

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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	90	Skilled Pediatric (SNF/PED)	90	32,850	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,298	4,298	8
9	SNF/PED					9
10	ICF	17,068	6,802	629	24,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,068	6,802	4,927	28,797	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.66%

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 6/01/81

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

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

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/10 Fiscal Year: 8/31/10

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

Facility Name & ID Number **OAKVIEW HEIGHTS CONTINUOUS CAR** # **0026328** Report Period Beginning: **9/1/2009** Ending: **8/31/2010**

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	265,251	19,791	8,996	294,038		294,038		294,038		1
2	Food Purchase		140,102		140,102		140,102	(605)	139,497		2
3	Housekeeping	144,459	22,818		167,277		167,277		167,277		3
4	Laundry	56,221	13,394	300	69,915		69,915		69,915		4
5	Heat and Other Utilities			135,643	135,643		135,643	(286,877)	(151,234)		5
6	Maintenance	51,498	59,749	22,120	133,367		133,367	936	134,303		6
7	Other (specify):*										7
8	TOTAL General Services	517,429	255,854	167,059	940,342		940,342	(286,546)	653,796		8
	B. Health Care and Programs										
9	Medical Director			9,125	9,125		9,125		9,125		9
10	Nursing and Medical Records	1,504,604	139,009	9,318	1,652,931		1,652,931		1,652,931		10
10a	Therapy		3,606	764,548	768,154		768,154		768,154		10a
11	Activities	70,302	1,997	1,569	73,868		73,868		73,868		11
12	Social Services	46,893	78	1,377	48,348		48,348		48,348		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,621,799	144,690	785,937	2,552,426		2,552,426		2,552,426		16
	C. General Administration										
17	Administrative	68,179			68,179		68,179	117,713	185,892		17
18	Directors Fees										18
19	Professional Services			472,501	472,501		472,501	(15,566)	456,935		19
20	Dues, Fees, Subscriptions & Promotions			47,057	47,057		47,057	(27,242)	19,815		20
21	Clerical & General Office Expenses	97,869	17,594	22,753	138,216		138,216	45,453	183,669		21
22	Employee Benefits & Payroll Taxes			452,325	452,325		452,325		452,325		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,635	18,635		18,635	6,487	25,122		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			82,054	82,054		82,054		82,054		26
27	Other (specify):*							31,643	31,643		27
28	TOTAL General Administration	166,048	17,594	1,095,325	1,278,967		1,278,967	158,488	1,437,455		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,305,276	418,138	2,048,321	4,771,735		4,771,735	(128,058)	4,643,677		29

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

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

Facility Name & ID Number

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL #0026328

Report Period Beginning:

9/1/2009

Ending:

8/31/2010

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			225,769	225,769		225,769		225,769			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			342,261	342,261		342,261	(4,912)	337,349			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,751	8,751		8,751	1,931	10,682			35
36	Other (specify):*											36
37	TOTAL Ownership			576,781	576,781		576,781	(2,981)	573,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			191,110	191,110		191,110		191,110			39
40	Barber and Beauty Shops	9,705	1,089		10,794		10,794		10,794			40
41	Coffee and Gift Shops		8,632		8,632		8,632	(9,525)	(893)			41
42	Provider Participation Fee			62,528	62,528		62,528		62,528			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	9,705	9,721	253,638	273,064		273,064	(9,525)	263,539			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,314,981	427,859	2,878,740	5,621,580		5,621,580	(140,564)	5,481,016			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(605)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,341)	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	(4,912)	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	(34,444)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,839)	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	(18,343)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,484)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(49,080)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (49,080)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (140,564)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

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OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328

Report Period Beginning: 9/1/2009

Ending: 8/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING INCOME	\$ (9,525)	41	1
2	MISC INCOME	(8,818)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,343)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL# 0026328

Report Period Beginning:

9/1/2009

Ending:

8/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(605)	0	0	0	0	0	0	0	0	0	0	(605)	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	(5,341)	(281,536)	0	0	0	0	0	0	0	0	0	(286,877)	5
6	Maintenance	0	936	0	0	0	0	0	0	0	0	0	936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,946)	(280,600)	0	(286,546)	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	117,713	0	0	0	0	0	0	0	0	0	117,713	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(34,444)	18,878	0	0	0	0	0	0	0	0	0	(15,566)	19
20	Fees, Subscriptions & Promotions	(27,839)	597	0	0	0	0	0	0	0	0	0	(27,242)	20
21	Clerical & General Office Expenses	(8,818)	54,271	0	0	0	0	0	0	0	0	0	45,453	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,487	0	0	0	0	0	0	0	0	0	6,487	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	31,643	0	0	0	0	0	0	0	0	0	31,643	27
28	TOTAL General Administration	(71,101)	229,589	0	158,488	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,047)	(51,011)	0	(128,058)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI# 0026328

Report Period Beginning:

9/1/2009

Ending:

8/31/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,912)	0	0	0	0	0	0	0	0	0	0	(4,912)	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	1,931	0	0	0	0	0	0	0	0	0	1,931	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,912)	1,931	0	(2,981)	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	(9,525)	0	0	0	0	0	0	0	0	0	0	(9,525)	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	(9,525)	0	0	0	0	0	0	0	0	0	0	(9,525)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(91,484)	(49,080)	0	(140,564)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE		N/A		OAKVIEW VILLA	MT CARMEL, IL	SUPPORTIVE LIVI
				GEN BAPTIST NH BO	PIGGOTT, AR	MANAGEMENT

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 UTILITIES	\$ 283,637	GENERAL BAPTIST N.H. BOARD, INC		\$ 2,101	\$ (281,536)	1
2	V	6 REPAIR & MAINT		GENERAL BAPTIST N.H. BOARD, INC		936	936	2
3	V	17 ADMIN SALARIES		GENERAL BAPTIST N.H. BOARD, INC		117,713	117,713	3
4	V	19 PROFESSIONAL FEES		GENERAL BAPTIST N.H. BOARD, INC		18,878	18,878	4
5	V	20 FEES, SUBSCRIPTIONS		GENERAL BAPTIST N.H. BOARD, INC		597	597	5
6	V	21 OFFICE SALARIES		GENERAL BAPTIST N.H. BOARD, INC		37,376	37,376	6
7	V	21 OFFICE EXPENSE		GENERAL BAPTIST N.H. BOARD, INC		16,895	16,895	7
8	V	24 TRAVEL & SEMINAR		GENERAL BAPTIST N.H. BOARD, INC		6,487	6,487	8
9	V	27 EMPLOYEE BENEFITS		GENERAL BAPTIST N.H. BOARD, INC		31,643	31,643	9
10	V	35 EQUIPMENT RENT		GENERAL BAPTIST N.H. BOARD, INC		1,931	1,931	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 283,637			\$ 234,557	\$ * (49,080)	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.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAI # 0026328 Report Period Beginning: 9/1/2009 Ending: 8/31/2010

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 HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 9/1/2009 Ending: 3/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization GEN BAPTIST N.H. BOARD INC
 Street Address PO BOX 363; 1287 W NORTH ST
 City / State / Zip Code PIGGOTT, AR 72454
 Phone Number (870-598-1020
 Fax Number (870-598-1025

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.

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	GENERAL BAPTIST NSG HOME				\$	\$	4,280,385	\$ 188,088	1
2	OAKVIEW HEIGHTS						5,337,943	234,557	2
3	OAKVIEW VILLA						1,002,530	44,052	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				\$	\$		\$ 466,697	25

Facility Name & ID Number

OAKVIEW HEIGHTS CONTINUOUS CARI

0026328

Report Period Beginning:

9/1/2009

Ending:

8/31/2010

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										
										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		4/13/04	\$ 6,098,158	\$ 5,787,040	4/13/44	5.8000	\$ 335,387	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	FIRST BANK		X	LINE OF CREDIT	VARIOUS	9/1/2009	VAR	195,315	VAR	6.0000	6,874	6							
7	GEN BAPTIST NH BOARD	X		LOAN	VARIOUS	1/2006	376,498	1,084,201	On demand	None		7							
8												8							
9	TOTAL Facility Related						\$ 6,474,656	\$ 7,066,556			\$ 342,261	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 6,474,656	\$ 7,066,556			\$ 342,261	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,646 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2009 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 2010 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:	2005	_____	8	FOR BHF USE ONLY		
	2006	_____	9			
	2007	_____	10			
	2008	_____	11			
	2009	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2009 \$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL 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 2009 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 2009.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,358 B. General Construction Type: Exterior Concrete/Sandstone 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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	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 Depreciation-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	\$ 25,854	30	\$ 25,854	\$	\$ 749,771	4
5				2005	3,461,500	86,538	40	86,538		439,899	5
6				2006	1,109,737	27,743	40	27,743		133,289	6
7											7
8											8
	Improvement Type**										
9	ROOF			1982	3,837		7			3,837	9
10	BUILDING IMPROVEMENTS			1994	2,914		10			2,914	10
11	ROOF			1996	68,042	2,268	30	2,268		31,942	11
12	ROOF			1996	11,450	382	30	382		5,280	12
13	ELECTRICAL - NEW WIRING			1997	23,632	945	25	945		12,131	13
14	DRYWALL			1997	21,125	1,408	15	1,408		17,839	14
15	CARPET			1998	7,927		7			7,927	15
16	SIGN			1998	2,000	133	15	133		1,622	16
17	WALL PAPER			1998	2,435		7			2,435	17
18	PLASTIC COAT - ROOF - WING 5			1998	12,500	417	30	417		5,208	18
19	12 LAVATORY FAUCETS			1998	4,470	298	15	298		3,775	19
20	9 OVERHEAD LIGHTS			1998	921	61	15	61		778	20
21	EXIT SIGN			1998	449	30	15	30		380	21
22	OTHER MG-INCLUDING PLUMBING			1998	9,003	600	15	600		7,502	22
23	CARPET, CURTAINS, BLINDS			1998	11,249		10			11,249	23
24	CARPET, CURTAINS, BLINDS			1998	19,656		10			19,656	24
25	FUEL TANK			1999	8,935	596	15	596		6,751	25
26	WALL PAPER			1999	4,135	276	15	276		3,147	26
27	KITCHEN			2000	4,230	247	10	247		4,231	27
28	BRITTINGTON AIR & WATER			2000	1,992		7			1,992	28
29	BUILDING HANDRAILS			2000	3,818		7			3,818	29
30	NORTH-SIDE HEATERS			2001	6,090		7			6,090	30
31	WATER HEATERS			2001	15,196		7			15,196	31
32	TILE - WING 7			2000	3,753		7			3,573	32
33	FIRE DOORS			2000	4,861	486	10	486		4,739	33
34	LAND IMPROVEMENTS			1982	14,363		10			14,363	34
35	GAZEBO			1997	3,495		10			3,495	35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	PARKING LOT REPAVEMENT	1997	\$ 12,677	\$	10	\$	\$	\$ 12,677	37
38	LANDSCAPING	1997	8,836	589	15	589		7,462	38
39	DITCH WORK	1997	700	47	15	47		603	39
40	RESEAL PARKING LOT	1999	3,336		5			3,336	40
41	LANDSCAPING	1999	976	65	15	65		743	41
42	LAND IMPROVEMENTS	2000	647	43	15	43		449	42
43	LAND IMPROVEMENTS	2001	380	25	15	25		243	43
44	LAND IMPROVEMENTS	2005	316,403	21,094	15	21,094		107,226	44
45	POLE BARN	2007	12,485	832	15	832		9,502	45
46	LAND IMPROVEMENTS - PAVING	2008	14,053	937	15	937		1,874	46
47	SHELTER HOUSE	2008	10,188	679	15	679		1,641	47
48	PURF PIPE IN PARKING LOT	2009	4,110	274	15	274		320	48
49	RESEAL PARKING LOT	2009	5,218	348	15	348		696	49
50	SILVERLINE WINDOWS	2009	8,092	539	15	539		629	50
51	PARKING LOT REPAVEMENT	2009	12,469	797	15	797		797	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,029,910	\$ 174,551		\$ 174,551	\$	\$ 1,673,027	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 517,982	\$ 49,978	\$ 49,978	\$	VAR	\$ 411,404	71
72	Current Year Purchases	31,349	699	699		VAR	699	72
73	Fully Depreciated Assets	170,900					170,900	73
74								74
75	TOTALS	\$ 720,231	\$ 50,677	\$ 50,677	\$		\$ 583,003	75

D. Vehicle Depreciation (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	1986 MAZDA TRUCK	1992	\$ 4,474	\$	\$	\$	5	\$ 4,474	76
77	FACILITY USE	1996 CHEVY VAN	1995	23,548				5	23,548	77
78	FACILITY USE	1998 FORD PICKUP	2002	9,799				5	9,799	78
79	FACILITY USE	VAN - DONATED	2009	2,700	540	540		5	720	79
80	TOTALS			\$ 40,521	\$ 540	\$ 540	\$		\$ 38,541	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)	\$ 6,939,878	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,768	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 225,768	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,294,571	85

**

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328

Report Period Beginning:

9/1/2009

Ending: 8/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 10,682 Description: Carpet Clean Mach 515; Cooler Rental 14; Postage Mach 976; Copy Machs 7,246; GB Alloc 1,931

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 994	\$	\$ 994
2	Books and Supplies		668		668
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	\$	\$ 1,662	\$	\$ 1,662
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,662		

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	10a-3	hrs	\$	4,604	\$ 298,021	\$	4,604	\$ 298,021	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,579	109,839		2,579	109,839	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,444	356,688	3,606	5,444	360,294	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,627	\$ 764,548	\$ 3,606	12,627	\$ 768,154	14

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 Report Period Beginning: 9/1/2009 Ending: 8/31/2010
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 8/31/2010 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 424,272	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	705,618		3
4	Supply Inventory (priced at)	47,803		4
5	Short-Term Investments			5
6	Prepaid Insurance	66,406		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,244,099	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216		13
14	Buildings, at Historical Cost	6,029,910		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	760,753		16
17	Accumulated Depreciation (book methods)	(2,288,228)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,651,651	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,895,750	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 467,652	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,279,516		29
30	Accrued Salaries Payable	138,602		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,072		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	26,335		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	ACCRUED PROVIDER TAX	8,370		36
37	ADV BILLING; RES TRUST; SEC DEP	(150,812)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,782,735	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,787,040		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)	\$ 5,787,040	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,569,775	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,674,025)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,895,750	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,037,714)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,037,714)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(636,312)	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)	\$ (636,312)	17
	B. Transfers (Itemize):		
18	ROUNDING	1	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,674,025)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **OAKVIEW HEIGHTS CONTINUOUS CARE & R # 0026328** Report Period Beginning: **9/1/2009**Ending: **8/31/2010**

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,377,788	1
2	Discounts and Allowances for all Levels	(2,344,461)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,033,327	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,699,915	6
7	Oxygen	10,377	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,710,292	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	5,194	13
14	Non-Patient Meals	605	14
15	Telephone, Television and Radio	5,341	15
16	Rental of Facility Space		16
17	Sale of Drugs	121,175	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,867	19
20	Radiology and X-Ray	1,387	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 206,569	23
D. Non-Operating Revenue			
24	Contributions	5,416	24
25	Interest and Other Investment Income***	4,912	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,328	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	9,525	28
28a	MISC INC 8,818; OIL LEASE ROYALTIES 6,409	15,227	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,752	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,985,268	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	940,342	31
32	Health Care	2,552,426	32
33	General Administration	1,278,967	33
B. Capital Expense			
34	Ownership	576,781	34
C. Ancillary Expense			
35	Special Cost Centers	210,536	35
36	Provider Participation Fee	62,528	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,621,580	40
41	Income before Income Taxes (line 30 minus line 40)**	(636,312)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (636,312)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation. FORM 990

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

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

Facility Name & ID Number **OAKVIEW HEIGHTS CONTINUOUS CARE & REHAB**

0026328

Report Period Beginning: **9/1/2009**

Ending:

8/31/2010

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	1,952	1,995	\$ 58,356	\$ 29.25	1
2	Assistant Director of Nursing	14	14	139	9.93	2
3	Registered Nurses	12,710	13,069	282,012	21.58	3
4	Licensed Practical Nurses	23,616	24,944	429,842	17.23	4
5	CNAs & Orderlies	62,009	65,248	708,432	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,030	2,223	27,724	12.47	9
10	Activity Assistants	4,765	4,970	42,578	8.57	10
11	Social Service Workers	3,412	3,575	46,893	13.12	11
12	Dietician					12
13	Food Service Supervisor	2,010	2,223	28,215	12.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,862	28,343	237,036	8.36	15
16	Dishwashers					16
17	Maintenance Workers	4,421	4,493	51,498	11.46	17
18	Housekeepers	16,097	16,863	144,459	8.57	18
19	Laundry	6,319	6,783	56,221	8.29	19
20	Administrator	1,852	2,127	68,179	32.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,547	6,933	97,869	14.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,601	2,835	25,823	9.11	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTICIAN	933	1,031	9,705	9.41	33
34	TOTAL (lines 1 - 33)	178,150	187,669	\$ 2,314,981 *	\$ 12.34	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	Monthly	\$ 8,996	1-3	35
36	Medical Director	Monthly	9,125	9-3	36
37	Medical Records Consultant	Monthly	1,995	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	Monthly	1,592	11-3	44
45	Social Service Consultant	Monthly	1,584	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,292		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	Ownership %	Amount	Description	Amount	Description	Amount	
ROY BIGGERSTAFF	ADMINISTRATOR	N/A	\$ 65,294	Workers' Compensation Insurance	\$ 163,867	IDPH License Fee	\$	
GAY EDMONDS	ADMINISTRATOR	N/A	2,885	Unemployment Compensation Insurance	20,039	Advertising: Employee Recruitment	8,023	
				FICA Taxes	174,299	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance		Background Checks	48 1,378	
				Employee Meals		Dues and Subscriptions	8,113	
				Illinois Municipal Retirement Fund (IMRF)*		Drug Testing	1,704	
				Hospital and Employee Benefits	94,120	Advertising and Promotion	27,839	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,179			GBNH Board Alloc	597	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	(27,839)	
			\$			Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 19,815	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)				
						G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			Description	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount	
Voccollect Healthcare Systems	Accunurse Charting Syst		\$ 24,158			\$	Out-of-State Travel	
Duane Morris LLP/John Farrar	Legal fees 52,034 / 748		52,782				\$	
Wilcox, McCorkle & Co, LTD	Auditing/Acctg/Consulting		9,300					
BKD, LLP	Consulting/Mcr Recovery		29,150				In-State Travel	
Healthlink, Inc	Admin fees for proc claims		42				6,886	
CLIA Lab/ Rehab Care Group	Lab Cert 150/Admin fee 876		1,026					
Gibson Tech Svcs	Survey fac for wireless access		1,188					
MDI	Clin/Fin Software hosting		27,659				Seminar Expense	
CTS 38,532/ Tech Profs 3,699	Network Svc/Software Maint/Sv		42,231				11,749	
Chase 149/ Menards 20	Comp battery/Comp Room		169				GBNH Board Alloc	
Great Amer Leasing Corp	Copy Mach Rental		1,159				6,487	
GBNH Board	Management fees		283,637				Entertainment Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 472,501	TOTAL		\$	()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 25,122

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION** # **0026328** Report Period Beginning: **9/1/2009** Ending: **8/31/2010**

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. IL HEALTH CARE ASSOC - \$4,554
- (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. \$ 19,165 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. \$ 62,528
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 benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 605
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation. Training and meetings - Schedules attached.
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? _____
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: WILCOX, MCCORKLE & COMPANY, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.