

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0033712</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Oakwood Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2015</u> to <u>6/30/2016</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2213 Veterans Road</u> <u>Morton</u> <u>61550</u>																									
Number City Zip Code																									
County: <u>Tazewell</u>																									
Telephone Number: <u>309-266-9781</u> Fax # <u>309-266-9468</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Matthew D. Steffen</u></td></tr><tr><td>(Title) <u>Finance and Operations Director</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Matthew D. Steffen</u>	(Title) <u>Finance and Operations Director</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Matthew D. Steffen</u>																								
	(Title) <u>Finance and Operations Director</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>8/8/1988</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Matthew D. Steffen</u> Telephone Number: <u>309-266-9781</u> Email Address: _____																									

Facility Name & ID Number Oakwood Estates

0033712 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,856	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	4,317			4,317	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,317			4,317	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.72%

D. How many bed-hold days during this year were paid by the Department? 82 (Do not include bed-hold days in Section B.)

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

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: 6/30/16 Fiscal Year: 6/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	54,735	2,609	780	58,124	(104)	58,020		58,020			1
2	Food Purchase		27,595		27,595		27,595		27,595			2
3	Housekeeping	5,693	1,303		6,996		6,996		6,996			3
4	Laundry		2,139		2,139		2,139		2,139			4
5	Heat and Other Utilities			13,076	13,076		13,076		13,076			5
6	Maintenance	15,157	3,264	8,275	26,696	(122)	26,574		26,574			6
7	Other (specify):*											7
8	TOTAL General Services	75,585	36,910	22,131	134,626	(226)	134,400		134,400			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records		20,875	5,125	26,000	(11,420)	14,580		14,580			10
10a	Therapy	288,923			288,923	(267)	288,656		288,656			10a
11	Activities		2,200		2,200	(70)	2,130		2,130			11
12	Social Services	53,568		3,166	56,734	(819)	55,915		55,915			12
13	CNA Training					12,818	12,818		12,818			13
14	Program Transportation			3,175	3,175		3,175		3,175			14
15	Other (specify):* DD Training		50		50	(16)	34		34			15
16	TOTAL Health Care and Programs	342,491	23,125	11,466	377,082	226	377,308		377,308			16
	C. General Administration											
17	Administrative	25,985			25,985		25,985		25,985			17
18	Directors Fees											18
19	Professional Services			3,312	3,312		3,312		3,312			19
20	Dues, Fees, Subscriptions & Promotions			2,044	2,044		2,044	(132)	1,912			20
21	Clerical & General Office Expenses	(39,063)	3,423		(35,640)		(35,640)		(35,640)			21
22	Employee Benefits & Payroll Taxes			118,607	118,607		118,607		118,607			22
23	Inservice Training & Education			285	285		285		285			23
24	Travel and Seminar			479	479		479	(377)	102			24
25	Other Admin. Staff Transportation			17	17		17		17			25
26	Insurance-Prop.Liab.Malpractice			5,526	5,526		5,526		5,526			26
27	Other (specify):* Miscellaneous			3,351	3,351	(2,760)	591		591			27
28	TOTAL General Administration	(13,078)	3,423	133,621	123,966	(2,760)	121,206	(509)	120,697			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	404,998	63,458	167,218	635,674	(2,760)	632,914	(509)	632,405			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			61,411	61,411		61,411		61,411			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Management Fees											36
37	TOTAL Ownership			61,411	61,411		61,411		61,411			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					2,760	2,760		2,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,784	39,784		39,784		39,784			42
43	Other (specify):* Newsletter											43
44	TOTAL Special Cost Centers			39,784	39,784	2,760	42,544		42,544			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	404,998	63,458	268,413	736,869		736,869	(509)	736,360			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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		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	(132)	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)	\$ (132)		\$	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 Amount	2 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))	\$ (132)		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 Yes	2 No	3 Amount	4 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

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)	(35)	24	3
4	Depreciation of non-care vehicles		30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming		22	6
7	Out-of-state Travel (Board of Directors)	(342)	24	7
8	Interest Expense		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	(377)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estates# 0033712

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(132)	0	0	0	0	0	0	0	0	0	0	(132)	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	(377)	0	0	0	0	0	0	0	0	0	0	(377)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(509)	0	0	0	0	0	0	0	0	0	0	(509)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(509)	0	0	0	0	0	0	0	0	0	0	(509)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	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)	(509)	0	0	0	0	0	0	0	0	0	0	(509)	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 Home for the Handicapped, Inc.		Apostolic Christian Timber Ridge	Morton	Community	Morton	CILA Residential
		Linden Estate	Morton	Residential		Services for the
				Services		Developmentally
						Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

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

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

VII. RELATED PARTIES (continued)

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

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	Dennis Mott	BOD						4
5	Roger Beutel	BOD						5
6	Bryan Stoller	BOD						6
7	Kathy Woodruff	BOD						7
8	Ed Leman	BOD						8
9	Tim Steffen	BOD						9
10	Royce Scheiler	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: 7/1/2015 Ending: 6/30/2016

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	Vice-Chairman	Director	0.00	714	0.5		Travel	\$ 95		1
2	Ben Knochel	Director	Director	0.00	0	0.5		Travel	0		2
3	Paul Kelson	Director	Director	0.00	159	0.5		Travel	21		3
4	Dennis Mott	Director	Director	0.00	476	0.5		Travel	64	line 24; col. 3	4
5	Roger Beutel	Sec/Treasurer	Director	0.00	0	0.5			0		5
6	Bryan Stoller	Chairman	Director	0.00	157	0.5		Travel	21		6
7	Kathy Woodruff	Director	Director	0.00	1,330	0.5		Travel	177	line 24; col. 3	7
8	Ed Leman	Director	Director	0.00	0	0.5			0		8
9	Tim Steffen	Director	Director	0.00	757	0.5		Travel	101	line 24; col. 3	9
10	Royce Scheiler	Director	Director	0.00	0	0.5			0		10
11											11
12											12
13								TOTAL	\$ 479		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: 7/1/2015 Ending: 7/30/2016

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	Oakwood Estates	COUNTY	Tazewell
---------------	-----------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

A. Square Feet: 7,140

B. General Construction Type: Exterior Brick VeneerFrame Wood ConstructionNumber 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	LTC Facility	91,781	1988	\$ 9,477	1
2					2
3	TOTALS	91,781		\$ 9,477	3

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				\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	300--Garage			1989	23,005		25			23,005	9	
10	301--Facility			1989	202,314	5,058	40	5,058		139,091	10	
11	302--Door For Porch Enclosure			1995	733	18	40	18		394	11	
12	303--Back Door For Porch			1995	775	19	40	19		417	12	
13	305--Door for Porch Enclosure			1995	709	18	40	18		382	13	
14	306--Lighting for Porch			1995	1,249	31	40	31		672	14	
15	771--Fiber Optic Cable			2006	1,261	84	15	84		883	15	
16	780--Flooring			2007	7,109	474	15	474		4,502	16	
17	857--Telephone System			2008	882	59	15	59		529	17	
18	858--Roofing Project			2008	33,760	2,251	15	2,251		20,256	18	
19	883--Lighting Project			2009	2,500	167	15	167		1,333	19	
20	939--Replace Sprinkler Main with Galvanized Pipe			2010	9,267	618	15	618		4,325	20	
21	997--Misc repair to agree to TB			2011	39		1			39	21	
22	1002--Carrier Furnace			2012	2,686	179	15	179		895	22	
23	1013--Cabinets, Countertops, Handles			2012	4,705	235	20	235		1,176	23	
24	1015--Porch			2012	10,869	543	20	543		2,717	24	
25	1027--Heat Pumps and Condensing Unit			2013	2,400	160	15	160		640	25	
26	1028--Conversion to WC accessible facility			2014	900,839	30,028	30	30,028		90,084	26	
27	1051--Reconciling item			2012	1,203		1			1,203	27	
28	1065--15 Bedside Cabinets			2014	1,600	80	15	80		240	28	
29	1071--Gutters			2014	5,115	341	20	341		1,023	29	
30	1080--Window Tx			2014	4,700	313	15	313		940	30	
31	1105--New Carrier Condenser and Coil			2014	10,021	668	15	668		1,336	31	
32	1172--3 Doors project			2016	16,517	1,101	15	1,101		1,101	32	
33	1191--OE Porch Floor			2016	3,708	247	15	247		247	33	
34	343--Landscaping			1988	9,369		10			9,369	34	
35	344--Dainage/Sewer			1988	1,368	46	30	46		1,299	35	
36	345--Driveways			1988	16,544		15			16,544	36	

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

7/1/2015

Ending:

6/30/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 346--Irrigation System	1988	\$ 7,650	\$	25	\$	\$	\$ 7,650	37
38 347--Concrete	1988	7,277		20			7,277	38
39 348--Parking Signs	1988	41		12			41	39
40 349--Underground Gas & Waterline	1988	621	21	30	21		590	40
41 350--Sod	1988	3,790		10			3,790	41
42 351--Drainage / Sewer	1989	4,287	143	30	143		3,930	42
43 352--Landscaping	1989	458		8			458	43
44 353--Resurface Driveway	1999	10,526		15			10,526	44
45 859--Exit Ramps	2008	1,697	113	15	113		1,018	45
46 929--Ramp Railings	2008	7,384	492	15	492		3,938	46
47 1134--Oakwood Driveway - Ring Road	2015	7,521	501	15	501		1,003	47
48 1183--OE driveway	2016	15,850	1,057	15	1,057		1,057	48
49 354--Organization Costs	1988	26,269		5			26,269	49
50 358--Kitchen Serving Door	1988	1,747		20			1,747	50
51 359--Fire Prevention Sprinkler System	1989	24,890		25			24,890	51
52 360--Lighting Fixtures	1989	3,764		10			3,764	52
53 361--New Facility Wiring	1989	23,166		20			23,166	53
54 362--Water & Gas Plumbing	1989	36,140		25			36,140	54
55 364--Cabinets & Countertop	1991	2,010		20			2,010	55
56 563--Counter tops	2002	900	60	15	60		870	56
57 565--Counter tops	2002	425	28	15	28		411	57
58 1108--Patient Lift Systems	2014	81,075	5,405	15	5,405		16,092	58
59 1132--Whirlpool	2015	15,475	1,032	15	1,032		2,063	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)		\$ 1,558,210	\$ 51,590		\$ 51,590	\$	\$ 503,342	70

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

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	\$91,498	\$5,183	\$5,183	\$	11	\$46,927	71
72	Current Year Purchases	23,866	4,423	4,423		6	9,663	72
73	Fully Depreciated Assets	65,882	214	214		9	65,882	73
74	Disposed Assets							74
75	TOTALS	\$181,246	\$9,820	\$9,820	\$		\$122,472	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	2	
	Reference	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)	\$1,748,933	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$61,410	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$61,410	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)	\$625,814	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.

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
- Beginning
- Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	#N/A	#N/A		#N/A
3	Classroom Wages (a)	#N/A	2,550		#N/A
4	Clinical Wages (b)	#N/A	600		#N/A
5	In-House Trainer Wages (c)	#N/A	2,441		#N/A
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ #N/A	\$ #N/A	\$	\$ #N/A
10	SUM OF line 9, col. 1 and 2 (e)	\$ #N/A			

C. CONTRACTUAL INCOME

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

\$89,776

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	44
DROP-OUTS	
1. From this facility	#N/A
2. From other facilities (f)	
TOTAL TRAINED	#N/A

(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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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.

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	\$ 626,858	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	58,923	844,176	3
4	Supply Inventory (priced at)	646	20,456	4
5	Short-Term Investments		4,210,788	5
6	Prepaid Insurance	(34,928)	28,424	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	386	437,701	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 25,427	\$ 6,168,403	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,477	551,258	13
14	Buildings, at Historical Cost	1,247,966	7,593,602	14
15	Leasehold Improvements, at Historical Cost	94,382	646,351	15
16	Equipment, at Historical Cost	343,310	3,146,086	16
17	Accumulated Depreciation (book methods)	(572,016)	(6,737,633)	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		11,605,276	21
22	Other Long-Term Assets (specify):		41,448	22
23	Other(specify): <u>Investment in Other Facilities</u>		10,486,365	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,123,119	\$ 27,332,753	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,148,546	\$ 33,501,156	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,890	\$ 475,909	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,917	583,687	30
31	Accrued Taxes Payable (excluding real estate taxes)		680	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	11,194	280,001	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Rounding</u>	(723)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 47,278	\$ 1,340,277	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Capital Lease</u>		37,523	43
44	<u>Investment from Other Facilities</u>	2,544,078	10,307,331	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,544,078	\$ 10,344,854	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,591,356	\$ 11,685,131	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,442,810)	\$ 21,816,025	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,148,546	\$ 33,501,156	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,374,140)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,374,140)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(68,670)	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)	\$ (68,670)	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)	\$ (1,442,810)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

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	\$ 665,496	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 665,496	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	1,953	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,953	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	750	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 750	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 668,199	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	134,626	31
32	Health Care	377,082	32
33	General Administration	123,966	33
	B. Capital Expense		
34	Ownership	61,411	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,784	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 736,869	40
41	Income before Income Taxes (line 30 minus line 40)**	(68,670)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (68,670)	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) ICFID/DD	665,496	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 665,496	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	0	0	\$ 0	\$	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	0	0	0		3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	0	0	0		5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	387	419	4,958	11.83	10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	153	168	4,675	27.83	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	2,754	2,966	35,767	12.06	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	809	887	15,116	17.04	17
18	Housekeepers	346	346	3,676	10.62	18
19	Laundry	0	0	0		19
20	Administrator	584	666	25,985	39.02	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	806	898	23,371	26.03	22
23	Office Manager	296	326	7,473	22.92	23
24	Clerical	152	173	2,552	14.75	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	1,364	1,600	41,328	25.83	29
30	Habilitation Aides (DD Homes)	17,451	18,695	211,396	11.31	30
31	Medical Records	0	0	0		31
32	Other Health Care Therapy	1,224	1,374	25,228	18.36	32
33	Other(specify) Day Program	186	205	3,473	16.94	33
34	TOTAL (lines 1 - 33)	26,512	28,723	\$ 404,998 *	\$ 14.10	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 780	1-3	35
36	Medical Director	Flat Fee	324	9-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	Flat Fee	864	10-3	39
40	Physical Therapy Consultant	4	286	10-3	40
41	Occupational Therapy Consultant	6	434	10a-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	27	1,926	10a-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consultant	2	198	12-3	46
47	Dental Consultant	0	0	10a-3	47
48	Psychiatrist Consultant	5	1,042	10a-3	48
49	TOTAL (lines 35 - 48)	69	\$ 5,855		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	10-3	50
51	Licensed Practical Nurses	0	0	10-3	51
52	Certified Nurse Assistants/Aides	95	1,877	10a-3	52
53	TOTAL (lines 50 - 52)	95	\$ 1,877		53

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 - \$710, Institute on Public Policy - \$523

(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.

\$ 3,238

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.

N/A

(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.

\$ 39,784

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.

\$ 187

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No, they have been adjusted out.

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 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?

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.

No

Attach invoices and a summary of services for all architect and appraisal fees

HFS 3745 (N-4-99)

IL478-2471

Schedule V - Costs Center Expenses		
Lines	Description	Amount
1	Day Program Costs	
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
15	Bad Debt	-
27	Dental costs	2,760
27	Charitable Contributions	150
27	Fines & Penalties	-
27	Miscellaneous	8
	Other Expenses	2,918

Schedule V - Reclassifications				Amount
Lines	Description	Increase	Decrease	
6	Communication equipment rental	-		
35	Communication equipment rental		-	
32	Interest Expense	-		
36	Interest Expense		-	
11	Donated labor	-		
1	Donated labor	-		
4	Donated labor	-		
6	Donated labor	-		
21	Donated labor	-		
10	Donated labor	-		
10a	Donated labor	-		
12	Donated labor	-		
27	Donated labor		-	
38	Medically necessary transportation	-		
14	Medically necessary transportation		-	
10a	Disability Pay to Benefits		-	
22	Disability Pay to Benefits	-		
13	Nurse aid trainer wages	12,818		
1	Nurse aid trainer wages		104	
6	Nurse aid trainer wages		122	
10	Nurse aid trainer wages		11,420	
10a	Nurse aid trainer wages		267	
11	Nurse aid trainer wages		70	
12	Nurse aid trainer wages		819	
15	Nurse aid trainer wages		16	
17	Nurse aid trainer wages		-	
39	Dental costs	2,760		
27	Dental costs		2,760	
		15,578	15,578	

Schedule V, Line 39 - Ancillary Service Centers		
Dental costs for 23 visits	\$	2,760

Schedule VI B - Non-paid workers			
Lines	Description	Amount	
31	Donated Labor	\$	-
Department	Time in Hours	Time in Dollars	
Activities	-	-	
Kitchen	-	-	
Laundry	-	-	
Maintenance	-	-	
Nursing	-	-	
PT/OT	-	-	
Social Service Programs	-	-	
Office	-	-	
Totals	-	\$	-

Schedule VII - Compensation Received From Other Nursing Homes	
Virgil Metzger - \$714.00 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Ben Knochel - \$0.00 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Paul Kelson - \$159.15 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Dennis Mott - \$476.25 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Bryan Stoller - \$156.54 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Kathy Woodruff - \$1,329.67 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	
Tim Steffen - \$757.49 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate	

Sch. XV - Balance Sheet, Line 9; Other Current Assets	
A/R - N.A. Training	8,681
A/R - Bequests	6,000
A/R - Health Insurance	412,161
A/R - Employees	(426,456)
	386

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets	
Investment in Related Entities	-

Sch. XVII - Income Statement, Line 28; Other Revenue	
Developmental training	493,159
Farm Income	900
Gain/(Loss) on Sale of Assets	(33,531)
Increase in Cash Value of Life Insurance	-
Miscellaneous	600
Cost to Market Adjustment on Investments	##
	461,128

Sch. XVII - Income Statement, Line 41 - Income Before Taxes	
Income before taxes per cost report	(68,670)
Income from related parties	1,770,276
Estimated excess for year, Form 990, p.1, line 18	1,701,606

Sch. XVIII - A. Staffing and Salary Costs	
Sch. V. Cost Center Expenses, Column 1, Row 45	404,998
Sch. XVIII - A. Staffing and Salary Costs, Column 3, Row 34	(404,998)
Variance	-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation	
Salaries, Sch V, Line 45, Col 1	404,998
Prior Year PTO Accrual	(19,519)
Current Year PTO Accrual	18,931
Prior Year Wage Accrual	10,281
Current Year Wage Accrual	(12,992)
Section 125 Wages not applicable to FICA taxes	(8,299)
Less: Wages over FICA taxation limit of SS Wages (\$0 x 6.2%/7.65%)	-
Add: Wages Allocated to other facilities	(15,900)
Add: ACCS Wages	
Add: wages included in employee meal calculation	
Cash basis salaries	377,500
FICA rate	7.650%
Calculated FICA	28,879
FICA per Sch XIX	28,879
Variance	(0)

Sch. XX - General Information		
12. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	267
	Activities Director	70
	Day Program	16
	Head Cook	104
	Maintenance	122
	Nursing	11,420
	Soc. Serv. / QMRP	819
		12,818

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

16. Out of State Travel	
Administration	
Administrator	46
Assistant Administrator	-
	46
Board of Directors	
Virgil Metzger (Not out of State)	
Ben Knochel	-
Paul Kelson (Not out of State)	
Dennis Mott	64
Bryan Stoller (Not out of State)	
Kathy Woodruff	177
Tim Steffen	101
	342

Nursing	
None	-
	-

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

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:

Bryan Stoller, Chairman
Virgil Metzger, Vice Chairman
Paul Kelson, Secretary/Treasurer
Kathy Woodruff, Director
Dennis Mott, Director
Tim Steffen, Director
Ed Leman, Director
Royce Scheiler, Director
Ben Knochel, Director (term began 05/21/2016)
Roger Beutel, Director (term ended 5/21/2016)

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No Board members have ownership in an entity that conducted business transactions with any of these nursing homes.

AIDE CLASSES

Oakwood Estate -- 0033712

From: 7/1/2015

to

6/30/2016

COMPLETED FOR 2016

CLASS DATE	72																												
	TR								OE				LE				CILA												
	# of Students	CLASS		OJT		# of Students	CLASS		OJT		# of Students	CLASS		OJT		# of Students	CLASS		OJT										
		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages		Hrs	Wages	HRS	Wages									
completed	50	31	1,240	\$	10,540.00	2480	\$	21,080.00	6	240	\$	2,040.00	480	\$	4,080.00	2	80	\$	680.00	160	\$	1,360.00	11	440	\$	3,740.00	880	\$	7,480.00
still enrolled, not complete	8	3	60	\$	510.00	120	\$	1,020.00	3	60	\$	510.00	120	\$	1,020.00	1	20	\$	170.00	40	\$	340.00	1	20	\$	170.00	40	\$	340.00
dropouts	2	2	40	\$	340.00	80	\$	680.00	0	0	\$	-	0	\$	-	0	0	\$	-	0	\$	-	0	0	\$	-	0	\$	-
			\$	-	0	\$	-				\$	-	0	\$	-			\$	-	0	\$	-			\$	-	0	\$	-
Total	2200	36	1340	\$	11,390.00	2680	\$	22,780.00	9	300	\$	2,550.00	600	\$	5,100.00	3	100	\$	850.00	200	\$	1,700.00	12	460	\$	3,910.00	920	\$	7,820.00

WAGES					Hours				
TR	OE	LE	CILA		TR	OE	LE	CILA	
Kristen Dancey	10								8
Cheryl Hays	10s	81.00			841.19	188.33	62.78	288.77	7.25
Don Bowers	12q	49.50			587.93	131.63	43.88	201.83	
Evie Mogler	12r	4.00			62.01	13.88	4.63	21.29	22.936
Gary Folkerts	6	33.00			542.70	121.50	40.50	186.30	
Crystal Streitmatter	17								
Jenny Smith	10ot	24.00			352.88	79.00	26.33	121.14	20
Kathy Kelch	10	140.75			2,414.14	540.48	180.16	828.74	5.734
Leigh Mason	12q								
Lori Brittain	1	28.00			466.10	104.35	34.78	160.00	
Sam Getz	10								
Isaac Aberle	11								
Randy Mogler	12r	101.00			1,582.25	354.23	118.08	543.16	
Rob Mooney	12r	20.00			311.37	69.71	23.24	106.89	
Sherrie Parnham	12r	4.00			63.56	14.23	4.74	21.82	
Tina Leman	12m	39.00			570.11	127.64	42.55	195.71	
Mark Baker	12q	48.00			477.43	106.89	35.63	163.89	
Isaac Aberle	11	24.00			314.14	70.33	23.44	107.84	
Gayle Fidler	10	7.00			98.06	21.95	7.32	33.66	
Vikki Steele	15	6.50			73.48	16.45	5.48	25.22	
Stephanie Barth	10a								
Kathy Kelch	10	1,767.25			30,311.87	6,786.24	2,262.08	10,405.57	
Gayle Fidler	10	1,298.00			18,183.80	4,071.00	1,357.00	6,242.20	
OE									
Jodi Fehr	17								
Evie Mogler	12r								
LE									
Rob Mooney	12r								
CILA									
Sherrie Parnham	12r								
Leigh Wamsley	12q								
					57,253.02	12,817.84	4,272.61	19,654.02	
					2,238.41	501.14	167.05	768.41	

Total trainer wages 3675 \$ 93,997.50 \$ 2,660.00 Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits

	TR	OE	LE	CILA
Drop-Outs				
Number from this Facility	2	0	0	0
Clinical Wages	\$ 680.00	\$ -	\$ -	\$ -
Classroom Wages	\$ 340.00	\$ -	\$ -	\$ -
In-House Trainer Wages	\$ 570.00	\$ -	\$ -	\$ -
Completed				
Number from this Facility	31	6	2	11
Clinical Wages	\$ 11,050.00	\$ 2,550.00	\$ 850.00	\$ 3,910.00
Classroom Wages	\$ 22,100.00	\$ 600.00	\$ 1,700.00	\$ 7,820.00
In-House Trainer Wages	\$ 37,029.00	\$ 2,441.00	\$ 2,848.00	\$ 13,103.00

Supplies 4654.38

Schedule V		TR	OE	LE	CILA
	Line	Change	Change	Change	Change
Dietary	1	(466.00)	(104.00)	(35.00)	(160.00)
Maintenance	6	(543.00)	(122.00)	(41.00)	(186.00)
Nursing	10	(51,008.00)	(11,420.00)	(3,807.00)	(17,510.00)
Therapy	10a	-	-	-	-
OT/PT	10ot	(353.00)	(79.00)	(26.00)	(121.00)
Activities	11	(314.00)	(70.00)	(23.00)	(108.00)
RSD	12r	(2,019.00)	(452.00)	(151.00)	(693.00)
QMRP's	12q	(1,065.00)	(239.00)	(80.00)	(366.00)
MSSD	12m	(570.00)	(128.00)	(43.00)	(196.00)
Training Wages	13	57,253.00	12,818.00	4,273.00	19,654.00
Day Program	15	(73.00)	(16.00)	(5.00)	(25.00)
Administrator	17	-	-	-	-
OJT	12ojt	-	-	-	-
Speech	10s	(841.00)	(188.00)	(63.00)	(289.00)
Adjustment	12	(1.00)	-	1.00	-
		-	-	-	-