

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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

<p>I. Facility ID Number: <u>1000139</u></p> <p>Facility Name: <u>Oak Hill SLF</u></p> <hr/> <p>Address: <u>76 East Rollins Road</u> <u>Round Lake Beach</u> <u>60073</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: (<u>(847) 201-1100</u> Fax # _____)</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>7/30/2012</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Other <u>Limited Partnership</u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 282 - 6300</u></p> <p>Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ *</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____ *	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																												
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																												
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																												
	<input type="checkbox"/> "Sub-S" Corp.	_____																																												
	<input type="checkbox"/> Limited Liability Co.	_____																																												
	<input type="checkbox"/> Trust																																													
	<input checked="" type="checkbox"/> Other <u>Limited Partnership</u>																																													
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																												
	(Type or Print Name) _____																																													
	(Title) _____																																													
Paid Preparer	(Signed) _____ *	(Date) _____																																												
	(Print Name and Title) _____																																													
	(Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																																													
	(Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>																																													

Facility Name Oak Hill SLF

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	94	Single Unit Apartment	94	34,404	1
2		Double Unit Apartment			2
3		Other			3
4	94	TOTALS	94	34,404	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	18,138	12,092		30,230	5
6	Double Unit					6
7	Other					7
8	TOTALS	18,138	12,092		30,230	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.87%

D. Indicate the number of paid bed-hold days the SLF had during this year

464 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 44 (Do not include bed-hold days in Section B.)

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

YES NO

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

YES NO

G. List all services provided by your facility for non-residents.

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

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding?

No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding?

No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding?

No If yes, did the facility make all of the required payments of interest and principle? N/A

If no, explain. N/A

Facility Name: Oak Hill SLF

Report Period Beginning:

1/1/2016

Ending: 12/31/2016

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	260,911	183,495	16,661	461,067	(771)	460,296	1
2	Housekeeping, Laundry and Maintenance	94,914	36,259	119,616	250,789	9,941	260,730	2
3	Heat and Other Utilities			123,922	123,922	214	124,136	3
4	Other (specify):							4
5	TOTAL General Services	355,825	219,754	260,199	835,778	9,384	845,162	5
B. Health Care and Programs								
6	Health Care/ Personal Care	495,580	4,933	38,934	539,447	12,989	552,436	6
7	Activities and Social Services	51,025	4,161	22,091	77,277	3,376	80,653	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	546,605	9,094	61,025	616,724	16,365	633,089	9
C. General Administration								
10	Administrative and Clerical	210,116	13,607	509,178	732,901	(120,165)	612,736	10
11	Marketing Materials, Promotions and Advertising	85,357	2,460	62,968	150,785	27,151	177,936	11
12	Employee Benefits and Payroll Taxes			216,288	216,288		216,288	12
13	Insurance-Property, Liability and Malpractice			32,784	32,784	1,970	34,754	13
14	Other (specify):					25,190	25,190	14
15	TOTAL General Administration	295,473	16,067	821,218	1,132,758	(65,854)	1,066,904	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,197,903	244,915	1,142,442	2,585,260	(40,105)	2,545,155	16
Capital Expenses								
D. Ownership								
17	Depreciation			909,004	909,004	(514,741)	394,263	17
18	Interest			301,797	301,797	(1,802)	299,995	18
19	Real Estate Taxes			155,433	155,433		155,433	19
20	Rent -- Facility and Grounds					8,268	8,268	20
21	Rent -- Equipment			3,762	3,762	307	4,069	21
22	Other (specify): Amortization/MIP			103,994	103,994		103,994	22
23	TOTAL Ownership			1,473,990	1,473,990	(507,967)	966,023	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,197,903	244,915	2,616,432	4,059,250	(548,073)	3,511,177	24

Oak Hill SLF

Report Period Beginning: 1/1/2016
 Ending: 12/31/2016

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Non-Straight Line Depreciation	\$ (516,000)	17 1
2	Guest Meals	(5,470)	01 2
3	Employee Meals	(940)	01 3
4	Maintenance Fees	(70)	02 4
5	Damage Recovery	(123)	10 5
6	Pet Fee	(2,000)	07 6
7	NSF Fee	(210)	10 7
8	Late Fees	(50)	10 8
9	Termination Fee	(83)	10 9
10	Other Income	(1,950)	10 10
11	Meals & Entertainment	(1,231)	11 11
12	Bank Service Charges	(1,276)	10 12
13	Charitable Contributions	(1,500)	10 13
14	Resident Gifts	(199)	10 14
15	Resident Reimbursables	(535)	10 15
16	Bad Debt - Tenant	(8,177)	10 16
17	Bad Debt - Medicaid	(22,075)	10 17
18	Meals & Entertainment	(14)	10 18
19	Cable TV	(1,216)	02 19
20	Management Fees	(42,681)	10 20
21	Service Provider Fee	(187,501)	10 21
22	Asset Management Fee	(11,255)	10 22
23	Partnership Mgmt Fee	(11,255)	10 23
24	Interest Income-Escrows	(237)	18 24
25	Interest Income	(1,565)	18 25
26	Additional R&M	7,034	02 26
27			27
28			28
29	PATHWAY MANAGEMENT LLC.		29
30	Maintenance	3,320	02 30
31	Utilities	214	03 31
32	Health Care / Personal Care	5,308	06 32
33	Administrative	92,111	10 33
34	Marketing	10,379	11 34
35	Insurance	828	13 35
36	Employee Benefits	12,665	14 36
37	Depreciation	2,218	17 37
38	Rent - Building	7,336	20 38
39	Rent - Equipment	49	21 39
40			40
41	PATHWAY SENIOR LIVING LLC.		41
42	Dietary	3,639	01 42
43	Maintenance	873	02 43
44	Health Care / Personal Care	7,081	06 44
45	Community Life	5,376	07 45
46	Administrative	76,606	10 46
47	Marketing	18,003	11 47
48	Insurance	1,142	13 48
49	Employee Benefits	12,525	14 49
50	Rent - Building	932	20 50
51	Rent - Equipment	258	21 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			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(548,073)	101

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.89	\$ 27.61	1
2	Licensed Practical Nurses	2.00	24.06	2
3	Certified Nurse Assistants	11.32	12.17	3
4	Activity Director & Assistants	1.00	24.56	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10.09	12.43	7
8	Dishwashers			8
9	Maintenance Workers	1.32	18.92	9
10	Housekeepers	2.01	10.24	10
11	Laundry			11
12	Managers			12
13	Other Administrative	4.17	24.24	13
14	Clerical			14
15	Marketing	0.94	43.46	15
16	Other			16
17	Total (lines 1 thru 16)	34.76	\$ 16.57	17

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

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

VI. (B) Management fees paid to unrelated parties

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

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
See Attached			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached					

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

Name of related entity: N/A If yes, what is the value of those services? \$ N/A
 (Please attach a separate schedule itemizing those services.)

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

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

Facility Name: Oak Hill SLF

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

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

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	94		2012		\$ 13,516,738	\$ 911,222	35	\$ 386,193	\$ (525,029)	\$ 1,544,771	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Supplemental Page 5's				19,308			965	965	2,369	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 13,536,046	\$ 911,222		\$ 387,158	\$ (524,064)	\$ 1,547,140	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 71,054	\$	\$ 7,105	7,105		\$ 24,141	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 71,054	\$	\$ 7,105	7,105		\$ 24,141	20

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

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

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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		
1									1
2	Civil Engineering	2013	6,694		20	335	335	1,339	2
3	Smoking Shelter	2014	3,996		20	200	200	599	3
4	Parking Lot Seal Coating	2016	5,745		20	287	287	287	4
5	Kick Plates For Doors	2016	2,873		20	144	144	144	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	TOTAL (lines 1 thru 33)		\$ 19,308	\$		\$ 965	\$ 965	\$ 2,369	34

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

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

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

Facility Name & ID Number Oak Hill SLF

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$

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

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2016

Ending: 2/31/2016

IX. RENTAL COSTS**A. Building and Fixed Equipment**1. Name of Party Holding Lease: N/A2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6	Allocated from Pathway			/ /	8,268			6
7	TOTAL				\$ 8,268			7

8. Is movable equipment rental included in building rental?

 YES NO9. Rental amount for movable equipment \$ 4,069

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

X. INTEREST EXPENSE

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense		
		YES	NO			Original	Balance					
	A. Directly Facility Related											
	Long-Term											
1	Centennial Mortgage		X	Mortgage	1/1/13	\$ 7,200,000	\$ 6,908,149	12/1/52	4.3500	\$ 301,797	1	
2											2	
3											3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 7,200,000	\$ 6,908,149			\$ 301,797	7	
	B. Non-Facility Related											
8	Interest Income-Escrows		X		/ /			/ /			(237)	8
9	Interest Income		X		/ /			/ /			(1,565)	9
10	TOTALS (lines 7, 8 and 9)					\$ 7,200,000	\$ 6,908,149			\$ 299,996	10	

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

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

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 846,265	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	313,133		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,965		6
7	Other Prepaid Expenses	9,606		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,358,672		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,536,641	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	615,000		13
14	Buildings, at Historical Cost	13,516,738		14
15	Leasehold Improvements, at Historical Cost	2,084,722		15
16	Equipment, at Historical Cost	2,383,441		16
17	Accumulated Depreciation (book methods)	(5,247,406)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	850,349		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,202,844	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,739,485	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,158	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,714		30
31	Accrued Taxes Payable	158,500		31
32	Accrued Interest Payable	25,042		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	531,376		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 842,790	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,908,149		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 6,908,149	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,750,939	\$	45
46	TOTAL EQUITY	\$ 8,988,546	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 16,739,485	\$	47

*(See instructions.)

Facility Name: Oak Hill SLF

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,828,519	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,828,519	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,758	8
9	Non-Resident Meals	4,410	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,168	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,802	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,802	14
D. Other Revenue (specify):			
15		4,486	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,486	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,841,975	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	835,778	19
20	Health Care/ Personal Care	616,724	20
21	General Administration	1,132,758	21
B. Capital Expense			
22	Ownership	1,473,990	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 4,059,250	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (217,275)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (217,275)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 1,658,414	32
33	Private Pay - Net Inpatient Revenue	1,238,061	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Managed Care</u>	932,044	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,828,519	37