

		FOR BHF USE			

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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>1000124</u></p> <p>Facility Name: <u>Oakwood Estates</u></p> <hr/> <p>Address: <u>200 South Logan St</u> <u>Stronghurst</u> <u>61480</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Henderson</u></p> <p>Telephone Number: (<u>309</u>) <u>924-1910</u> Fax # <u>309 924-1277</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>07/09/10</u></p> <p>Type of Ownership:</p> <table border="0" style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501c3</u></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 type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501c3</u>	<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 type="checkbox"/> Other _____		<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>01/01/17</u> to <u>12/31/17</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 border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>James G. Hull, CPA</u> <u>Owner</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>1900 Harrison St</u> <u>Quincy, IL 62301</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>217 228-1950</u> Fax <u>217-222-6053</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) <u>James G. Hull, CPA</u> <u>Owner</u>		(Firm Name & Address) <u>1900 Harrison St</u> <u>Quincy, IL 62301</u>		(Telephone) <u>217 228-1950</u> Fax <u>217-222-6053</u>	
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In the event there are further questions about this report, please contact:
 Name: James G. Hull, C.P.A. Telephone Number: (217 228-1950)
 Email Address: _____

Facility Name Oakwood Estates

Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	16	Single Unit Apartment	16	5,840	1
2	2	Double Unit Apartment	2	1,460	2
3		Other			3
4	18	TOTALS	18	7,300	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	2,071	3,163		5,234	5
6	Double Unit		720		720	6
7	Other					7
8	TOTALS	2,071	3,883		5,954	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.56%

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

101 Also, indicate the number of unpaid bed-hold days the SLF had during this year. (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)

n/a

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

* 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?

If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? yes If yes, did the facility make all of the required payments of interest and principle? yes

If no, explain.

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?

If no, explain.

Facility Name: Oakwood Estates

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	54,910	43,460	1,696	100,066	(3,025)	97,041	1
2	Housekeeping, Laundry and Maintenance		7,270	24,177	31,447		31,447	2
3	Heat and Other Utilities			20,384	20,384		20,384	3
4	Other (specify):			4,999	4,999	(3,481)	1,518	4
5	TOTAL General Services	54,910	50,730	51,256	156,896	(6,506)	150,390	5
B. Health Care and Programs								
6	Health Care/ Personal Care	181,583	4,111	605	186,299		186,299	6
7	Activities and Social Services		2,562		2,562		2,562	7
8	Other (specify):		325		325		325	8
9	TOTAL Health Care and Programs	181,583	6,998	605	189,186		189,186	9
C. General Administration								
10	Administrative and Clerical	48,863	2,245	8,813	59,921		59,921	10
11	Marketing Materials, Promotions and Advertising			3,915	3,915		3,915	11
12	Employee Benefits and Payroll Taxes			56,706	56,706		56,706	12
13	Insurance-Property, Liability and Malpractice			13,513	13,513		13,513	13
14	Other (specify):			14,532	14,532		14,532	14
15	TOTAL General Administration	48,863	2,245	97,479	148,587		148,587	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	285,356	59,973	149,340	494,669	(6,506)	488,163	16
Capital Expenses								
D. Ownership								
17	Depreciation			50,033	50,033	(14)	50,019	17
18	Interest			55,483	55,483	(1,756)	53,727	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			990	990		990	21
22	Other (specify):							22
23	TOTAL Ownership			106,506	106,506	(1,770)	104,736	23
24	GRAND TOTAL (Sum of lines 16 and 23)	285,356	59,973	255,846	601,175	(8,276)	592,899	24

Facility Name: Oakwood Estates

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.15	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	14.26	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	2	12.31	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers	1	23.43	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9	\$	17

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

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

VI. (B) Management fees paid to unrelated parties

	Amount of Fee		
1	\$	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
Henderson County Retirement Center		Stronghurst	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: _____ If yes, what is the value of those services? \$ _____
 (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: Oakwood Estates

Report Period Beginning:

01/01/17

Ending:

12/31/17

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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	20		2009	2009	\$ 1,631,080	\$ 41,823	39	\$ 41,822	\$ (1)	\$ 341,551	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements		2009	24,610	1,641	15	1,641		13,399	6
7		Building Equipment		2009	5,764	288	20	288		2,353	7
8		SLF Flooring		2014	15,324	1,027	15	1,022	(5)	3,339	8
9		Generator Upgrade		2017	41,282	516	20	516		516	9
10		Office Flooring		2017	2,911	16	15	16		16	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,720,971	\$ 45,311		\$ 45,305	\$ (6)	\$ 361,174	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	\$ 93,784	\$ 4,722	\$ 4,714	(8)	8	\$ 69,209	18
19	Vehicles	3,675				5	3,675	19
20	TOTAL (lines 18 and 19)	\$ 97,459	\$ 4,722	\$ 4,714	(8)		\$ 72,884	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: Oakwood Estates

Report Period Beginning: 01/01/17

Ending: 12/31/17

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? YES NO

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

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

9. Rental amount for movable equipment \$ 990

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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		USDA		X	Mortgage	10/22/08	\$ 673,400	\$ 571,766	10/22/38	4.5000	\$ 26,108	1
2		Security Savings		X	Mortgage	10/22/08	849,849	568,724	8/1/39	5.8750	29,375	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 1,523,249	\$ 1,140,490			\$ 55,483	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 1,523,249	\$ 1,140,490			\$ 55,483	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: Oakwood Estates

Report Period Beginning: 01/01/17

Ending:

12/31/17

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 179,148	\$ 580,835	1
2	Cash-Patient Deposits	(25,770)	(25,770)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	79,061	535,784	3
4	Supply Inventory (priced <u>FIFO</u>)	6,842	34,121	4
5	Short-Term Investments		536,601	5
6	Prepaid Insurance	15,783	19,023	6
7	Other Prepaid Expenses	3,871	18,778	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 258,935	\$ 1,699,372	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		22,500	13
14	Buildings, at Historical Cost	1,678,843	4,774,092	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	139,586	1,411,880	16
17	Accumulated Depreciation (book methods)	(434,058)	(3,501,682)	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): <u>CIP</u>	125,098	136,862	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,509,469	\$ 2,843,652	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,768,404	\$ 4,543,024	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 56,079	\$ 121,105	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,585	81,594	30
31	Accrued Taxes Payable		8,365	31
32	Accrued Interest Payable	2,356	4,016	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>GROUP INSURNACE</u>		(1,335)	35
36	<u>ROUNDING</u>		1	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 76,020	\$ 213,746	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,140,490	1,688,663	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)	\$ 1,140,490	\$ 1,688,663	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,216,510	\$ 1,902,409	45
46	TOTAL EQUITY	\$ 550,976	\$ 2,640,615	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,767,486	\$ 4,543,024	47

*(See instructions.)

Facility Name: Oakwood Estates

Report Period Beginning: 01/01/17

Ending:

12/31/17

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	\$ 664,378	1
2	Discounts and Allowances	(6,805)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 657,573	3
B. Other Operating Revenue			
4	Special Services	79	4
5	Other Health Care Services	5,800	5
6	Special Grants		6
7	Gift and Coffee Shop	87	7
8	Barber and Beauty Care		8
9	Non-Resident Meals	3,025	9
10	Laundry	2,880	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 11,871	11
C. Non-Operating Revenue			
12	Contributions	222,082	12
13	Interest and Other Investment Income	1,756	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 223,838	14
D. Other Revenue (specify):			
15	See List Attached	3,772	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,772	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 897,054	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	156,896	19
20	Health Care/ Personal Care	189,186	20
21	General Administration	148,587	21
B. Capital Expense			
22	Ownership	106,506	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	Rounding	2	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 601,177	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 295,877	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 295,877	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 201,180	32
33	Private Pay - Net Inpatient Revenue	456,393	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 657,573	37

Oakwood Estates and Retirement Village

01/01/17 to 12/31/17

	Single PA	Double PA	Single PVT	Double PVT	Bedholds Paid	Bedholds Unpaid		
January	186	0	277	62	2	0		527
February	168	0	252	56	0	0		476
March	186	0	279	62	0	0		527
April	180	0	257	60	13	0		510
May	186	0	244	62	35	0		527
June	180	0	269	55	6	0		510
July	184	0	279	62	2	0		527
August	186	0	270	62	9	0		527
September	155	0	233	60	26	0		474
October	155	0	270	57	5	0		487
November	150	0	254	60	3	0		467
December	155	0	279	62	0	0		496
	2071	0	3163	720	101	0	0	6055

Oakwood Estates and Retirement Village
01/01/17 to 12/31/17

Schedule VII. B

Oakwood Receives clerical services from Henderson County Retirement Center in the amount of \$3500.04
Averages 4.05 hrs per week at \$16.61 per hour.

Oakwood receives maintenance services from Henderson County Retirement Center in the amount of \$9,999.96
Averages around 12 hrs per week at \$16 per hour

Oakwood receives Laundry services from Henderson County Retirement Center in the amount of \$720.00

Schedule VII. C.

Related Org	Nature of Purchase	Book Value	Actual Cost
Henderson County Retirement Center	Food	\$0.00	\$0.00

Schedule XII, Line 15

Nursing Services	\$0.00
Applications Income	\$50.00
Income From Vehicle use	\$1,868.38
Equipment Rental Income	\$0.00
Miscellaneous Income	\$1,754.40
Rebates	\$99.00
Gain on sale of asset	\$0.00
Rounding	\$0.00
	<u>\$3,771.78</u>

Schedule IV, Line 3, Column 3

Gas	\$1,411.67
Electric	\$16,715.66
Water	\$2,256.92
	<u>\$20,384.25</u>

Schedule IV, Line 2, Column 3

Laundry Services	\$720.00
Maintenance Services-Oaklane	\$9,999.96
Outside Services-Maint	\$8,446.55
Repairs-Buildings	\$2,485.30
Repairs-Equipment	\$192.65
Repairs-Grounds	\$2,332.50
	<u>\$24,176.96</u>

Schedule IV, Line 14, Column 3

Personal Purchases	24.78
Dues and Subscription	\$1,335.08
License Fee	\$0.00
Vehicular Exp	\$931.01
Transportation	\$66.95
Bus Driver	\$0.00
Legal Exp.	\$0.00
Professional Fees	\$2,333.23
Seminar Exp.	\$2,066.93
Training	\$319.90
Software Support	\$3,309.17
Data Processing	\$4,145.00
Contributions	\$0.00
Misc Exp.	\$0.00
	<u>\$14,532.05</u>

Oakwood Estates and Retirement Village
01/01/17 to 12/31/17

Schedule IV, Column 5

Line 14 Contributions \$0
Line 1 Employee and Guest Meals \$3,025.00
Line 18 Interest on unrestricted funds \$1,755.84
Line 17 Non-Straight Line Deprec \$14.00
Line 4 Resident Room Cable \$3,481.38

Schedule VII, Part A.

Oakwood Estates and Retirement Village is a wholly owned division of
Henderson County Retirement Center, Inc.