Employee Meals	17,514	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Participation Fees & Certificates			
				Employee Physicals	238	Dues (Employers Assn, IHCA)			
				Employee Promotional	2,354	Subscriptions (journals, news, etc.)			
				Defined Contribution Pension Plan	634	Driving Records Verification			
				Employee Scholarships	0				
				Benefits for Transferred wages	1,569	Less: Public Relations Expense		(
						Non-allowable advertising		(
						Yellow page advertising		(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,371	TOTAL (agree to Schedule V, line 22, col.8)		\$ 116,716	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		
			\$			\$	Out-of-State Travel		
							\$		
							Board of Directors travel		
							Administrative travel		
							In-State Travel		
							Board of Directors travel		
							Administrative travel		
							Seminar Expense		
							Less out of state travel		
							Entertainment Expense		
							(
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL		
C. Professional Services							\$		
Vendor/Payee	Type		Amount						
Koch Consulting	Accounting		\$ 2,715						
Quantum Solutions Corp	Software Consultant		2,435						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,150						

* Attach copy of IMRF notifications

**See instructions.

Page 21

06/30/2009

Amount
0
154
0
1,358
168
)
)
)
1,680

Amount
564
0
187
44
(564)
)
231

Facility Name & ID Number Oakwood Estate

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$839
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 148 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,444
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 17,514 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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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? N/A
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Koch Consulting
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V - Costs Center Expenses

Lines	Description	Amount
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
27	Dental costs	2,708
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	(4,717)
	Other Expenses	(2,009)

Schedule V - Reclassifications

Lines	Description	Increase	Decrease
6	Communication equipment rental	-	-
35	Communication equipment rental	-	-
11	Donated labor	173	-
1	Donated labor	55	-
4	Donated labor	-	-
6	Donated labor	55	-
21	Donated labor	-	-
10	Donated labor	-	-
10a	Donated labor	-	-
12	Donated labor	-	-
27	Donated labor	-	283
38	Medically necessary transportation	-	-
14	Medically necessary transportation	-	-
10a	Disability Pay to Benefits	-	2,482
22	Disability Pay to Benefits	2,482	-
13	Nurse aid trainer wages	2,273	-
1	Nurse aid trainer wages	-	13
6	Nurse aid trainer wages	-	15
10	Nurse aid trainer wages	-	2,087
10a	Nurse aid trainer wages	-	16
11	Nurse aid trainer wages	-	5
12	Nurse aid trainer wages	-	134
15	Nurse aid trainer wages	-	-
17	Nurse aid trainer wages	-	3
39	Dental costs	2,708	-
27	Dental costs	-	2,708
		7,746	7,746

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 28 visits	\$ 2,708
----------------------------	----------

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	\$ 283
	Department	Time in Hours Time in Dollars
Activities		23.00 173
Kitchen		7.25 55
Laundry		- -
Maintenance		5.50 55
Nursing		- -
PT/OT		- -
Social Service Programs		- -
Office		- -
Totals		35.75 \$ 283

Schedule VII - Compensation Received From Other Nursing Homes

Virgil Metzger - \$423 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Roger Aberle - \$2,081 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Stan Virkler - \$715 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Dennis Mott - \$218 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Keith Pflum - \$887 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	
Warren Zahner - \$936 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate	

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

Investment in Related Entities	-
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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	4,717
Cost to Market Adjustment on Investments	-
	4,717

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

Income before taxes per cost report	(125,275)
Income from related parties	(531,137)
Estimated excess for year, Form 990, p.1, line 18	(656,412)

Sch. XVIII - A. Staffing and Salary Costs

Sch. V. Cost Center Expenses, Column 1, Row 45	483,345
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(483,345)
Variance	-

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

Salaries, Sch V, Line 45, Col 1	483,345
Prior Year PTO Accrual at 06/30/08	30,811
Current Year PTO Accrual at 06/30/09	(35,153)
Prior Year Wage Accrual at 06/30/08	22,804
Current Year Wage Accrual at 06/30/09	(28,764)
Section 125 Wages not applicable to FICA taxes	(12,035)
Less: Wages over FICA taxation limit of \$94.2k SS Wages (\$0 x 6.2%/7.65%)	-
Wages Allocated to other facilities	(59,845)
Add: ACSS Wages	
Add: wages included in employee meal calculation	10,207
Cash basis salaries	411,370
FICA rate	7.650%
Calculated FICA	31,470
FICA per Sch XIX	31,470
Variance	(0)

Sch. XX - General Information

12. Nurse Aide Trainer Wages:		
	Administrator	3
	Therapy / PT / OT	16
	Activities Director	5
	Day Program	-
	Head Cook	13
	Maintenance	15
	Nursing	2,087
	Soc. Serv. / QMRP	134
		2,273

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

Virgil Metzger (Not out of State)	
Stan Virkler	102
Roger Aberle	297
Keith Pflum (Not out of State)	
Dennis Mott	31
Warren Zahner	134
	564

Nursing

None	-
	-

Oakwood Estate, #0033712

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

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

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

Daniel Schumacher, Chairman (term ended 03/21/2009)
Stan Virkler, Vice Chairman
Keith Pflum, Secretary/ Treasurer
Virgil Metzger, Director (term began 03/21/2009)
Warren Zahner, Director
Ron Hodel, Director
Cleve Klopfenstein, Director
Roger Aberle, Director
Roger Beutel, Director
Dennis Mott, 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.

Oakwood Estate, #0033712

	Pioneer Park	PARC	TCRC	Van-Pioneer Park	Cost per Trip	Cost per Day		Total Cost per Year	Less Depreciation	Reallocation Amounts	Sch. V Col. 7 Line #	Schedule for Reallocation
Trips per Day	2	1	2	0								
Miles per trip	40	40	5	40								
Gas/Depreciation Price per Mile	\$1.25	\$1.35	\$1.25	\$0.75								
Hours per trip	1 1/4	1 1/4	3/4	1 1/4								
Attendant Wages	\$8.50	\$8.50	\$8.50									
Driver Wages	\$12.75	\$12.75	\$12.75	\$10.50								
Gas & Depreciation	\$ 50.00	\$ 54.00	\$ 6.25	\$ 30.00	\$ 110.25	\$ 166.50	56.63%	-	-	-	14	Sch. VI Ln. 29
Depreciation						\$ -					Sch XI (F)	Sch. VI Ln. 29
Driver Wages	\$ 15.94	\$ 31.88	\$ 9.56	\$ 13.13	\$ 57.38	\$ 82.88	28.19%	-	-	-	6	Sch. VI Ln. 1
Attendant Wages	\$ 10.63	\$ 10.63	\$ 6.38	\$ -	\$ 27.64	\$ 44.65	15.19%	-	-	-	10	Sch. VI Ln. 29
Total	\$ 76.57	\$ 96.51	\$ 22.19	\$ 43.13	\$ 195.27	\$ 294.03		-		-		

