

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HTS CONT C & REH CTR

Address: 1320 WEST 9TH ST RR4 MOUNT CARMEL 62863
Number City Zip Code

County: WABASH

Telephone Number: 618 263-4337 Fax # 618 262-7080

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1981

Type of Ownership:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code	501(c)(3)	☐	Corporation	☐	Other
		☐	"Sub-S" Corp.	☐	
		☐	Limited Liability Co.	☐	
		☐	Trust	☐	
		☐	Other	☐	

In the event there are further questions about this report, please contact:
Name: Brett Millikin Telephone Number: 870-598-1020 OR 870-514-1271
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 09/01/2015 to 08/31/2016 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)	12/30/16
	(Type or Print Name)	Brett Millikin
	(Title)	CFO
Paid Preparer	(Signed)	
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone)	() Fax # ()

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR

0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</u>	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	<u>90</u>	TOTALS	<u>90</u>	<u>32,940</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>213</u>		<u>5,615</u>	<u>5,828</u>	8
9	SNF/PED					9
10	ICF	<u>16,275</u>	<u>6,508</u>		<u>22,783</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,488</u>	<u>6,508</u>	<u>5,615</u>	<u>28,611</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.86%

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

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

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 06/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/01/81 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 90 and days of care provided 3,607

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 08/31/2016 Fiscal Year: 08/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **OAKVIEW HTS CONT C & REH CTR** # **0026328** Report Period Beginning: **09/01/2015** Ending: **08/31/2016**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	173,591	37,080	8,773	219,444		219,444		219,444			1
2	Food Purchase		164,683		164,683		164,683	(1,203)	163,480			2
3	Housekeeping	104,201	2,131	36	106,368		106,368		106,368			3
4	Laundry	42,012	5,966		47,978		47,978		47,978			4
5	Heat and Other Utilities			115,369	115,369		115,369	(86)	115,283			5
6	Maintenance	66,333	36,521	17,496	120,350		120,350	1,538	121,888			6
7	Other (specify):*											7
8	TOTAL General Services	386,137	246,381	141,674	774,192		774,192	249	774,441			8
	B. Health Care and Programs											
9	Medical Director			17,800	17,800		17,800		17,800			9
10	Nursing and Medical Records	1,536,394	118,991	1,924	1,657,309		1,657,309		1,657,309			10
10a	Therapy		2,847	591,532	594,379		594,379		594,379			10a
11	Activities	43,229	1,807	3,532	48,568		48,568		48,568			11
12	Social Services	31,650		2,057	33,707		33,707		33,707			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,611,273	123,645	616,845	2,351,763		2,351,763		2,351,763			16
	C. General Administration											
17	Administrative	93,139			93,139		93,139		93,139			17
18	Directors Fees											18
19	Professional Services			44,751	44,751		44,751	14,204	58,955			19
20	Dues, Fees, Subscriptions & Promotions			20,583	20,583		20,583	(4,252)	16,331			20
21	Clerical & General Office Expenses	164,633	12,623	281,139	458,395		458,395	(20,449)	437,946			21
22	Employee Benefits & Payroll Taxes			370,666	370,666		370,666	68,813	439,479			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,282	8,282		8,282	(8,282)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,785	76,785		76,785	20,129	96,914			26
27	Other (specify):*											27
28	TOTAL General Administration	257,772	12,623	802,206	1,072,601		1,072,601	70,163	1,142,764			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,255,182	382,649	1,560,725	4,198,556		4,198,556	70,412	4,268,968			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			181,509	181,509		181,509	9,957	191,466			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198,470	198,470		198,470	13,564	212,034			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,669	21,669		21,669	1,364	23,033			35
36	Other (specify):*											36
37	TOTAL Ownership			401,648	401,648		401,648	24,885	426,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			197,470	197,470		197,470		197,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,706	197,706		197,706		197,706			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			395,176	395,176		395,176		395,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,255,182	382,649	2,357,549	4,995,380		4,995,380	95,297	5,090,677			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	(1,203)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,520)	5		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	(7,233)	32		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	(4,252)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,114)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,322)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (52,322)		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

ID#0026328

Report Period Beginning:09/01/2015

Ending:08/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (12,039)	21	1
2	TRAVEL	(8,282)	24	2
3	LEGAL FEES	(17,793)	19	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
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21				21
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31				31
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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	(38,114)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR# 0026328

Report Period Beginning:

09/01/2015

Ending:

08/31/2016**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,203)	0	0	0	0	0	0	0	0	0	0	(1,203)	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	(1,520)	1,434	0	0	0	0	0	0	0	0	0	(86)	5
6	Maintenance	0	1,538	0	0	0	0	0	0	0	0	0	1,538	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,723)	2,972	0	0	0	0	0	0	0	0	0	249	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	(17,793)	31,997	0	0	0	0	0	0	0	0	0	14,204	19
20	Fees, Subscriptions & Promotions	(4,252)	0	0	0	0	0	0	0	0	0	0	(4,252)	20
21	Clerical & General Office Expenses	(12,039)	(8,410)	0	0	0	0	0	0	0	0	0	(20,449)	21
22	Employee Benefits & Payroll Taxes	0	68,813	0	0	0	0	0	0	0	0	0	68,813	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,282)	0	0	0	0	0	0	0	0	0	0	(8,282)	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	20,129	0	0	0	0	0	0	0	0	0	20,129	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(42,366)	112,529	0	0	0	0	0	0	0	0	0	70,163	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,089)	115,501	0	0	0	0	0	0	0	0	0	70,412	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	9,957	0	0	0	0	0	0	0	0	0	9,957	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,233)	20,797	0	0	0	0	0	0	0	0	0	13,564	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	1,364	0	0	0	0	0	0	0	0	0	1,364	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,233)	32,118	0	0	0	0	0	0	0	0	0	24,885	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)	(52,322)	147,619	0	0	0	0	0	0	0	0	0	95,297	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
SEE P6 Suup		GENERAL BAPT NH OF CAMPBELL	CAMPBELL, MO	GEN BAPT HCARE	PIGGOTT, AR	MGMT
		GENERAL BAPT NH OF PIGGOTT	PIGGOTT, AR	OAKVIEW VILLA	MT CARMEL, IL	SUPP LIVING
				MAGNOLIA MANOR	PIGGOTT, AR	ASST LIVING

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

☐ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	General Baptist Nursing Home Board		\$ 1,434	\$ 1,434	1
2	V	6	Maintenance		General Baptist Nursing Home Board		1,538	1,538	2
3	V	19	Professional Services		General Baptist Nursing Home Board		31,997	31,997	3
4	V	21	Mgmt Fees	245,030	General Baptist Nursing Home Board		223,214	(21,816)	4
5	V	21	Supplies		General Baptist Nursing Home Board		13,406	13,406	5
6	V	22	Employee Benefits & Payroll Taxes		General Baptist Nursing Home Board		68,813	68,813	6
7	V	26	Insurance		General Baptist Nursing Home Board		20,129	20,129	7
8	V	30	Depreciation		General Baptist Nursing Home Board		9,957	9,957	8
9	V	32	Interest Expense		General Baptist Nursing Home Board		20,797	20,797	9
10	V	35	Rental & Leasing		General Baptist Nursing Home Board		1,364	1,364	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 245,030			\$ 392,649	\$ * 147,619	14

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

Facility Name & ID Number

OAKVIEW HTS CONT C & REH CTR

0026328

Report Period Beginning:

09/01/2015

Ending:

08/31/2016

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	Carol Blanton, President	BOD						1
2	Greg Stevens, Secretary	BOD						2
3	James Featherston, Treasuer	BOD						3
4	Mary Martha Curtis, Board Member	BOD						4
5	Clydus Gray, Board Member	BOD						5
6	Kenneth Curtis, Board Member	BOD						6
7	Kevin Smith, Board Member	BOD						7
8	Tracy Robison, Board Member	BOD						8
9	Jim Poole, Board Member	BOD						9
10	James McGee, Board Member	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 OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											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 OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 8/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization GEN BAPTIST N.N BOARD INC
Street Address 1287 W NORTH STREET
City / State / Zip Code PIGGOTT, AR 72454
Phone Number (870-598-1020
Fax Number (870-598-1025

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	Oakview Heights (OH)	Direct Costs	14,230,177		\$ 1,103,953	\$ 627,574	5,061,328	\$ 392,649	1
2	Oakview Villa (OV)	Direct Costs	14,230,177		1,103,953	627,574	750,043	58,187	2
3	Campbell (CB)	Direct Costs	14,230,177		1,103,953	627,574	4,234,194	328,482	3
4	Piggott (PG)	Direct Costs	14,230,177		1,103,953	627,574	3,160,552	245,190	4
5	Magnolia Manor (MM)	Direct Costs	14,230,177		1,103,953	627,574	1,024,060	79,445	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				\$ 5,519,764	\$ 3,137,871		\$ 1,103,953	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	GERSHMAN MORTGAGE		X	MORTGAGE REFINANCED	\$21,505.00	08/2013	\$ 6,007,277	\$ 5,763,236	08/2053	3.0000	\$ 174,265	1	
2	DE LAGE LANDEN FIN		X	PATIENT TRANSPORT VAN	\$844.00	02/2015	44,472	31,623	01/2020	5.2300	1,889	2	
3												3	
4												4	
5												5	
	Working Capital												
6	FNB OF PARAGOULD		X	LINE OF CREDIT	\$1,500.00	02/2015	500,000	499,363	02/2017	5.0000	22,316	6	
7	GEN BAPTIST NH BOARD	X		LOAN		01/2006	376,498	1,245,931	ON DEM	NONE		7	
8												8	
9	TOTAL Facility Related				\$23,849.00		\$ 6,928,247	\$ 7,540,153			\$ 198,470	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,928,247	\$ 7,540,153			\$ 198,470	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,868 Line # 26

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	N/A	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.)				\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).				\$	#VALUE!	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	#VALUE!	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011		8		
		2012		9		
		2013		10		
		2014		11		
		2015		12		
				13	FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2015 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HTS CONT C & REH CTR COUNTY WABASH

FACILITY IDPH LICENSE NUMBER 0026328

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 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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: 60,358

B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories ONE

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).
OAKVIEW VILLA SUPPORTIVE LIVING COMMUNITY, 30 UNITS

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	RESIDENT USE	352,863	1981	\$ 89,216	1
2	RESIDENT USE	270,630	1994	60,000	2
3	TOTALS	623,493		\$ 149,216	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	90		1981	1982	\$ 775,625	\$	30	\$	\$	\$ 775,625
5				2005	3,461,500	86,538	40	86,538		959,123
6				2006	1,109,737	27,743	40	27,743		299,747
7										
8										
	Improvement Type**									
9	Roof			1982	3,837		7			3,837
10	Land Improvements			1982	14,363		10			14,363
11	Building Imp.- Smith Consult.			1994	2,914		10			2,914
12	Roof			1996	68,042	2,268	30	2,268		45,550
13	Roof			1996	11,450	382	30	382		7,570
14	Parking Lot Repavement			1997	12,677		10			12,677
15	Ditch Work			1997	700		15			700
16	Gazebo			1997	3,495		10			3,495
17	Electrical-New Wing			1997	23,632	945	25	945		17,803
18	Landscaping			1997	8,837		15			8,837
19	Drywall			1997	21,125		15			21,125
20	12 Lavatory+Faucets			1998	4,470		15			4,470
21	9 Overhead Lights			1998	921		15			921
22	Exit Sign			1998	449		15			449
23	Other MG- Including Plumbing			1998	9,003		15			9,003
24	Wall Paper			1998	2,435		7			2,435
25	Plastic Coat-Roof-Wing 5			1998	12,500	417	30	417		7,708
26	Carpet			1998	7,927		7			7,927
27	Sign			1998	2,000		15			2,000
28	Carpet,Curtains, Blinds			1998	11,249		10			11,249
29	Carpet,Curtains, Blinds			1998	19,656		10			19,656
30	Landscaping			1999	976		15			976
31	Wall Paper			1999	4,135		15			4,135
32	Reseal Parking Lot			1999	3,336		5			3,336
33	Fuel Tank			1999	8,935		15			8,935
34	Land Improvements			2000	647		15			647
35	Kitchen			2000	4,231		10			4,231
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 OAKVIEW HTS CONT C & REH CTR

0026328

Report Period Beginning:

09/01/2015 Ending: 08/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Building Handrails	2000	\$ 3,818	\$	7	\$	\$	\$ 3,818	37
38	Brittington Air & Water	2000	1,992		7			1,992	38
39	Tile-Wing 7	2000	3,753		7			3,753	39
40	Fire Doors	2000	4,861		10			4,861	40
41	Land Improvements	2001	380	11	15	11		380	41
42	North-Side Heaters	2001	6,090		7			6,090	42
43	Water Heaters	2001	15,196		7			15,196	43
44	Land Improvements	2005	316,403	21,094	15	21,094		233,787	44
45	Pole Barn	2007	12,485	832	15	832		7,976	45
46	Shelter House	2008	10,188	679	15	679		5,717	46
47	Land Improvements - Paving	2008	14,053	937	15	937		7,495	47
48	Reseal Parking Lot	2008	5,218	348	15	348		2,783	48
49	Silverline Windows	2009	8,092	540	15	540		3,866	49
50	Purf Pipe in Parking Lot	2009	4,110	274	15	274		1,964	50
51	Parking Lot Repavement	2009	12,469	831	15	831		5,784	51
52	Sidewalk	2011	5,556	370	15	370		1,821	52
53	Breezeway	2011	9,748	650	15	650		3,087	53
54	Sewer Replacement	2012	39,848	2,657	15	2,657		9,962	54
55	Water Heater	2012	8,600	573	15	573		2,102	55
56	HVAC	2013	6,665	171	39	171		484	56
57	Parking Lot Repavement	2014	15,645	1,565	10	1,565		2,934	57
58	Roof	2014	11,580	386	30	386		724	58
59	Water Heater	2015	7,900	790	10	790		1,152	59
60	Roof	2015	9,658	322	30	322		470	60
61	Flooring	2016	4,885	669	7	669		669	61
62	A/c Unit	2016	5,652	495	10	495		495	62
63	Flooring	2016	673	76	7	76		76	63
64	Flooring	2016	673	68	7	68		68	64
65	Bathroom Remodel	2016	970	44	10	44		44	65
66	Land Drainage Improvement	2016	840	11	10	11		11	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,158,805	\$ 152,684		\$ 152,684	\$	\$ 2,591,004	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	\$ 108,748	\$ 17,496	\$ 17,496	\$	7	\$ 67,324	71
72	Current Year Purchases	18,085	1,211	1,211		7	1,211	72
73	Fully Depreciated Assets	693,659	1,224	1,224		7	693,659	73
74								74
75	TOTALS	\$ 820,491	\$ 19,931	\$ 19,931	\$		\$ 762,193	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	FACILITY USE	86 Mazda Truck-B2000	1992	\$ 4,474	\$	\$	\$	5	\$ 4,474
77	FACILITY USE	Donated Van	2009	2,700				5	2,700
78	FACILITY USE	Ford E-250	2015	44,472	8,894	8,894		5	13,712
79								5	
80	TOTALS			\$ 51,646	\$ 8,894	\$ 8,894	\$		\$ 20,886

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	7,180,158
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	181,509
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	181,509
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,374,083

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

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)	\$			

- (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.

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	

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	3,218	\$ 263,622	\$	3,218	\$ 263,622	1
2	Licensed Speech and Language Development Therapist		hrs		1,181	99,819		1,181	99,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,836	228,092	2,847	2,836	230,939	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	7,235	\$ 591,532	\$ 2,847	7,235	\$ 594,379	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 520,788	\$ 536,868	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,381,592	1,618,014	3
4	Supply Inventory (priced at)	11,317	15,847	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,633	10,462	6
7	Other Prepaid Expenses	3,022	3,022	7
8	Accounts Receivable (owners or related parties)	425,637		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,348,989	\$ 2,184,213	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216	179,216	13
14	Buildings, at Historical Cost	6,158,804	8,304,671	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,137	1,038,632	16
17	Accumulated Depreciation (book methods)	(3,374,084)	(4,202,785)	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)	\$ 3,806,073	\$ 5,319,734	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,155,062	\$ 7,503,947	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 348,282	\$ 350,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,745,294	1,745,294	29
30	Accrued Salaries Payable	58,110	66,208	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,491	7,876	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,408	19,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ADV BILLING SEC DEPOSITS RES TR	97,684	162,946	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,270,269	\$ 2,352,810	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,794,859	8,025,525	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)	\$ 5,794,859	\$ 8,025,525	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,065,128	\$ 10,378,335	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,910,066)	\$ (2,874,388)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,155,062	\$ 7,503,947	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,769,578)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,769,578)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,488)	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)	\$ (140,488)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,910,066)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR

0026328

Report Period Beginning: 09/01/2015

Ending: 08/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,322,693	1
2	Discounts and Allowances for all Levels	(1,994,669)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,328,024	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,346,136	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,346,136	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,203	14
15	Telephone, Television and Radio	1,520	15
16	Rental of Facility Space		16
17	Sale of Drugs	126,259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,204	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,186	23
	D. Non-Operating Revenue		
24	Contributions	3,274	24
25	Interest and Other Investment Income***	7,233	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,507	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	12,039	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,039	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,854,892	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	774,192	31
32	Health Care	2,351,763	32
33	General Administration	1,072,601	33
	B. Capital Expense		
34	Ownership	401,648	34
	C. Ancillary Expense		
35	Special Cost Centers	197,470	35
36	Provider Participation Fee	197,706	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,995,380	40
41	Income before Income Taxes (line 30 minus line 40)**	(140,488)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (140,488)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,304,223	44
45	Private Pay - Net Inpatient Revenue	1,166,920	45
46	Medicare - Net Inpatient Revenue	519,888	46
47	Other-(specify) <u>Manage Care/Hospice</u>	336,994	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,328,024	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,083	2,092	\$ 67,893	\$ 32.45	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	18,285	18,364	422,991	23.03	3
4	Licensed Practical Nurses	16,902	16,975	294,758	17.36	4
5	CNAs & Orderlies	68,458	68,754	732,462	10.65	5
6	CNA Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	4,179	4,197	43,229	10.30	10
11	Social Service Workers	2,085	2,094	31,650	15.11	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	19,915	20,001	173,591	8.68	15
16	Dishwashers		0			16
17	Maintenance Workers	4,212	4,230	66,333	15.68	17
18	Housekeepers	11,845	11,896	104,201	8.76	18
19	Laundry	4,805	4,826	42,012	8.71	19
20	Administrator	2,043	2,052	93,139	45.39	20
21	Assistant Administrator	2,342	2,352	57,930	24.63	21
22	Other Administrative	2,621	2,632	72,543	27.56	22
23	Office Manager		0			23
24	Clerical	2,072	2,081	34,160	16.42	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records	1,439	1,445	18,290	12.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,286	163,991	\$ 2,255,182 *	\$ 13.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	MONTHLY	17,800	9-3	36
37	Medical Records Consultant	MONTHLY	1,924	10-3	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)		\$ 19,724		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
SCOTTIE COLE	ADMINISTRATOR	N/A	\$ 93,139	Workers' Compensation Insurance		\$ 107,997	IDPH License Fee	\$	
				Unemployment Compensation Insurance		40,714	Advertising: Employee Recruitment	459	
				FICA Taxes		169,388	Health Care Worker Background Check	3,211	
				Employee Health Insurance		51,623	(Indicate # of checks performed 97)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			DRUG TESTING	447	
				OTHER EMPLOYEE BENEFITS		944	LICENSES	4,095	
				GBHC BD ALLOC PAY TAXES & OTH BENE		68,813	DUES & SUBSCRIPTIONS	8,119	
TOTAL (agree to Schedule V, line 17, col. 1)							ADVERTISING & MARKETING	4,252	
(List each licensed administrator separately.)									

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)

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

NO

(2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ILL HEALTH CARE ASSOC \$7,155

(3)

Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

7

(6)

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

\$

31,622

Line

10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

197,706

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

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.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.

\$

NONE

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$

1,203

(16)

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?

0

d. Have vehicle usage logs been maintained?

YES

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

YES

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

N/A

g. Does the facility transport residents to and from day training?

NO

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

\$

N/A

(17)

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

YES

Firm Name:

Watler Accounting Certified Public Accountants, P.C.

(18)

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

YES

(19)

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

See page 39 of the instructions for details.

N/A

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

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER 04-5179
LEGAL INVOICE LIST
AUGUST 31 2016

VendorName	InvoiceNumber	InvoiceDate	InvAmount	Allowable	Non-Allowable	Description
Duane Morris LLP	2110778	09/18/15	612.00		612.00	General (Various) Legal Svcs
Duane Morris LLP	2129534	11/17/15	1,153.00		1,153.00	General (Various) Legal Svcs
Duane Morris LLP	2149556	01/25/16	1,108.00		1,108.00	General (Various) Legal Svcs
Duane Morris LLP	2206825	07/25/16	11,895.00		11,895.00	General (Various) Legal Svcs
Duane Morris LLP	2206826	07/25/16	1,259.50		1,259.50	General (Various) Legal Svcs
Duane Morris LLP	2215669	08/18/16	1,765.00		1,765.00	General (Various) Legal Svcs
			17,792.50		17,792.50	

