

		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: <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>07/01/2024</u> to <u>06/30/2025</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: _____																									
Date of Initial License for Current Owners: <u>8/8/1988</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Crystal Streitmatter</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</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>Crystal Streitmatter</u>	(Title) <u>Administrator</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>											
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Crystal Streitmatter</u>																								
	(Title) <u>Administrator</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</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																							
☒ 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 _____																								
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:

07/01/2024

Ending:

06/30/2025

III. STATISTICAL DATA

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

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD		0	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD					0				11
12	SC									12
13	DD 16 OR LESS	4,347							4,347	13
14	TOTALS	4,347							4,347	14

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

74.43%

D. How many bed reserve days during this year were paid by the Department?

26

(Do not include bed reserve days in Section B.)

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

X

NO

I. On what date did you start providing long term care at this location?

Date started

8/8/1988

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

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

06/30/2025

Fiscal Year:

06/30/2025

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	0	4,471	1,635	6,106	(97)	6,009	0	6,009			1
2	Food Purchase		46,000		46,000	0	46,000	0	46,000			2
3	Housekeeping	4,232	3,619	0	7,851	0	7,851	0	7,851			3
4	Laundry	0	2,646	0	2,646	0	2,646	0	2,646			4
5	Heat and Other Utilities			17,053	17,053	0	17,053	0	17,053			5
6	Maintenance	17,540	5,092	17,126	39,758	0	39,758	0	39,758			6
7	Other (specify):*	0	0	0	0	0	0	0	0			7
8	TOTAL General Services	21,772	61,828	35,814	119,414	(97)	119,317	0	119,317			8
	B. Health Care and Programs											
9	Medical Director	0	0	0	0	0	0	0	0			9
10	Nursing and Medical Records	906,881	20,911	1,728	929,520	0	929,520	0	929,520			10
10a	Therapy	47,890	0	1,415	49,305	(3,297)	46,008	0	46,008			10a
11	Activities	0	8,435	0	8,435	483	8,918	0	8,918			11
12	Social Services	183,073	13	5,885	188,971	(25,514)	163,457	0	163,457			12
13	CNA Training	12,182	10	0	12,192	28,995	41,187	0	41,187			13
14	Program Transportation	0	0	4,838	4,838	0	4,838	0	4,838			14
15	Other (specify):* Bad Debt & Day Prog	0	0	0	0	0	0	0	0			15
16	TOTAL Health Care and Programs	1,150,026	29,369	13,866	1,193,261	667	1,193,928	0	1,193,928			16
	C. General Administration											
17	Administrative	18,872	0	0	18,872	0	18,872	0	18,872			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			16,256	16,256	0	16,256	0	16,256			19
20	Dues, Fees, Subscriptions & Promotions			3,616	3,616	0	3,616	0	3,616			20
21	Clerical & General Office Expenses	88,014	618	4,433	93,065	0	93,065	0	93,065			21
22	Employee Benefits & Payroll Taxes			227,233	227,233	0	227,233	0	227,233			22
23	Inservice Training & Education			602	602	0	602	0	602			23
24	Travel and Seminar			674	674	0	674	(674)	0			24
25	Other Admin. Staff Transportation		0	0	0	0	0	0	0			25
26	Insurance-Prop.Liab.Malpractice			7,988	7,988	0	7,988	0	7,988			26
27	Other (specify):*	0	0	4,801	4,801	(4,801)	0	0	0			27
28	TOTAL General Administration	106,886	618	265,603	373,107	(4,801)	368,306	(674)	367,632			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,278,684	91,815	315,283	1,685,782	(4,231)	1,681,551	(674)	1,680,877			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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			70,695	70,695	0	70,695	(581)	70,114			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			0	0	0	0	0	0			32
33	Real Estate Taxes			0	0	0	0	0	0			33
34	Rent-Facility & Grounds			0	0	0	0	0	0			34
35	Rent-Equipment & Vehicles			0	0	0	0	0	0			35
36	Other (specify):* Investment Fees			0	0	0	0	0	0			36
37	TOTAL Ownership			70,695	70,695	0	70,695	(581)	70,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	0	0	0	0	4,231	4,231	0	4,231			39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0			40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0			41
42	Provider Participation Fee	0	0	57,039	57,039	0	57,039	0	57,039			42
43	Other (specify):* Newsletter	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	0	57,039	57,039	4,231	61,270	0	61,270			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,278,684	91,815	443,017	1,813,516	0	1,813,516	(1,255)	1,812,261			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	\$		\$	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				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				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				24
25	Fund Raising, Advertising and Promotional				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)	\$ 0		\$ 0	30

BHF USE ONLY							
48		49		50		51	

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)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 0		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	0		2
3	Out-of-state Travel (Administrative Staff)	0	24	3
4	Depreciation of non-care vehicles	(581)	30	4
5	Offset medically necessary transportation income		38	5
6	Benefits allocated to day programming	0	22	6
7	Out-of-state Travel (Board of Directors)	(674)	24	7
8	Interest Expense	0	36	8
9	Out-of-state Travel (Administrative Staff)	0	10	9
10	Offset day training transportation income	0	10	10
11	Offset day training transportation income	0	14	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	(1,255)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	0	0	0	0	0	0	0	0	0	0	0	0	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	(674)	0	0	0	0	0	0	0	0	0	0	(674)	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	(674)	0	0	0	0	0	0	0	0	0	0	(674)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(674)	0	0	0	0	0	0	0	0	0	0	(674)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(581)	0	0	0	0	0	0	0	0	0	0	(581)	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	(581)	0	0	0	0	0	0	0	0	0	0	(581)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,255)	0	0	0	0	0	0	0	0	0	0	(1,255)	45

VII. RELATED PARTIES

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

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

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		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.

Ownership Listing-1

ID# 0033712

Ending: 06/30/2025

-Names of trust beneficiaries must be listed.

Place of Residence

Building Co.

Ownership	Ownership
-----------	-----------

Percentage

1	Apostolic Christian Church of America			Peoria	IL	100.00000	
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							

STATE OF ILLINOIS

Ownership Listing-2

Oakwood Estates

ID#0033712

Report Period Beginning:07/01/2024

Ending:06/30/2025

-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.

Building Co.

	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
100							
101							
102							
103							
104							
105							
106							
107							
108							
109							
110							
111							
112							
113							
114							
115							
116							
117							
118							
119							
120							
121							
122							
123							
124							
125							

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	Blair Metzger	BOD						1
2	Matt Zimmerman	BOD						2
3	John Sauder	BOD						3
4	Heidi Haerr	BOD						4
5	Greg Wiegand	BOD						5
6	Ben Knochel	BOD						6
7	Daniel Leman	BOD						7
8	Kent Schmidgall	BOD						8
9	Wendy Sauder	BOD						9
10	Lee Klopfenstein	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	Blair Metzger	Director	Director	0.00	2,034	0.5		Travel	\$ 271	line24 col 3	1
2	Matt Zimmerman	President	Director	0.00	0	0.5			0		2
3	John Sauder	Treasurer	Director	0.00	0	0.5			0		3
4	Heidi Haerr	Secretary	Director	0.00	0	0.5			0		4
5	Greg Wiegand	Director	Director	0.00	0	0.5			0		5
6	Ben Knochel	Director	Director	0.00	0	0.5			0		6
7	Daniel Leman	Director	Director	0.00	0	0.5			0		7
8	Kent Schmidgall	Vice President	Director	0.00	1,179	0.5		Travel	157	line24 col 3	8
9	Wendy Sauder	Director	Director	0.00	0	0.5			0		9
10	Lee Klopfenstein	Director	Director	0.00	1,840	0.5		Travel	245	line24 col 3	10
11											11
12											12
13								TOTAL	\$ 674		13

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

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

Facility Name & ID Number Oakwood Estates # 0033712 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	Morgan Stanley (LAL)		X	Timing of State Payments and Interest		12/2008	4,667,000	0	None	6.4337			6						
7													7						
8													8						
9	TOTAL Facility Related						\$ 4,667,000	\$ 0			\$ 0		9						
	B. Non-Facility Related*																		
10													10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0		14						
15	TOTALS (line 9+line14)						\$ 4,667,000	\$ 0			\$ 0		15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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.)

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Oakwood Estates

COUNTY

Tazewell

FACILITY IDPH LICENSE NUMBER

0033712

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 0.00	\$ 0.00

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 2023 tax bills which were listed in Section A to this statement. Be sure to use the 2023 tax bill which is normally paid during 2024.

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

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			1989	\$ 202,314	\$ 5,058	40	\$ 5,058	\$	184,611	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	300--Garage			1989	23,005	0	25	0		23,005	9
10	343--Landscaping			1988	9,369	0	10	0		9,369	10
11	344--Dainage/Sewer			1988	1,368	0	30	0		1,368	11
12	346--Irrigation System			1988	7,650	0	25	0		7,650	12
13	347--Concrete			1988	7,277	0	20	0		7,277	13
14	348--Parking Signs			1988	41	0	12	0		41	14
15	349--Underground Gas & Waterline			1988	621	0	30	0		621	15
16	350--Sod			1988	3,790	0	10	0		3,790	16
17	351--Drainage / Sewer			1989	4,287	0	30	0		4,287	17
18	352--Landscaping			1989	458	0	8	0		458	18
19	353--Resurface Driveway			1999	10,526	0	15	0		10,526	19
20	354--Organization Costs			1988	26,269	0	5	0		26,269	20
21	358--Kitchen Serving Door			1988	1,747	0	20	0		1,747	21
22	563--Counter tops			2002	900	0	15	0		900	22
23	565--Counter tops			2002	425	0	15	0		425	23
24	771--Fiber Optic Cable			2006	1,261	0	15	0		1,261	24
25	780--Flooring			2007	7,109	0	15	0		7,109	25
26	859--Exit Ramps			2008	1,697	0	15	0		1,697	26
27	883--Lighting Project			2009	2,500	0	15	0		2,500	27
28	929--Ramp Railings			2008	7,384	0	15	0		7,384	28
29	939--Replace Sprinkler Main with Galvanized Pipe			2010	9,267	0	15	0		9,267	29
30	997--Misc repair to agree to TB			2011	39	0	1	0		39	30
31	1002--Carrier Furnace			2012	2,686	179	15	179		2,507	31
32	1013--Cabinets, Countertops, Handles			2012	4,705	235	20	235		3,294	32
33	1015--Porch			2012	10,869	543	20	543		7,608	33
34	1027--Heat Pumps and Condensing Unit			2013	2,400	160	15	160		2,080	34
35	1028--Conversion to WC accessible facility			2014	900,839	30,028	30	30,028		360,336	35
36	1051--Reconciling item			2012	1,203	0	1	0		1,203	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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	1065--15 Bedside Cabinets	2014	\$ 2,563	\$ 171	15	\$ 171	\$	\$ 2,050	37
38	1071--Gutters	2014	1,600	80	20	80		960	38
39	1080--Window Tx	2014	5,115	341	15	341		4,092	39
40	1105--New Carrier Condenser and Coil	2014	4,700	313	15	313		3,760	40
41	1108--Patient Lift Systems	2014	81,075	5,405	15	5,405		64,738	41
42	1132--Whirlpool	2015	15,475	1,032	15	1,032		11,348	42
43	1134--Oakwood Driveway - Ring Road	2015	7,521	501	15	501		5,515	43
44	1172--3 Doors project	2016	16,517	1,101	15	1,101		11,011	44
45	1183--OE driveway	2016	15,850	1,057	15	1,057		10,566	45
46	1191--OE Porch Floor	2016	3,708	247	15	247		2,472	46
47	1203--Sidewalks, patio, driveway	2017	9,233	616	15	616		5,540	47
48	1249--Roof Replacement	2018	35,836	2,389	15	2,389		19,113	48
49	1286--Vapor Barrier and Insulation in crawl space	2019	6,945	463	15	463		3,241	49
50	1298--VoIP Phone System for OE	2019	3,270	218	15	218		1,526	50
51	1300--OE Womens Wing FloorFolio Flooring	2019	2,517	168	15	168		1,175	51
52	1325--OE Womens Wing Bedroom Flooring	2020	5,084	508	10	508		2,796	52
53	1327--OE Men's Bedroom Flooring	2020	2,837	284	10	284		1,560	53
54	1335--OE - Dry Sprinkler System	2020	4,840	323	15	323		1,775	54
55	1371--Commercial Dishwasher	2021	5,700	814	7	814		3,664	55
56	1422--2022 Chrysler Voyager VIN: 2C4RC1CG6NR144324	2023	56,638	8,091	11	8,091		20,228	56
57	1413--Shower Repair - Flooring	2023	2,238	149	15	149		224	57
58	1469--Concrete Driveway/Parking Lot	2024	18,700	1,247	15	1,247		1,870	58
59	1469--Concrete Driveway/Parking Lot	2024	74,453	4,482	15	4,482		6,482	59
60	1473--Flooring for Bedrooms	2024	5,023	502	10	502		753	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)		\$ 1,639,444	\$ 66,705		\$ 66,705	\$ 0	\$ 875,088	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	\$48,260	\$3,408	\$3,408	\$0	14	\$37,547	71
72	Current Year Purchases	0	0	0	0		0	72
73	Fully Depreciated Assets	79,224	0	0	0	8	79,224	73
74	Disposed Assets	0	0	0	0		0	74
75	TOTALS	\$127,484	\$3,408	\$3,408	\$0		\$116,771	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							\$0			76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$0	\$0	\$0	\$0		\$0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,776,405	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$70,113	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$70,113	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$991,859	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	Fully depreciated vehicles	\$0	\$0	\$0	86
87	Purchased Vehicles/Repairs	7,235	581	1,008	87
88	Vehicle Equipment	0	0	0	88
89	Vehicles	0	0	0	89
90	Disposed Assets	0	0	0	90
91	TOTALS	\$7,235	\$581	\$1,008	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:
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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA80

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies	1	1		2
3	Classroom Wages (a)	280	6,240		6,520
4	Clinical Wages (b)	2,730	640		3,370
5	In-House Trainer Wages (c)	8,004	1,876		9,880
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 11,015	\$ 8,757	\$ 0	\$ 19,772
10	SUM OF line 9, col. 1 and 2 (e)	\$ 19,772			

C. CONTRACTUAL INCOME

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

\$3,766

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	47
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	25
TOTAL TRAINED	85

(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.)

12345678										
	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 prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Other (specify):									12
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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 100	\$ 1,323,869	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	141,058	2,157,094	3
4	Supply Inventory (priced at 1,095)	1,095	37,958	4
5	Short-Term Investments	0	24,653,463	5
6	Prepaid Insurance	3,054	42,747	6
7	Other Prepaid Expenses	0	103,043	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): <u>A/R Bequests</u>	0	2,323,013	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 145,307	\$ 30,641,187	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	9,477	605,663	13
14	Buildings, at Historical Cost	1,279,441	15,083,844	14
15	Leasehold Improvements, at Historical Cost	182,291	1,826,599	15
16	Equipment, at Historical Cost	288,227	4,158,304	16
17	Accumulated Depreciation (book methods)	(966,596)	(11,224,902)	17
18	Deferred Charges	0	0	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	0	17,695,157	21
22	Other Long-Term Assets (specify): <u>Cash Surrender Value</u>	0	390,086	22
23	Other(specify): <u>Inter-Company Assets/Liab</u>	0	31,265,881	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 792,840	\$ 59,800,632	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 938,147	\$ 90,441,819	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,777	\$ 715,962	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	0	29
30	Accrued Salaries Payable	55,825	1,135,617	30
31	Accrued Taxes Payable (excluding real estate taxes)	0	1,967	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	38,064	770,048	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36		0	0	36
37		0	0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 118,666	\$ 2,623,594	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>Inter-Company Assets/Liab</u>	5,293,727	31,265,881	43
44	<u>Rounding / Other</u>	(0)	0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,293,727	\$ 31,265,881	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,412,393	\$ 33,889,475	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,474,246)	\$ 56,552,344	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 938,147	\$ 90,441,819	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,803,868)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,803,868)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(670,378)	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)	\$ (670,378)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,474,246)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Oakwood Estates

0033712

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 1,136,606	1
2	Discounts and Allowances for all Levels	(0)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,136,606	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	0	6
7	Oxygen	0	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	4,247	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	0	21
22	Laundry	0	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,247	23
	D. Non-Operating Revenue		
24	Contributions	2,285	24
25	Interest and Other Investment Income***	0	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,285	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	Developmental Training	0	28
28a	Misc Income; Gain on sale of Assets	0	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,143,138	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	119,414	31
32	Health Care	1,193,261	32
33	General Administration	373,107	33
	B. Capital Expense		
34	Ownership	70,695	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	57,039	36
	D. Other Expenses (specify):		
37		0	37
38		0	38
39	Misc Expense; Loss on sale of Assets	0	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,813,516	40
41	Income before Income Taxes (line 30 minus line 40)**	(670,378)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (670,378)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	0	48
49	Medicare Part A		49
50	Other-(specify) ICF/DD	1,136,606	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)	\$ 1,136,606	56

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	449	532	\$ 27,680	\$ 52.03	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	1,154	1,332	60,395	45.34	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	0	0	0		10
11	Social Service Workers	134	154	5,063	32.88	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	519	597	17,540	29.38	17
18	Housekeepers	138	155	4,232	27.30	18
19	Laundry	0	0	0		19
20	Administrator	252	284	18,872	66.45	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,803	1,994	88,013	44.14	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	283	306	12,182	39.81	25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	4,835	5,325	168,054	31.56	28
29	Resident Services Coordinator	266	284	9,956	35.06	29
30	Habilitation Aides (DD Homes)	31,071	35,395	818,807	23.13	30
31	Medical Records	0	0	0		31
32	Other Health Care: Other (Speech) / Other (Day Program)	1,325	1,531	47,890	31.28	32
33	Other(specify) Other (Day Program)	0	0	0		33
34	TOTAL (lines 1 - 33)	42,229	47,889	\$ 1,278,684 *	\$ 26.70	34

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	22	\$ 1,635	L1-C3	35
36	Medical Director	0	0	L9-C3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	Flat Fee	474	L10-C3	38
39	Pharmacist Consultant	Flat Fee	1,728	L10-C3	39
40	Physical Therapy Consultant	12	740	L10-C3	40
41	Occupational Therapy Consultant	11	676	L10a-C3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0	L10a-C3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	0		45
46	Other(specify) Psychologist Consultant	36	3,531	L12-C3	46
47	Dental Consultant	0	0	L10a-C3	47
48	Psychiatrist Consultant	10	2,353	L10a-C3	48
49	TOTAL (lines 35 - 48)	89	\$ 11,138		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	L10- C1	50
51	Licensed Practical Nurses	0	0	L10- C1	51
52	Certified Nurse Assistants/Aides	0	0	L10a- C1	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Page 21 Support		
C. Professional Services		
SIKICH	Accounting	1,276
KOCH CONSULTANTS	Accounting	1,931
OTHER DATA PROCESSING	Data Processing	150
QUANTUM SOLUTIONS INC	Data Processing	1,695
CONSTANT CONTACT	Data Processing	80
UKG	Data Processing	8,298
QUALEX/DOCTRAC	Data Processing	256
RELIAS	Data Processing	1,317
TARRYTOWN	Data Processing	250
HEYL, ROYSTER	Legal	765
MYRON S. STEEVES	Legal	237
Rounding		0
		16,256
		-
D. Employee Benefits and Payroll Taxes		
	Amount	
Workers' Compensation Insurance		
Unemployment Compensation Insurance		
FICA Taxes		
Employee Health Insurance		
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Defined Contribution Pension Plan		38,064
Employee Physicals		1,609
Employee Promotional		308
Scholarships		5,023
Rounding		0
	Total	45,004
	From PG21	182,229
		227,233
		-
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)		
QBS		59
Other Licenses & Permits		266
AAIM Employers' Association		79
Other Dues, Fees, Subs		40
Spotify		12
Driving Records		540
Rounding		(0)
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
	Total	996
	From PG21	2,620
		3,616
		-

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Crystal Streitmatter		Administrator	0	\$ 18,872	Workers' Compensation Insurance		\$ 6,116	IDPH License Fee		\$	
			0	0	Unemployment Compensation Insurance		0	Advertising: Employee Recruitment		142	
					FICA Taxes		92,319	Health Care Worker Background Check		131	
					Employee Health Insurance		82,052	(Indicate # of checks performed 5)			
					Employee Meals		1,742	Patient Background Checks		70	
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		2,277	
					See Support Page 21A		45,004	See Support Page 21A		996	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 18,872							
B. Administrative - Other									Less: Public Relations Expense		()
Description				Amount					Non-allowable advertising		()
				\$					Yellow page advertising		()
									TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,616
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services		Type		Amount	Description		Line #	Amount	Description		Amount
See Support Page 21A				\$ 16,256				\$	Out-of-State Travel		\$
									In-State Travel		
									Seminar Expense		
									Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 16,256	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakwood Estates

#

Report Period Beginning:

Ending:

XX. GENERAL INFORMATION:

- (1)

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

NO
- (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
IL HEALTHCARE ASSOCIATION (IHCA)	1,344
Other, please specify INSTITUTE ON PUBLIC POLICY	667
Other, please specify DON MOSS & ASSOCIATES	267
	2,277 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.

IL HEALTHCARE ASSOCIATION (IHCA)	
Other, please specify INSTITUTE ON PUBLIC POLICY	
Other, please specify DON MOSS & ASSOCIATES	
Other, please specify	
	0 Total
- (4)

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

IL HEALTHCARE ASSOCIATION (IHCA)	1,344
Other, please specify INSTITUTE ON PUBLIC POLICY	667
Other, please specify DON MOSS & ASSOCIATES	267
Other, please specify	0
	2,277 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	6,879	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.

\$	57,039
----	--------

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?

YES

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.

\$	0	Has any meal income been offset against related costs?	NO	Indicate the amount.	\$ N/A
----	---	--	----	----------------------	--------
- (12)

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.

\$ N/A

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

88

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?

YES

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ 0
- (13)

Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name: Koch Consultants, Ltd.
- (14)

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

YES
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

YES

See page 39 of the instructions for details.

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

Schedule V - Costs Center Expenses		
Lines	Description	Amount
1	Day Program Costs	-
43	Facility Bulletin / Newsletter	-
36	Investment Management Fees	-
36	Interest Expense	-
34	Facility Rental	-
15	Bad Debt	-
27	Dental costs	4,231
27	Charitable Contributions	-
27	Fines & Penalties	-
27	Miscellaneous	-
	Other Expenses	4,231

Schedule V - Reclassifications		Amount	
Lines	Description	Increase	Decrease
34	Facility Rental	-	
35	Facility Rental		-
32	Interest Expense	-	
36	Interest Expense		-
11	Donated labor	570	
1	Donated labor	-	
4	Donated labor	-	
6	Donated labor	-	
21	Donated labor	-	
10	Donated labor	-	
15	Donated labor	-	
10a	Donated labor	-	
12	Donated labor	-	
27	Donated labor		570
38	Medically necessary transportation	-	
14	Medically necessary transportation		-
10a	Disability Pay to Benefits		
22	Disability Pay to Benefits		
13	Nurse aid trainer wages	28,995	
1	Nurse aid trainer wages		97
6	Nurse aid trainer wages		-
10	Nurse aid trainer wages		-
10a	Nurse aid trainer wages		3,297
11	Nurse aid trainer wages		87
12	Nurse aid trainer wages		25,514
10a	Nurse aid trainer wages		-
17	Nurse aid trainer wages		-
10	Sundry	-	
27	Sundry		-
39	Dental costs	4,231	
27	Dental costs		4,231
		33,796	33,796

Schedule V, Line 39 - Ancillary Service Centers		
Dental costs for 26 visits	\$	4,231

Schedule VI B - Non-paid workers		
Lines	Description	Amount
31	Donated Labor	\$ 570
	Department	Time in Hours Time in Dollars
Activities		38.00 570
Kitchen		- -
Laundry		- -
Day Program		- -
Maintenance		- -
Nursing		- -
PT/OT		- -
Social Service Programs		- -
Office		- -
Totals		38.00 \$ 570

Schedule VII - Compensation Received From Other Nursing Homes		
Blair Metzger - \$2,033.96 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate		
John Sauder - \$0.00 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate		
Lee Klopfenstein - \$1,840.46 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate		
Kent Schmidgall - \$1,179.29 - 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		-
A/R - Bequests		-
A/R - Health Insurance		-
A/R - Employees		-

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets		
Investment in Related Entities		-
Sch. XVII - Income Statement, Line 28; Other Revenue		
Developmental training		-
Farm Income		-
Gain/(Loss) on Sale of Assets		-
Increase in Cash Value of Life Insurance		-
Miscellaneous		-
Cost to Market Adjustment on Investments	-	-

Sch. XVII - Income Statement, Line 41 - Income Before Taxes		
Income before taxes per cost report		(670,378)
Income from related parties		4,770,044
Estimated excess for year, Form 990, p.1, line 19		4,099,667

Sch. XVIII - A. Staffing and Salary Costs		
Sch. V. Cost Center Expenses, Pg 4, Column 1, Row 45		1,278,684
Sch. XVIII - A. Staffing and Salary Costs, Pg 20, Column 3, Row 34		(1,278,684)
Variance		-

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation		
Salaries, Sch V, Line 45, Col 1		1,278,684
Prior Year PTO Accrual		27,834
Current Year PTO Accrual		(29,351)
Prior Year Wage Accrual		23,080
Current Year Wage Accrual		(26,474)
Section 125 Wages not applicable to FICA taxes		(68,728)
Less: Wages over FICA taxation limit of SS Wages (\$0 x 6.2%/7.65%)		-
Add: Wages Allocated to other facilities		-
Add: ACCS Wages		
Add: wages included in employee meal calculation		1,742
Cash basis salaries		1,206,787
FICA rate		7.650%
Calculated FICA		92,319
FICA per Sch XIX		92,319
Variance		0

Sch. XX - General Information		
8. Nurse Aide Trainer Wages:		
	Administrator	-
	Therapy / PT / OT	3,297
	Activities Director	87
	Day Program	-
	Head Cook	97
	Maintenance	-
	Nursing	-
	Soc. Serv. / QMRP	25,514
		28,995

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

16. Out of State Travel		
	Administration	
	Blake Stahl - CEO	-
		-
		-
	Board of Directors	
	Blair Metzger	271
	John Sauder	-
	Kent Schmidgall	157
	Lee Klopfenstein	245
		674
	Nursing	
	Jon D	-
		-

OAKWOOD ESTATE - - #0033712

ATTACHMENT TO SCHEDULE VII A

Related Organizations:

Apostolic Christian Timber Ridge #0016220
Linden Estate #0039305

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

Matt Zimmermann, President/Chairman
Kent Schmidgall, Vice President
Ben Knochel, Treasurer (term ended 05/17/2025)
Heidi Haerr, Secretary
Greg Wiegand, Director
Blair Metzger, Director
Daniel Leman, Director
Lee Klopfenstein, Director
Wendy Sauder, Director
John Sauder, Treasurer (term began 05/17/2025)

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: 07/01/2024 to 06/30/2025



CLASS DATE		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	
DSP Starting Wage	completed	53	24	960	\$ 18,720.00	1920	\$ 37,440.00	6	240	\$ 4,680.00	480	\$ 9,360.00	5	200	\$ 3,900.00	400	\$ 7,800.00	18	720	\$ 14,040.00	1,440	\$ 28,080.00
\$ 19.50	still enrolled, not complete	21	12	240	\$ 4,680.00	480	\$ 9,360.00	4	80	\$ 1,560.00	160	\$ 3,120.00	3	60	\$ 1,170.00	120	\$ 2,340.00	2	40	\$ 780.00	80	\$ 1,560.00
	dropouts	32	16	320	\$ 6,240.00	640	\$ 12,480.00	7	140	\$ 2,730.00	280	\$ 5,460.00	4	80	\$ 1,560.00	160	\$ 3,120.00	5	100	\$ 1,950.00	200	\$ 3,900.00
				\$ -	0	\$ -			\$ -	0	\$ -			\$ -	0	\$ -			\$ -	0	\$ -	
Total		3180	52	1520	\$ 29,640.00	3040	\$ 59,280.00	17	460	\$ 8,970.00	920	\$ 17,940.00	12	340	\$ 6,630.00	680	\$ 13,260.00	25	860	\$ 16,770.00	1720	\$ 33,540.00
		8,280		1,280		2,560		380		760		280		560		820		1,640				

23-70335 23-70331 23-7033585-004

TRAINER WAGES

TRAINER WAGES		Classification	Hours	Wages		TR	OE	LE	CILA		
Karen	McKillip	11	12.0	\$	277.18	\$	40.09	132.49	40.09	29.64	74.96
Jill	Gingrich	11	12.0	\$	325.13	\$	47.03	155.41	47.03	34.76	87.93
Jennifer	Smith	10ot	120.0	\$	5,192.27	\$	751.08	2,481.84	751.08	555.15	1,404.20
Vicki	Barnett	1	24.0	\$	672.73	\$	97.31	321.56	97.31	71.93	181.93
Jolene	Wake	12m	24.0	\$	819.72	\$	118.58	391.81	118.58	87.64	221.68
				\$	-	\$	-	-	-	-	-
				\$	-	\$	-	-	-	-	-
Angie	Frank	13	2,080.00	\$	91,430.56	\$	13,225.80	43,702.66	13,225.80	9,775.59	24,726.50
Michelle	Rogers	10s	48.0	\$	2,317.87	\$	335.29	1,107.91	335.29	247.82	626.85
Christina	Wiegand	12r	48.0	\$	1,602.05	\$	231.74	765.76	231.74	171.29	433.26
Katherine	Martin	21	12.0	\$	424.90	\$	61.46	203.10	61.46	45.43	114.91
Felicia	Burton	21	24.00	\$	640.27	\$	92.62	306.04	92.62	68.46	173.16
Jason	Stevenor	21	24.00	\$	1,604.64	\$	232.12	767.00	232.12	171.57	433.96
Lori	Wright	10a	283.00	\$	15,282.00	\$	2,210.60	7,304.60	2,210.60	1,633.92	4,132.87
Andriya	Thompson	13	2,080.00	\$	79,855.36	\$	11,551.40	38,169.86	11,551.40	8,537.99	21,596.10
	OE			\$	-	\$	-	-	-	-	-
Crystal	Streitmatter	17		\$	-	\$	-	-	-	-	-
Brenda	Seggebruch	12r		\$	-	\$	-	-	-	-	-
	LE			\$	-	\$	-	-	-	-	-
Robert	Mooney	12r		\$	-	\$	-	-	-	-	-
				\$	-	\$	-	-	-	-	-
	CILA			\$	-	\$	-	-	-	-	-
Eric	Williams	12r		\$	-	\$	-	-	-	-	-
Leigh	Mason	12q		\$	-	\$	-	-	-	-	-
						\$	28,995.14	95,810.04	28,995.14	21,431.19	54,208.31

Hours

TR	OE	LE	CILA
5.74	1.74	1.28	3.25
5.74	1.74	1.28	3.25
57.36	17.36	12.83	32.45
11.47	3.47	2.57	6.49
11.47	3.47	2.57	6.49
-	-	-	-
-	-	-	-
994.21	300.88	222.39	562.52
22.94	6.94	5.13	12.98
22.94	6.94	5.13	12.98
5.74	1.74	1.28	3.25
11.47	3.47	2.57	6.49
11.47	3.47	2.57	6.49
135.27	40.94	30.26	76.53
994.21	300.88	222.39	562.52
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-
2,290.04	693.04	512.25	1,295.68

Total trainer wages

41.8378 4791.0

\$ 200,444.68

\$ 3,470.00

Give this number to Kathy Tanner for Training Billing for Next Year - Assumes 15% Video Classes and 25% Benefits

23-70335 23-7033585-(23-7033585-004

Raise

9% 17990.84045

\$ 218,435.52

8,280

26.38

120Hrs 3,165.73

52.5 Hrs 1,385.01

			TR	OE	LE	CILA
Drop-Outs						
Number from this Facility	\$	7.00	16	7	4	5
Clinical Wages	\$	280.00	\$ 12,480.00	\$ 280.00	\$ 3,120.00	\$ 3,900.00
Classroom Wages	\$	2,730.00	\$ 6,240.00	\$ 2,730.00	\$ 1,560.00	\$ 1,950.00
In-House Trainer Wages	\$	8,004.00	\$ 6,724.00	\$ 8,004.00	\$ 1,681.00	\$ 2,101.00
	\$	-				
Completed	\$	-				
Number from this Facility	\$	6.00	24	6	5	18
Clinical Wages	\$	6,240.00	\$ 23,400.00	\$ 6,240.00	\$ 5,070.00	\$ 14,820.00
Classroom Wages	\$	640.00	\$ 46,800.00	\$ 640.00	\$ 10,140.00	\$ 29,640.00
In-House Trainer Wages	\$	1,876.00	\$ 50,426.00	\$ 1,876.00	\$ 10,926.00	\$ 31,937.00

Supplies

4654.38

Schedule V

		<u>Line</u>	<u>Change</u>	<u>Change</u>	<u>Change</u>	<u>Change</u>
Dietary	1	1	(322.00)	(97.00)	(72.00)	(182.00)
Maintenance	6	6	-	-	-	-
Nursing	10	10	-	-	-	-
Therapy	10a	10a	(7,305.00)	(2,211.00)	(1,634.00)	(4,133.00)
OT/PT	10ot	10a	(2,482.00)	(751.00)	(555.00)	(1,404.00)
Activities	11	11	(288.00)	(87.00)	(64.00)	(163.00)
RSD	12r	12	(766.00)	(232.00)	(171.00)	(433.00)
QMRP's	12q	12	-	-	-	-
MSSD	12m	12	(392.00)	(119.00)	(88.00)	(222.00)
Training Wages	13	13	95,810.00	28,995.00	21,431.00	54,208.00
Day Program	15	15	-	-	-	-
Administrator	17	17	-	-	-	-
OJT	12ojt	12	-	-	-	-
Speech	10s	10a	(1,108.00)	(335.00)	(248.00)	(627.00)
HR	21	21				
Adjustment		12	(83,147.00)	(25,163.00)	(18,599.00)	(47,044.00)
			-	-	-	-