

Facility Name & ID Number Oakwood Estates

0033712 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,282			4,282	13
14	TOTALS	4,282			4,282	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.32%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 8/8/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/18 Fiscal Year: 06/30/2018

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	63,005	3,332	1,140	67,477	(192)	67,285	67,285			1
2	Food Purchase		29,884		29,884		29,884	29,884			2
3	Housekeeping	5,430	1,592		7,022		7,022	7,022			3
4	Laundry		1,492		1,492		1,492	1,492			4
5	Heat and Other Utilities			15,832	15,832		15,832	15,832			5
6	Maintenance	15,704	855	11,784	28,343	(227)	28,116	28,116			6
7	Other (specify):*										7
8	TOTAL General Services	84,139	37,155	28,756	150,050	(419)	149,631	149,631			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	71,610	12,085	10,303	93,998	(13,987)	80,011	80,011			10
10a	Therapy	379,048			379,048	(577)	378,471	378,471			10a
11	Activities		985		985	(119)	866	866			11
12	Social Services	53,790	97	5,031	58,918	(792)	58,126	58,126			12
13	CNA Training					15,867	15,867	15,867			13
14	Program Transportation			4,729	4,729		4,729	4,729			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	504,448	13,167	20,063	537,678	392	538,070	538,070			16
	C. General Administration										
17	Administrative	24,950			24,950		24,950	24,950			17
18	Directors Fees										18
19	Professional Services			872	872		872	872			19
20	Dues, Fees, Subscriptions & Promotions			2,436	2,436		2,436	(156)	2,280		20
21	Clerical & General Office Expenses	41,607	3,112		44,719		44,719	44,719			21
22	Employee Benefits & Payroll Taxes			135,245	135,245		135,245	135,245			22
23	Inservice Training & Education			569	569		569	569			23
24	Travel and Seminar			342	342		342	(404)	(62)		24
25	Other Admin. Staff Transportation			222	222		222	222			25
26	Insurance-Prop.Liab.Malpractice			7,545	7,545		7,545	(1,244)	6,301		26
27	Other (specify):*			3,130	3,130	(2,880)	250	250			27
28	TOTAL General Administration	66,557	3,112	150,361	220,030	(2,880)	217,150	(1,804)	215,346		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	655,144	53,434	199,180	907,758	(2,907)	904,851	(1,804)	903,047		29

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

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

Facility Name & ID Number

Oakwood Estates

#0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			63,481	63,481		63,481		63,481			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			5,584	5,584		5,584		5,584			34
35	Rent-Equipment & Vehicles			2	2		2		2			35
36	Other (specify):*											36
37	TOTAL Ownership			69,067	69,067		69,067		69,067			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					2,907	2,907		2,907			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,520	37,520		37,520		37,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,520	37,520	2,907	40,427		40,427			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	655,144	53,434	305,767	1,014,345		1,014,345	(1,804)	1,012,541			45

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

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	\$	6	\$	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		36		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		27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,244)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(156)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,400)		\$	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))	\$ (1,400)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Oakwood Estates

ID# 0033712

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset day training transportation income	\$	10	1
2	Offset day training transportation income		14	2
3	Out-of-state Travel (Administrative Staff)	(62)	24	3
4	Depreciation of non-care vehicles		30	4
5	Offset medically necessary transportation income	0	38	5
6	Benefits allocated to day programming	0	22	6
7	Out-of-state Travel (Board of Directors)	(342)	24	7
8	Interest Expense	0	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(404)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estates# 0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(156)	0	0	0	0	0	0	0	0	0	0	(156)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(404)	0	0	0	0	0	0	0	0	0	0	(404)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,244)	0	0	0	0	0	0	0	0	0	0	(1,244)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,804)	0	0	0	0	0	0	0	0	0	0	(1,804)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,804)	0	0	0	0	0	0	0	0	0	0	(1,804)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,804)	0	(1,804)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES			3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name		City	Name	City	Type of Business
Apostolic Christian LifePoints, Inc.	100%	Apostolic Christian Timber Ridge	#0016220	Morton	Apostolic Christian	Morton	CILA Residential
		Linden Estate	#0039305	Morton	CILA Services		Services for the
							Developmental
							& Intellectual
							Disabled

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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.

Facility Name & ID Number

Oakwood Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Virgil Metzger	BOD						1
2	Ben Knochel	BOD						2
3	Paul Kelson	BOD						3
4	Roger Beutel	BOD						4
5	Bryan Stoller	BOD						5
6	Kathy Woodruff	BOD						6
7	Ed Leman	BOD						7
8	Royce Scheiler	BOD						8
9	Kent Schmidgall	BOD						9
10	Wendy Witzig	BOD						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

Facility Name & ID Number

Oakwood Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Virgil Metzger	Director	Director	0.00	599	0.5		Travel	\$ 101	line24 col 3	1
2	Ben Knochel	Director	Director	0.00	0	0.5			0		2
3	Paul Kelson	Vice President	Director	0.00	0	0.5			0		3
4	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		4
5	Bryan Stoller	Director	Director	0.00	0	0.5			0		5
6	Kathy Woodruff	Director	Director	0.00	1,580	0.5		Travel	211	line24 col 3	6
7	Ed Leman	President	Director	0.00	0	0.5			0		7
8	Royce Scheiler	Director	Director	0.00	0	0.5			0		8
9	Kent Schmidgall	Director	Director	0.00	231	0.5		Travel	30	line24 col 3	9
10	Wendy Witzig	Director	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	\$ 342		13

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

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

Facility Name & ID Number Oakwood Estates

0033712 Report Period Beginning: 07/01/2017

Ending: 6/30/2018

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 Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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		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	Morgan Stanley (PLA/LAL)		x	State Payment Delays	Interest	10/2008	4,667,000		None	3.0000	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	4,667,000	\$		\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$		\$		\$	14							
15	TOTALS (line 9+line14)					\$	4,667,000	\$		\$	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakwood Estates COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0033712

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

07/01/2017 Ending:

06/30/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>LTC Facility</u>	<u>91,781</u>	<u>1988</u>	<u>\$ 9,477</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	91,781		\$ 9,477	3

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$ 149,206	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	343--Landscaping			1988	9,369		10			9,369	9
10	344--Dainage/Sewer			1988	1,368	23	30	23		1,368	10
11	346--Irrigation System			1988	7,650		25			7,650	11
12	347--Concrete			1988	7,277		20			7,277	12
13	348--Parking Signs			1988	41		12			41	13
14	349--Underground Gas & Waterline			1988	621	10	30	10		621	14
15	350--Sod			1988	3,790		10			3,790	15
16	351--Drainage / Sewer			1989	4,287	143	30	143		4,215	16
17	352--Landscaping			1989	458		8			458	17
18	353--Resurface Driveway			1999	10,526		15			10,526	18
19	354--Organization Costs			1988	26,269		5			26,269	19
20	358--Kitchen Serving Door			1988	1,747		20			1,747	20
21	563--Counter tops			2002	900		15			900	21
22	565--Counter tops			2002	425		15			425	22
23	771--Fiber Optic Cable			2006	1,261	84	15	84		1,051	23
24	780--Flooring			2007	7,109	474	15	474		5,450	24
25	300--Garage			1989	56,765	2,251	20	2,251		47,762	25
26	859--Exit Ramps			2008	1,697	113	15	113		1,244	26
27	883--Lighting Project			2009	2,500	167	15	167		1,667	27
28	929--Ramp Railings			2008	7,384	492	15	492		4,923	28
29	939--Replace Sprinkler Main with Galvanized Pipe			2010	9,267	618	15	618		5,560	29
30	997--Misc repair to agree to TB			2011	39		1			39	30
31	1002--Carrier Furnace			2012	2,686	179	15	179		1,253	31
32	1013--Cabinets, Countertops, Handles			2012	4,705	235	20	235		1,647	32
33	1015--Porch			2012	10,869	543	20	543		3,804	33
34	1027--Heat Pumps and Condensing Unit			2013	2,400	160	15	160		960	34
35	1028--Conversion to WC accessible facility			2014	900,839	30,028	30	30,028		150,140	35
36	1051--Reconciling item			2012	1,203		1			1,203	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1065--15 Bedside Cabinets	2014	\$ 2,563	\$ 171	15	\$ 171	\$	\$ 854	37
38	1071--Gutters	2014	1,600	80	20	80		400	38
39	1080--Window Tx	2014	5,115	341	15	341		1,705	39
40	1105--New Carrier Condenser and Coil	2014	4,700	313	15	313		1,567	40
41	1108--Patient Lift Systems	2014	81,075	5,405	15	5,405		26,902	41
42	1132--Whirlpool	2015	15,475	1,032	15	1,032		4,127	42
43	1134--Oakwood Driveway - Ring Road	2015	7,521	501	15	501		2,006	43
44	1172--3 Doors project	2016	16,517	1,101	15	1,101		3,303	44
45	1183--OE driveway	2016	15,850	1,057	15	1,057		3,170	45
46	1191--OE Porch Floor	2016	3,708	247	15	247		742	46
47	1203--Sidewalks, patio, driveway	2017	9,233	616	15	616		1,231	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)		\$ 1,449,123	\$ 51,442		\$ 51,442	\$	\$ 496,572	70

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

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 87,584	\$ 8,777	\$ 8,777	\$	11	\$ 39,207	71
72	Current Year Purchases	3,533	505	505		7	505	72
73	Fully Depreciated Assets	42,829	369	369		8	42,829	73
74	Disposed Assets							74
75	TOTALS	\$ 133,946	\$ 9,651	\$ 9,651	\$		\$ 82,541	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,592,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,093	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 579,113	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 0 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	160	3,230		3,390
4	Clinical Wages (b)	680	760		1,440
5	In-House Trainer Wages (c)	2,234	2,497		4,731
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 3,074	\$ 6,487	\$	\$ 9,561
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,561			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	28
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	13
TOTAL TRAINED	52

- (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.

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Oakwood Estates**# **0033712**Report Period Beginning: **07/01/2017**Ending: **06/30/2018****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2018**

(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	\$ 400	\$ 209,612	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	100,355	1,501,780	3
4	Supply Inventory (priced at 646)	646	25,002	4
5	Short-Term Investments		6,616,946	5
6	Prepaid Insurance	5,715	36,676	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,223	8
9	Other(specify): <u>Self Insured health ins. assets</u>	247	927,457	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 107,363	\$ 9,318,696	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	550,863	13
14	Buildings, at Historical Cost	1,245,694	8,360,074	14
15	Leasehold Improvements, at Historical Cost	87,071	1,533,563	15
16	Equipment, at Historical Cost	226,110	2,931,931	16
17	Accumulated Depreciation (book methods)	(530,476)	(6,738,723)	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		11,880,431	21
22	Other Long-Term Assets (specify):		131,626	22
23	Other(specify): <u>Investment in other facilities</u>		13,200,006	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,037,876	\$ 31,849,771	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,145,239	\$ 41,168,467	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,378	\$ 361,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,180	756,141	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	35,890	403,110	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Rounding</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 99,448	\$ 1,521,289	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Captail Lease</u>			43
44	<u>Investment from other facilities</u>	2,714,681	13,200,006	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,714,681	\$ 13,200,006	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,814,129	\$ 14,721,295	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,668,890)	\$ 26,447,172	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,145,239	\$ 41,168,467	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,324,248)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,324,248)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(344,642)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (344,642)	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)	\$ (1,668,890)	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 677,412	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 677,412	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	391	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 391	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 677,803	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	150,050	31
32	Health Care	537,678	32
33	General Administration	220,030	33
B. Capital Expense			
34	Ownership	69,067	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,520	36
D. Other Expenses (specify):			
37	<u>Rounding</u>		37
38	<u>Loss on Sale/Disposal of Assets</u>	8,100	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,022,445	40
41	Income before Income Taxes (line 30 minus line 40)**	(344,642)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (344,642)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>ICF-ID/DD</u>	677,412	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 677,412	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

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

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

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	0	\$ 0	\$	1
2	Assistant Director of Nursing	0	0		2
3	Registered Nurses	2,449	71,610	29.24	3
4	Licensed Practical Nurses	0	0		4
5	CNAs & Orderlies	0	0		5
6	CNA Trainees	0	0		6
7	Licensed Therapist	0	0		7
8	Rehab/Therapy Aides	0	0		8
9	Activity Director	0	0		9
10	Activity Assistants	0	0		10
11	Social Service Workers	0	0		11
12	Dietician	0	0		12
13	Food Service Supervisor	247	7,646	30.96	13
14	Head Cook	3,584	55,382	13.68	14
15	Cook Helpers/Assistants	0	0		15
16	Dishwashers	0	0		16
17	Maintenance Workers	844	15,704	18.61	17
18	Housekeepers	416	5,407	13.00	18
19	Laundry	0	0		19
20	Administrator	561	24,950	44.47	20
21	Assistant Administrator	0	0		21
22	Other Administrative	1,080	36,383	33.69	22
23	Office Manager	218	4,074	18.69	23
24	Clerical	92	1,150	12.50	24
25	Vocational Instruction	0	0		25
26	Academic Instruction	0	0		26
27	Medical Director	0	0		27
28	Qualified MR Prof. (QMRP)	0	0		28
29	Resident Services Coordinator	1,915	53,790	26.12	29
30	Habilitation Aides (DD Homes)	24,443	359,435	13.42	30
31	Medical Records	0	0		31
32	Other Health Care: <u>OT/PT</u>	979	19,613	20.03	32
33	Other(specify)	0	0		33
34	TOTAL (lines 1 - 33)	36,828	\$ 655,144 *	\$ 16.47	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	260	\$ 1,140	1-3	35
36	Medical Director	0	0	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	Flat Fee	377	10-3	38
39	Pharmacist Consultant	Flat Fee	1,085	10-3	39
40	Physical Therapy Consultant	7	421	10-3	40
41	Occupational Therapy Consultant	5	291	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	29	2,033	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) <u>Psychologist Consulta</u>	0	0	12-3	46
47	<u>Dental Consultant</u>	0	0	10a-3	47
48	<u>Psychiatrist Consultant</u>	15	2,998	10a-3	48
49	TOTAL (lines 35 - 48)	315	\$ 8,346		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	461	8,874	10a-3	52
53	TOTAL (lines 50 - 52)	461	\$ 8,874		53

Facility Name & ID Number Oakwood Estates# 0033712Report Period Beginning: 07/01/2017Ending: 06/30/2018**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. IHCA - \$912, Institute on Public Policy - \$513
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,878 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. \$ 37,520
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 15,841 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 adjsted 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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Koch Consultants, LTD.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

OAKWOOD ESTATE - - #0033712

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Apostolic Christian Timber Ridge #0016220
Linden Estate #0039305

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

Ed Leman, Chairman
Paul Kelson, Vice Chairman
Roger Beutel, Director Secretary/Treasurer
Ben Knochel, Director
Wendy Sauder, Director
Royce Scheiler, Director
Kent Schmidgall, Director (term began 05/19/2018)
Bryan Stoller, Director
Kathy Woodruff, Director
Virgil Metzger, Director (term ended 05/19/2018)

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.