FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0047019

Facility Name: Oak Hill

Address: 623 Hamacher Street (Number) | Waterloo (City) | 62298 (Zip Code)

County: Monroe

Telephone Number: (618) 939-3488 **Fax #** (618) 939-5030

HFS ID Number:

Date of Initial License for Current Owners: 02/01/1952

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Matt Giedd **Telephone Number:** (763) 537-5700
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/24 to 11/30/25 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) George Green
(Title) Chairman of the Board - Monroe County

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Matt Giedd, Finance Manager
(Firm Name & Address) Health Dimensions Group, 12900 Whitewater Dr, Ste 201, Minneapolis, MN 55343
(Telephone) (763) 537 - 5700 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,560	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	5,187	13,753			22,762	3,502	1,685	46,889	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,187	13,753			22,762	3,502	1,685	46,889	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 89.21%

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)
Supportive Living Jail Meals

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1952

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 144

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/25 Fiscal Year: 11/30/25

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

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	822,195	82,454	10,002	914,651		914,651		914,651			1
2	Food Purchase		436,478		436,478		436,478	(88,091)	348,387			2
3	Housekeeping	284,334	43,376	1,575	329,286		329,286		329,286			3
4	Laundry	177,197	16,956	10,695	204,848		204,848		204,848			4
5	Heat and Other Utilities			248,489	248,489		248,489		248,489			5
6	Maintenance	233,532	32,963	456,476	722,971		722,971	(200,000)	522,971			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,517,259	612,227	727,237	2,856,722		2,856,722	(288,091)	2,568,631			8
	B. Health Care and Programs											
9	Medical Director			47,150	47,150		47,150		47,150			9
10	Nursing and Medical Records	5,069,569	30,575	2,147,894	7,248,038		7,248,038		7,248,038			10
10a	Therapy	47,388			47,388		47,388		47,388			10a
11	Activities	215,082	4,487	17,284	236,853		236,853		236,853			11
12	Social Services	113,790			113,790		113,790		113,790			12
13	CNA Training			226	226		226		226			13
14	Program Transportation											14
15	Other (specify):*	57,591			57,591		57,591		57,591			15
16	**TOTAL Health Care and Programs**	5,503,420	35,062	2,212,554	7,751,036		7,751,036		7,751,036			16
	C. General Administration											
17	Administrative	162,000			162,000		162,000		162,000			17
18	Directors Fees											18
19	Professional Services			74,200	74,200		74,200		74,200			19
20	Dues, Fees, Subscriptions & Promotions			13,000	13,000		13,000	(779)	12,221			20
21	Clerical & General Office Expenses	330,745	88,324	630,445	1,049,514	10,460	1,059,974	(302,460)	757,514			21
22	Employee Benefits & Payroll Taxes			2,273,433	2,273,433		2,273,433		2,273,433			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,791	2,791		2,791		2,791			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,271	54,271		54,271		54,271			26
27	Other (specify):*											27
28	**TOTAL General Administration**	492,745	88,324	3,048,140	3,629,209	10,460	3,639,669	(303,239)	3,336,429			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,513,424	735,613	5,987,931	14,236,967	10,460	14,247,427	(591,330)	13,656,096			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 Oak Hill #0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							199,861	199,861			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			10,460	10,460	(10,460)						35
36	Other (specify):*			174,072	174,072		174,072	(174,072)				36
37	**TOTAL Ownership**			184,532	184,532	(10,460)	174,072	25,789	199,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,554	800,444	890,998		890,998		890,998			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			300,912	300,912		300,912		300,912			42
43	Other (specify):*	1,113,242	216,506	593,077	1,922,825		1,922,825	(1,922,825)				43
44	**TOTAL Special Cost Centers**	1,113,242	307,060	1,694,433	3,114,735		3,114,735	(1,922,825)	1,191,910			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,626,666	1,042,673	7,866,896	17,536,234		17,536,234	(2,488,366)	15,047,867			45

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

Facility Name & ID Number Oak Hill **#** 0047019 **Report Period Beginning:** 12/1/24 **Ending:** 11/30/25

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

	Other Ownership Costs (Line 36)	Salary/Wage	Supplies	Other	Total
36A	Debt service to Monroe County			174,072	174,072
36B					-
36C					-
36D					-
36E					-
36F					-
36G					-
		-	-	174,072	174,072

	Other Special Cost Centers (Line 43)				
43A	Supportive Living Facility	1,086,488	216,506	619,831	1,922,825
43B					-
43C					-
43D					-
43E					-
43F					-
43G					-
		1,086,488	216,506	619,831	1,922,825

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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	$		$	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	(9,990)	21		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	(65,693)	21		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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66)	21		24
25	Fund Raising, Advertising and Promotional	(49,028)	21		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	(174,072)	4/5		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (300,279)		$	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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (300,279)		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		X	(1,978,631)	3	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ (1,978,631)		47

Oak Hill

ID# 0047019

Report Period Beginning: 12/1/24

Ending: 11/30/25

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (779)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	SLF Expenses	(1,978,631)	43	3
4	Telephone, TV & Radio in Resident Rooms	(9,990)		4
5	Interest and Other Investment Income	(65,693)		5
6	Fines and Penalties	(1,430)		6
7	Bad Debt	(66)		7
8	Fund Raising, Advertising and Promotional	(49,028)		8
9	Beauty Shop Rent	(3,931)	21	9
10	Jail Meal Income	(88,091)	2	10
11	Public Relations	(16,097)	21	11
12	Lease Commission	(150,000)	21	12
13	Referral Subscription	(6,225)	21	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**	(2,369,961)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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	(88,091)	0	0	0	0	0	0	0	0	0	0	(88,091)	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	(200,000)	0	0	0	0	0	0	0	0	0	(200,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(88,091)	(200,000)	0	0	0	0	0	0	0	0	0	(288,091)	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	(779)	0	0	0	0	0	0	0	0	0	0	(779)	20
21	Clerical & General Office Expenses	(302,460)	0	0	0	0	0	0	0	0	0	0	(302,460)	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	(303,239)	0	0	0	0	0	0	0	0	0	0	(303,239)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(391,330)	(200,000)	0	0	0	0	0	0	0	0	0	(591,330)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Hill # 0047019 **Report Period Beginning:** 12/1/24 **Ending:** 11/30/25

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

	Capital Expense	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)	
	D. Ownership													
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	(174,072)	0	0	0	0	0	0	0	0	0	(174,072)	36
37	**TOTAL Ownership**	0	(174,072)	0	0	0	0	0	0	0	0	0	(174,072)	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):*	(1,978,631)	0	0	0	0	0	0	0	0	0	0	(1,978,631)	43
44	**TOTAL Special Cost Centers**	(1,978,631)	0	0	0	0	0	0	0	0	0	0	(1,978,631)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,369,961)	(374,072)	0	0	0	0	0	0	0	0	0	(2,744,033)	45

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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
George Green - Board Chair	0			Magnolia Terrace	Waterloo, IL	AL
Monroe Couny	100					

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V		AL Salaries	(1,086,488)	Magnolia Terrace	0.00%	(1,086,488)		3
4	V		AL Supplies	(272,312)	Magnolia Terrace	0.00%	(272,312)		4
5	V		AL Other	(619,831)	Magnolia Terrace	0.00%	(619,831)		5
6	V	6	Building Fund	200,000				(200,000)	6
7	V	36	Trans To Monroe Co For Debt Service	174,072				(174,072)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ (1,604,559)			$ (1,978,631)	$ * (374,072)	14

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

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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 [X] NO

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

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

STATE OF ILLINOIS **Ownership Listing-1**

Oak Hill

ID# **0047019**

Report Period Beginning: **12/1/24**

Ending: **11/30/25**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Monroe County			Waterloo	IL	100.00000	100.00000	100.00000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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									49
50									50
51									51
52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Oak Hill

ID# **0047019**

Report Period Beginning: **12/1/24**

Ending: **11/30/25**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
96									96
97									97
98									98
99									99
100									100
101									101
102									102
103									103
104									104
105									105
106									106
107									107
108									108
109									109
110									110
111									111
112									112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125									125
126									126
127									127
128									128
129									129
130									130
131									131
132									132
133									133
134									134
135									135
136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	George Green		Board Chair	0.00	0	0	0.00	NA	$ 0	NA	1
2	Vicki Koerber		Board Member	0.00	0	0	0.00	NA	0	NA	2
3	Doug Garmer		Board Member	0.00	0	0	0.00	NA	0	NA	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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.)

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2025 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

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

NA

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Hill COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0047019

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 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,404 B. General Construction Type: Exterior Brick Frame Brick & Concrete Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (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).

Supportive Living Facility - Magnolia Terrace 50 beds

F. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease. N/A

I. Are you presently operating under a sublease agreement? No

J. 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.

N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	Facility	15.2 acres	2004	$ 340,870	1
2					2
3	TOTALS	#VALUE!		$ 340,870	3

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	14		2017	2017	$ 3,677,412	$	35	$ 73,548	$ 73,548	$ 588,384	4
5	130		2006	2006	13,325,251		40				5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	52,491			1,470	1,470	51,025	9
10	Various			2007	18,788					18,788	10
11	Various			2008	14,073			125	125	13,818	11
12	Various			2009	13,845					13,845	12
13	Various			2010	12,860					12,860	13
14	Various			2011	42,688			1,774	1,774	42,688	14
15	Various			2012	77,145			4,164	4,164	67,311	15
16	Various			2013	107,918			6,532	6,532	91,720	16
17	Various			2014	25,217					25,217	17
18	Various			2015	15,259			258	258	12,931	18
19	Various			2016	22,575					22,575	19
20	Various			2017	111,164			3,360	3,360	86,343	20
21	Various			2018	271,266			7,694	7,694	66,305	21
22	Various			2019	518,758			27,481	27,481	174,039	22
23	Various			2020	120,741			16,592	16,592	92,714	23
24	Various			2021	48,070			6,867	6,867	31,164	24
25	Various			2022	43,587			5,001	5,001	10,836	25
26	Various			2023	57,318			5,745	5,745	14,081	26
27	Various			2024	21,377			1,527	1,527	3,054	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
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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)		$ 18,597,805	$		$ 162,138	$ 162,138	$ 1,439,697	70

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

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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	$ 374,642	$	$ 36,594	$ 36,594	Various	$ 184,067	71
72	Current Year Purchases	20,705						72
73	Fully Depreciated Assets	1,014,156					1,014,156	73
74								74
75	TOTALS	$ 1,409,503	$	$ 36,594	$ 36,594		$ 1,198,223	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	Van/Bus	2015	2015	$ 42,892	$	$	$	5	$ 42,892	76
77	Silverado	2020	2020	7,900		1,129	1,129	5	6,586	77
78										78
79										79
80	TOTALS			$ 50,792	$	$ 1,129	$ 1,129		$ 49,478	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)	$ 20,398,970	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 199,861	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 199,861	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,687,398	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	SLF Assets - 2018	$ 83,680	$ 3,498	$ 35,252	86
87	SLF Assets - 2019	281,791	14,723	109,517	87
88	SLF Assets - 2021	23,788	2,769	11,985	88
89	SLF Assets - 2023	24,981	1,981	5,036	89
90	Other (see attached)	146,366	5,420	89,584	90
91	TOTALS	$ 560,606	$ 28,391	$ 251,375	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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2026	$
13.	/2027	$
14.	/2028	$

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

* 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.

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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 ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	39-03	hrs	$		$ 251,113	$		$ 251,113	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			59,960			59,960	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			319,339			319,339	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				123,760		123,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):					31,158	105,669		136,827	12
13	Other (specify):									13
14	TOTAL			$		$ 661,570	$ 229,429		$ 890,999	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 Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

SPECIAL SERVICES - SUPPLEMENTAL SCHEDULE

	Special Services - Supplies (Column 6 - Other)	Amount
13A	Medical Supplies	46,690
13B	Nursing Supplies	36,830
13C	Urinary Supplies	3,619
13D	Tube Feeding Supplies	1,389
13E	IV Therapy	(4,984)
13F	Oxygen	21,409
13G	Blood Glucose Monitoring	716
		105,669

	Special Services - Outside (Column 5- Other)	
13H	Labs	17,920
13I	Medicare X-Ray	12,851
13J	Ambulance	387
13K		
		31,158

STATE OF ILLINOIS

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/25 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 434,909	$	1
2	Cash-Patient Deposits	11,063		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,330,435		3
4	Supply Inventory (priced at)	160,089		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,844		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	80,020		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,036,360	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,195,537		14
15	Leasehold Improvements, at Historical Cost	1,441,509		15
16	Equipment, at Historical Cost	1,656,408		16
17	Accumulated Depreciation (book methods)	(2,719,992)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,573,462	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,609,822	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 553,476	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,063		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,733		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Advance Billing	348,026		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,228,298	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,228,298	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,381,524	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,609,822	$	48

*(See instructions.)

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS AND OTHER LIABILITIES

	Other Current Assets (line 9)	Amount	Amount
09A	Resident Refunds	69,801	
09B	A/R - Property Taxes	10,219	
09C			
09D			
09E			
09F			
09G			
		80,020	

	Other Current Liabilities (line 36)	Amount	Amount
36A	Security Deposits	348,026	
36B			
36C			
36D			
36E			
36F			
36G			
		348,026	

	Other Non-Current Assets (line 23)		
23A			
23B			
23C			
23D			
23E			
23F			
23G			
		-	

	Other Non-Current Liabilities (line 43)		
43A			
43B			
43C			
43D			
43E			
43F			
43G			
		-	

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,894,818	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,894,818	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(513,294)	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)**	$ (513,294)	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)**	$ 8,381,524	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,316,921	1
2	Discounts and Allowances for all Levels	(1,104,092)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,212,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,093,589	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,093,589	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	147,870	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,231	12
13	Barber and Beauty Care	3,931	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	19,622	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,654	23
	D. Non-Operating Revenue		
24	Contributions	200	24
25	Interest and Other Investment Income***	65,693	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 65,893	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached schedule	2,475,971	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,475,971	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,022,936	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,597,643	31
32	Health Care	8,436,306	32
33	General Administration	3,639,667	33
	B. Capital Expense		
34	Ownership	200,000	34
	C. Ancillary Expense		
35	Special Cost Centers	383,071	35
36	Provider Participation Fee	300,912	36
	D. Other Expenses (specify):		
37	SLF	1,978,631	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,536,230	40
41	**Income before Income Taxes (line 30 minus line 40)****	(513,294)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (513,294)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 5,400,643.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	6,060,134.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A	1,124,211.00	49
50	Other-(specify)	627,842.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,212,830	56

Facility Name & ID Number Oak Hill **#** 0047019 **Report Period Beginning:** 12/01/23 **Ending:** 11/30/24

SUPPLEMENTAL SCHEDULE OF REVENUES

	Other Revenue (Line 28)	Amount
28A	SLF Income	2,029,630
28B	Transportation Income	8,250
28C	Tax Referendum	350,001
28D	Jail Meals Income	88,090
28E		
28F		
28G		
		2,475,971

	Other Revenue (Line 29)	
29A		
29B		
29C		
29D		
29E		
29F		
29G		
		-

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,086	$ 142,717	$ 68.42	1
2	Assistant Director of Nursing	1,719	2,046	112,268	54.87	2
3	Registered Nurses	30,936	35,972	1,556,608	43.27	3
4	Licensed Practical Nurses	27,230	30,943	1,072,061	34.65	4
5	CNAs & Orderlies	69,316	78,768	2,060,219	26.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,028	2,204	47,388	21.50	8
9	Activity Director	1,650	1,854	49,493	26.70	9
10	Activity Assistants	8,121	8,925	165,589	18.55	10
11	Social Service Workers	3,632	4,273	113,790	26.63	11
12	Dietician	2,775	3,384	59,311	17.53	12
13	Food Service Supervisor	5,379	6,560	114,972	17.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,315	36,969	647,911	17.53	15
16	Dishwashers					16
17	Maintenance Workers	10,225	11,489	291,123	25.34	17
18	Housekeepers	13,790	16,224	284,333	17.53	18
19	Laundry	8,709	10,246	177,196	17.29	19
20	Administrator	2,240	2,715	131,421	48.41	20
21	Assistant Administrator					21
22	Other Administrative	3,320	3,860	162,000	41.97	22
23	Office Manager					23
24	Clerical	6,938	7,884	235,324	29.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,099	3,482	89,695	25.76	31
32	Other Health Care(specify)					32
33	Other(specify) SLF	42,887	47,129	1,113,247	23.62	33
34	TOTAL (lines 1 - 33)	276,269	317,013	$ 8,626,666 *	$ 27.21	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 5,490	01-03	35
36	Medical Director	Monthly	47,150	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 52,640		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,891	$ 330,115	10-3	50
51	Licensed Practical Nurses	2,354	123,597	10-3	51
52	Certified Nurse Assistants/Aides	43,949	1,516,250	10-3	52
53	TOTAL (lines 50 - 52)	51,194	$ 1,969,962		53

Facility Name & ID Number Oak Hill **#** 0047019 **Report Period Beginning:** 12/1/24 **Ending:** 11/30/25

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

		# of Hrs Actually Worked	# of Hrs Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
33A	Activity Supr. Salary - SLF	1,631	1,792	47,838	26.70
33B	Activity Supr. Benefit Pay - SLF	103	114	3,034	26.70
33C	LPN Salary - SLF	2,732	3,002	104,012	34.65
33D	LPN Benefit Pay. - SLF	117	128	4,443	34.65
33E	CNA Salary - SLF	14,096	15,490	401,300	25.91
33F	CNA Benefity Pay - SLF	1,223	1,344	34,830	25.91
33G	Cooks & Asst. Salary - SLF	5,092	5,595	98,065	17.53
	Cooks & Asst. Benefit Pay - SLF	245	269	4,719	17.53
33H	Dietary Aides Salary - SLF	6,414	7,048	123,528	17.53
33I	Laundry Aides Salary - SLF	3,717	4,085	70,639	17.29
33J	Hskp. Aides Salary - SLF	1,808	1,987	34,827	17.53
33K	Hskp. Aides Benefit Pay - SLF	88	96	1,687	17.53
33L	Maint. Asst. Salary - SLF	1,990	2,187	47,755	21.84
33M	OH Administrator Salary - SLF	1,668	1,833	72,194	39.39
33N	Clerical Salary - SLF	1,962	2,157	64,370	29.85
		42,887	47,129	1,113,241	370

Facility Name & ID Number Oak Hill # 0047019 Report Period Beginning: 12/1/24 Ending: 11/30/25

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
	Administrator	0	$ 36,000
	Administrator - EVG	0	2,118
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 38,118

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Schmersahl Treloar	Accounting	$ 7,200
Health Dimensions Group	Consulting	38,780
Monroe County	Consulting	27,248
YesPBJ	Consulting	972
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 74,200

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 224,448
Unemployment Compensation Insurance	68,194
FICA Taxes	644,254
Employee Health Insurance	1,041,792
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	293,279
Vaccines	1,297
Uniforms	171
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,273,435

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	13,000
Less: Public Relations Expense	( )
PAC and Lobbying payments	(779)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,221

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,791
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,791

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
LEADING AGE	12,221
	12,221 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE	779
	779 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

LEADING AGE	13,000
	13,000 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 65,741 Line 10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 300,912
This amount is to be recorded on line 42 of Schedule V.

(8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(9) 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

(10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? Yes Indicate the amount. $ 88,091

(12) Travel and Transportation

a. Are there costs included for out-of-state travel? No
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. $ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? N/A

d. Have vehicle usage logs been maintained? N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Schmersahl, Treloar, CPA's

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(15) 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.