

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

0026328 Report Period Beginning: 09/01/14 Ending: 08/31/15

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	90	Skilled (SNF)	90	32,850	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	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		95	5,618	5,713	8
9	SNF/PED					9
10	ICF	15,349	8,520		23,869	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,349	8,615	5,618	29,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.05%

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 _____ 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 _____

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 08/31/15 Fiscal Year: 08/31/15

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

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	221,133	22,466	10,520	254,119		254,119		254,119		1
2	Food Purchase		191,152		191,152		191,152	(396)	190,756		2
3	Housekeeping	123,509	8,114	230	131,853		131,853		131,853		3
4	Laundry	44,000	11,636		55,636		55,636		55,636		4
5	Heat and Other Utilities			134,417	134,417		134,417	316	134,733		5
6	Maintenance	60,791	38,772	16,527	116,090		116,090	963	117,053		6
7	Other (specify):*										7
8	TOTAL General Services	449,433	272,140	161,694	883,267		883,267	883	884,150		8
	B. Health Care and Programs										
9	Medical Director			7,700	7,700		7,700		7,700		9
10	Nursing and Medical Records	1,435,487	124,419	3,517	1,563,423		1,563,423		1,563,423		10
10a	Therapy		1,388	721,219	722,607		722,607		722,607		10a
11	Activities	35,016	1,734	2,637	39,387		39,387		39,387		11
12	Social Services	31,021	6	2,103	33,130		33,130		33,130		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,501,524	127,547	737,176	2,366,247		2,366,247		2,366,247		16
	C. General Administration										
17	Administrative	87,453			87,453		87,453		87,453		17
18	Directors Fees										18
19	Professional Services			92,988	92,988	(1,771)	91,217	(6,091)	85,126		19
20	Dues, Fees, Subscriptions & Promotions			14,417	14,417		14,417	(2,841)	11,576		20
21	Clerical & General Office Expenses	131,855	6,901	438,970	577,726	1,771	579,497	(175,229)	404,268		21
22	Employee Benefits & Payroll Taxes			348,834	348,834		348,834	53,189	402,023		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,633	11,633		11,633	(11,633)			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			72,411	72,411		72,411	6,492	78,903		26
27	Other (specify):*										27
28	TOTAL General Administration	219,308	6,901	979,253	1,205,462		1,205,462	(136,113)	1,069,349		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,170,265	406,588	1,878,123	4,454,976		4,454,976	(135,230)	4,319,746		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			173,468	173,468	173,468	9,278	182,746				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			197,061	197,061	197,061	21,517	218,578				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,419	14,419	14,419	1,930	16,349				35
36	Other (specify):*											36
37	TOTAL Ownership			384,948	384,948	384,948	32,725	417,673				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			212,458	212,458	212,458		212,458				39
40	Barber and Beauty Shops		21		21	21		21				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,638	212,638	212,638	(4,311)	208,327				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		21	425,096	425,117	425,117	(4,311)	420,806				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,170,265	406,609	2,688,167	5,265,041	5,265,041	(106,816)	5,158,225				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	(396)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,145)	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	(4,700)	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	(5,784)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,841)	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	(49,581)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (64,447)		\$	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	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (64,447)		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		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OAKVIEW HTS CONT C & REH CTR

ID# 0026328

Report Period Beginning: 09/01/14

Ending: 08/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MISC INCOME	\$ (5,249)	21	1
2	TRAVEL	(11,633)	24	2
3	LEGAL FEES	(28,388)	19	3
4	LATE FEE	(4,311)	42	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		(49,581)	49

STATE OF ILLINOIS

Summary A

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

0026328

Report Period Beginning:

09/01/14

Ending:

08/31/15

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	(396)	0	0	0	0	0	0	0	0	0	0	(396)	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	(1,145)	1,461	0	0	0	0	0	0	0	0	0	316	5
6	Maintenance	0	963	0	0	0	0	0	0	0	0	0	963	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,541)	2,424	0	883	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	(28,388)	22,297	0	0	0	0	0	0	0	0	0	(6,091)	19
20	Fees, Subscriptions & Promotions	(2,841)	0	0	0	0	0	0	0	0	0	0	(2,841)	20
21	Clerical & General Office Expenses	(11,033)	(164,196)	0	0	0	0	0	0	0	0	0	(175,229)	21
22	Employee Benefits & Payroll Taxes	0	53,189	0	0	0	0	0	0	0	0	0	53,189	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,633)	0	0	0	0	0	0	0	0	0	0	(11,633)	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	6,492	0	0	0	0	0	0	0	0	0	6,492	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(53,895)	(82,218)	0	(136,113)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,436)	(79,794)	0	(135,230)	29								

STATE OF ILLINOIS

Summary B

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

0026328

Report Period Beginning:

09/01/14 Ending:

08/31/15

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	9,278	0	0	0	0	0	0	0	0	0	9,278	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,700)	26,217	0	0	0	0	0	0	0	0	0	21,517	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	1,930	0	0	0	0	0	0	0	0	0	1,930	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,700)	37,425	0	32,725	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	(4,311)	0	0	0	0	0	0	0	0	0	0	(4,311)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(4,311)	0	0	0	0	0	0	0	0	0	0	(4,311)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(64,447)	(42,369)	0	(106,816)	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
NONE		GENERAL BAPT NH OF CAMPBELL	CAMPBELL, MO	GEN BAPT HCARE	PIGGOTT, AR	MGMT
NONE		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	\$	Heat and Other Utilities		\$ 1,461	\$ 1,461	1
2	V	6 Maintenance		Maintenance		963	963	2
3	V	19 Professional Services		Professional Services		22,297	22,297	3
4	V	21 Mgmt Fees	400,000	Salary & Wages		222,479	(177,521)	4
5	V	21 Supplies		Supplies		13,325	13,325	5
6	V	22 Employee Bene & Payroll Tax		Employee Bene & Payroll Tax		53,189	53,189	6
7	V	26 Insurance		Insurance		6,492	6,492	7
8	V	30 Depreciation		Depreciation		9,278	9,278	8
9	V	32 Interest Expense		Interest Expense		26,217	26,217	9
10	V	35 Rental & Leasing		Rental & Leasing		1,930	1,930	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 400,000			\$ 357,631	\$ * (42,369)	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: 09/01/14 Ending: 08/31/15

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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:

09/01/14

Ending: 08/31/15

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Oakview Heights (OH)	Direct Costs	13,327,374		\$ 962,385	\$ 598,693	4,952,564	\$ 357,631	1
2	Oakview Villa (OV)	Direct Costs	13,327,374		962,385	598,693	776,544	56,075	2
3	Campbell (CB)	Direct Costs	13,327,374		962,385	598,693	3,845,094	277,659	3
4	Piggott (PG)	Direct Costs	13,327,374		962,385	598,693	2,763,382	199,547	4
5	Magnolia Manor (MM)	Direct Costs	13,327,374		962,385	598,693	989,790	71,474	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				\$ 4,811,927	\$ 2,993,463		\$ 962,386	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	Name of Lender	2		3	4	5	6		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 REFINANCED		08/2013	\$ 6,007,277	\$ 5,847,032	08/2053	3.0000	\$ 176,739						
2	DE LAGE LANDEN FIN		X	PATIENT TRANSPORT VAN		02/2015	44,472	39,861	01/2020	5.2300	1,297						
3																	
4																	
5																	
Working Capital																	
6	FNB OF PARAGOULD		X	LINE OF CREDIT		02/2015	500,000	389,363	02/2015	5.0000	19,026						
7	GEN BAPTIST NH BOARD	X		LOAN		01/2006	376,498	1,058,565	ON DEM	NONE							
8																	
9	TOTAL Facility Related						\$ 6,928,247	\$ 7,334,821			\$ 197,061						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 6,928,247	\$ 7,334,821			\$ 197,061						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 32,365 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 2014 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 2015 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:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

2014 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 2014 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 2014.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <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 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENT USE</u>	<u>352,863</u>	<u>1981</u>	<u>\$ 89,216</u>	1
2	<u>RESIDENT USE</u>	<u>270,630</u>	<u>1994</u>	<u>60,000</u>	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	4
5			2005	3,461,500	86,538	40	86,538		872,587	5
6			2006	1,109,737	27,743	40	27,743		272,005	6
7										7
8										8
Improvement Type**										
9	Roof		1982	3,837		7			3,837	9
10	Land Improvements		1982	14,363		10			14,363	10
11	Building Imp.- Smith Consult.		1994	2,914		10			2,914	11
12	Roof		1996	68,042	2,268	30	2,268		43,282	12
13	Roof		1996	11,450	382	30	382		7,188	13
14	Parking Lot Repavement		1997	12,677		10			12,677	14
15	Ditch Work		1997	700		15			700	15
16	Gazebo		1997	3,495		10			3,495	16
17	Electrical-New Wing		1997	23,632	945	25	945		16,858	17
18	Landscaping		1997	8,837		15			8,837	18
19	Drywall		1997	21,125		15			21,125	19
20	12 Lavatory+Faucets		1998	4,470		15			4,470	20
21	9 Overhead Lights		1998	921		15			921	21
22	Exit Sign		1998	449		15			449	22
23	Other MG- Including Plumbing		1998	9,003		15			9,003	23
24	Wall Paper		1998	2,435		7			2,435	24
25	Plastic Coat-Roof-Wing 5		1998	12,500	417	30	417		7,292	25
26	Carpet		1998	7,927		7			7,927	26
27	Sign		1998	2,000		15			2,000	27
28	Carpet,Curtains, Blinds		1998	11,249		10			11,249	28
29	Carpet,Curtains, Blinds		1998	19,656		10			19,656	29
30	Landscaping		1999	976		15			976	30
31	Wall Paper		1999	4,135		15			4,135	31
32	Reseal Parking Lot		1999	3,336		5			3,336	32
33	Fuel Tank		1999	8,935		15			8,935	33
34	Land Improvements		2000	647	25	15	25		647	34
35	Kitchen		2000	4,231		10			4,231	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 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	25	15	25		369	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	21,093	15	21,093		21,261	44
45	Pole Barn	2007	12,485	832	15	832		7,143	45
46	Shelter House	2008	10,188	679	15	679		5,036	46
47	Land Improvements - Paving	2008	14,053	937	15	937		6,557	47
48	Reseal Parking Lot	2008	5,218	348	15	348		2,435	48
49	Silverline Windows	2009	8,092	540	15	540		3,327	49
50	Purf Pipe in Parking Lot	2009	4,110	274	15	274		1,690	50
51	Parking Lot Repavement	2009	12,469	831	15	831		4,953	51
52	Sidewalk	2011	5,556	370	15	370		1,451	52
53	Breezeway	2011	9,748	650	15	650		2,437	53
54	Sewer Replacement	2012	39,848	2,657	15	2,657		7,306	54
55	Water Heater	2012	8,600	573	15	573		1,529	55
56	HVAC	2013	6,665	171	39	171		313	56
57	Parking Lot Repavement	2014	15,645	1,369	10	1,369		1,369	57
58	Roof	2014	11,580	338	30	338		338	58
59	Water Heater	2015	7,900	362	10	362		362	59
60	Roof	2015	9,658	148	30	148		148	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)		\$ 6,145,112	\$ 150,515		\$ 150,515	\$	\$ 2,246,889	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	\$ 106,870	\$ 16,440	\$ 16,440	\$	7	\$ 60,822	71
72	Current Year Purchases	15,392	1,297	1,297		7	1,297	72
73	Fully Depreciated Assets	680,144	398	398		7	680,144	73
74								74
75	TOTALS	\$ 802,406	\$ 18,135	\$ 18,135	\$		\$ 742,263	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	76
77	FACILITY USE	96 Chevy Van	1995	23,548				5	23,548	77
78	FACILITY USE	Donated Van	2009	2,700				5	2,700	78
79	FACILITY USE	Ford E-250	2015	44,472	4,818	4,818		5	4,818	79
80	TOTALS			\$ 75,194	\$ 4,818	\$ 4,818	\$		\$ 35,540	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)	\$ 7,171,928	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,468	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,468	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)	\$ 3,024,692	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/14 Ending: 08/31/15
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 type="checkbox"/> YES <input checked="" 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 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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$	4,926	\$ 337,118	\$	4,926	\$ 337,118	1
2	Licensed Speech and Language Development Therapist		hrs		1,347	92,184		1,347	92,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,265	291,917	1,388	4,265	293,305	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			\$	10,538	\$ 721,219	\$ 1,388	10,538	\$ 722,607	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 HTS CONT C & REH CTR**

0026328

Report Period Beginning: **09/01/14**

Ending:

08/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **08/31/15** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 576,629	\$ 594,680	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	1,253,985	1,411,922	3
4	Supply Inventory (priced at)	13,676	18,558	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,106	36,778	6
7	Other Prepaid Expenses	2,622	2,622	7
8	Accounts Receivable (owners or related parties)	468,380		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,344,398	\$ 2,064,560	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	6,145,111	8,259,964	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	877,600	1,018,320	16
17	Accumulated Depreciation (book methods)	(3,216,123)	(3,971,853)	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)	\$ 3,955,804	\$ 5,485,647	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,300,202	\$ 7,550,207	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 621,389	\$ 637,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,447,928	389,363	29
30	Accrued Salaries Payable	54,110	61,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,928	35,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,618	20,275	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	ADV BILLING SEC DEPOSITS RES TR	13,891	19,124	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,182,864	\$ 1,162,708	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	5,886,893	9,208,558	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)	\$ 5,886,893	\$ 9,208,558	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,069,757	\$ 10,371,266	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,769,555)	\$ (2,821,059)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,300,202	\$ 7,550,207	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,019,832)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,019,832)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	250,277	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)	\$ 250,277	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)	\$ (1,769,555)	24 *

* This must agree with page 17, line 47.

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	\$ 5,806,014	1
2	Discounts and Allowances for all Levels	(2,148,974)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,657,040	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,664,224	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,664,224	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	396	14
15	Telephone, Television and Radio	1,145	15
16	Rental of Facility Space		16
17	Sale of Drugs	144,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,258	19
20	Radiology and X-Ray	463	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 181,121	23
D. Non-Operating Revenue			
24	Contributions	2,984	24
25	Interest and Other Investment Income***	4,700	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,684	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	5,249	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,249	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,515,318	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	883,267	31
32	Health Care	2,366,247	32
33	General Administration	1,205,462	33
B. Capital Expense			
34	Ownership	384,948	34
C. Ancillary Expense			
35	Special Cost Centers	212,479	35
36	Provider Participation Fee	212,638	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,265,041	40
41	Income before Income Taxes (line 30 minus line 40)**	250,277	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 250,277	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,624,342	44
45	Private Pay - Net Inpatient Revenue	1,257,534	45
46	Medicare - Net Inpatient Revenue	644,818	46
47	Other-(specify) <u>Manage Care/Hospice</u>	130,346	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,657,040	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A FRM 990 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.

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

0026328

Report Period Beginning:

09/01/14

Ending:

08/31/15

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	2,162	2,133	\$ 64,131	\$ 30.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,802	16,576	347,735	20.98	3
4	Licensed Practical Nurses	20,848	20,567	361,615	17.58	4
5	CNAs & Orderlies	63,494	62,639	662,005	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,734	3,684	35,016	9.50	10
11	Social Service Workers	2,080	2,052	31,021	15.12	11
12	Dietician					12
13	Food Service Supervisor	2,794	2,756	29,349	10.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,142	21,844	191,784	8.78	15
16	Dishwashers					16
17	Maintenance Workers	4,057	4,002	60,791	15.19	17
18	Housekeepers	14,021	13,832	123,509	8.93	18
19	Laundry	5,063	4,995	44,000	8.81	19
20	Administrator	2,080	2,052	87,453	42.62	20
21	Assistant Administrator	2,080	2,052	59,072	28.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,333	5,261	72,784	13.83	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,690	164,445	\$ 2,170,265 *	\$ 13.20	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 7,700	9-3	36
37	Medical Records Consultant	MONTHLY 2,047	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)	\$ 9,747		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			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
SCOTTIE COLE	ADMINISTRATOR	N/A	\$ 52,807	Workers' Compensation Insurance	\$ 108,968	IDPH License Fee	\$		
CATHY ASH	ADMINISTRATOR	N/A	34,646	Unemployment Compensation Insurance	47,621	Advertising: Employee Recruitment			
			0	FICA Taxes	163,127	Health Care Worker Background Check	3,400		
				Employee Health Insurance	28,087	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		DRUG TESTING	609		
				OTHER EMPLOYEE BENEFITS	1,031	LICENSES	2,150		
				GBHC BD ALLOC PAY TAXES & OTH BENE	53,189	DUES & SUBSCRIPTIONS	5,417		
						ADVERTISING & MARKETING	2,841		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,453			Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	(2,841)		
Description			Amount			Yellow page advertising	()		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
DUANE MORRIS LLP	Legal		\$ 28,388			\$	Out-of-State Travel	\$	
BKD CPAs	Accting		(2,221)						
WILCOX & CO	Accting		10,000						
CTS	Software/Computer Maint		28,447				In-State Travel		
JK COMP SOLUTIONS, INC.	Software/Computer Maint		770						
MDI	Software/Computer Maint		25,293						
ATS	Software/Computer Maint		540				Seminar Expense		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 91,217	TOTAL		\$	Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$4,356
- (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. \$ 33,820 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. \$ 208,327
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. \$ 396
- (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: WILCOX MCCORKLE & COMPANY
- (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
TRIAL BALANCE (GROUPING)
AUGUST 31 2015

Sub1	Account Number	Account Description		Amount	TOTAL
MEDICAID GROUPING					
A11	69100.000	Wages - Supervisor	Dietary	28,172	
A11	69110.000	Wages - Regular	Dietary	184,093	
A11	69150.000	Wages - Vacation/Holiday/Sick	Dietary	8,867	221,133
A12	69670.000	Supplies (Non-Food)	Dietary	22,466	22,466
A13	69850.000	Purchased Services	Dietary	10,520	10,520
A22	69680.000	Food Supplements	Dietary	10,122	
A22	69690.000	Raw Food	Dietary	181,030	191,152
A31	71100.000	Wages - Supervisor	Housekeeping	16,840	
A31	71110.000	Wages - Regular	Housekeeping	99,451	
A31	71150.000	Wages - Vacation/Holiday/Sick	Housekeeping	7,217	123,509
A32	71660.000	Chemicals	Housekeeping	621	
A32	71670.000	Supplies	Housekeeping	3,771	
A32	71690.000	Paper/Plastic	Housekeeping	3,373	
A32	71720.000	Small Equipment Purchase	Housekeeping	349	8,114
A33	71850.000	Purchased Services	Housekeeping	230	230
A41	70110.000	Wages - Regular	Laundry	40,995	
A41	70150.000	Wages - Vacation/Holiday/Sick	Laundry	3,005	44,000
A42	70660.000	Chemicals	Laundry	9,954	
A42	70670.000	Supplies	Laundry	59	
A42	70690.000	Linen	Laundry	1,623	11,636
A53	72520.000	Electricity	Plant & Maintenance	99,708	
A53	72525.000	Cable Television	Plant & Maintenance	7,611	
A53	72530.000	Water	Plant & Maintenance	17,320	
A53	72535.000	Sewer	Plant & Maintenance	9,778	134,417
A61	72110.000	Wages - Regular	Plant & Maintenance	59,897	
A61	72150.000	Wages - Vacation/Holiday/Sick	Plant & Maintenance	894	60,791
A62	72660.000	Building Repair & Maintenance	Plant & Maintenance	19,198	
A62	72667.000	Vehicle Repair & Maintenance	Plant & Maintenance	1,348	
A62	72670.000	Supplies	Plant & Maintenance	5,056	
A62	72690.000	Grounds Maintenance	Plant & Maintenance	4,197	
A62	72695.000	Grounds Landscaping	Plant & Maintenance	399	
A62	72720.000	Small Equipment Purchase	Plant & Maintenance	43	
A62	72730.000	Repair & Maintenance	Plant & Maintenance	8,531	38,772

A63	72540.000	Trash Removal	Plant & Maintenance	6,750	
A63	72550.000	Service Contracts	Plant & Maintenance	4,637	
A63	72675.000	Pest Control	Plant & Maintenance	3,101	
A63	72850.000	Purchased Services	Plant & Maintenance	1,851	
A63	72900.000	Other	Plant & Maintenance	189	16,527
B101	63100.000	Wages - R.N.	Nursing Medicare Dist.	56,989	
B101	64100.000	Wages - R.N.	Nursing Non Distinct	272,978	
B101	64110.000	Wages - L.P.N.	Nursing Non Distinct	343,138	
B101	64120.000	Wages - Aides	Nursing Non Distinct	619,174	
B101	64145.000	Wages - Ward Clerk	Nursing Non Distinct	9,005	
B101	64150.000	Wages - Vacation/Holiday/Sick	Nursing Non Distinct	70,071	
B101	67100.000	Wages - DON	Nursing Administration	63,551	
B101	67150.000	Wages - Vacation/Holiday/Sick	Nursing Administration	580	1,435,487
B102	64600.000	Supplies (Non-Medical)	Nursing Non Distinct	23,820	
B102	67600.000	Supplies (Non-Medical)	Nursing Administration	1,143	
B102	67720.000	Small Equipment Purchased	Nursing Administration	264	
B102	86900.000	Non-Billable Non-Distinct	Medical Supplies	13,345	
B102	86905.000	Blood Sugar Testing	Medical Supplies	717	
B102	86915.000	Nursing Supplies	Medical Supplies	25,690	
B102	86920.000	Briefs	Medical Supplies	33,820	
B102	86925.000	Small Equipment Purchase	Medical Supplies	2,096	
B102	86930.000	Oxygen	Medical Supplies	23,526	124,419
B103	64850.000	Medical Records Consultant	Nursing Non Distinct	2,047	
B103	67850.000	Purchased Services	Nursing Administration	1,470	3,517
B10a2	80670.000	Supplies	Physical Therapy	1,388	1,388
B10a3	80250.000	Workers Compensation	Physical Therapy	952	
B10a3	80950.000	Purchased Services/part A	Physical Therapy	196,056	
B10a3	80951.000	Purchased Services/part B	Physical Therapy	94,908	
B10a3	81250.000	Workers Compensation	Occupational Therapy	583	
B10a3	81950.000	Purchased Services/ Part A	Occupational Therapy	230,999	
B10a3	81951.000	Purchased Services/part B	Occupational Therapy	105,536	
B10a3	82950.000	Purchased Services/part A	Speech Therapy	49,109	
B10a3	82951.000	Purchased Services/part B	Speech Therapy	43,014	
B10a3	82952.000	Purchased Services Insurance	Speech Therapy	44	
B10a3	82953.000	Purchased Services Private Pay	Speech Therapy	17	721,219
B111	61110.000	Wages - Regular	Activities	33,621	
B111	61150.000	Wages - Vacation/Holiday/Sick	Activities	1,395	35,016
B112	61650.000	Supplies	Activities	1,734	1,734
B113	61660.000	Entertainment	Activities	460	
B113	61850.000	Purchased Services	Activities	2,177	2,637

B121	62100.000	Wages - Supervisor	Social Services	31,021	31,021
B122	62650.000	Supplies	Social Services	6	6
B123	62850.000	Purchased Services	Social Services	2,103	2,103
B93	83050.000	Medical Director	Medical Director	7,700	7,700
C171	73100.000	Wages - Administrator	General & Administration	87,453	87,453
C193	73430.000	Legal Fees	General & Administration	28,388	
C193	73440.000	Accounting Fees	General & Administration	7,779	
C193	73520.000	Software Maintenance	General & Administration	56,821	92,988
C203	73510.000	Advertising	General & Administration	1,043	
C203	73515.000	Adv. Help Wanted	General & Administration	375	
C203	73810.000	Dues & Subscriptions	General & Administration	5,417	
C203	73835.000	Back Ground Check	General & Administration	3,400	
C203	73845.000	Drug Testing	General & Administration	609	
C203	73855.000	Marketing	General & Administration	1,423	
C203	73870.000	Licenses	General & Administration	2,150	14,417
C211	73110.000	Wages - Regular	General & Administration	70,983	
C211	73150.000	Wages - Vacation/Holiday/Sick	General & Administration	1,801	
C211	75100.000	Wages	Operations	59,072	131,855
C212	73670.000	Office Supplies	General & Administration	5,495	
C212	73860.000	Postage	General & Administration	1,355	
C212	73880.000	Printing	General & Administration	50	6,901
C213	65600.000	Supplies (Non-Medical)	Nursing Res. Care	6,476	
C213	72500.000	Telephone/Internet	Plant & Maintenance	16,854	
C213	73445.000	Late Fees	General & Administration	5,784	
C213	73455.000	Service Charge	General & Administration	25	
C213	73580.000	Taxes - General	General & Administration	513	
C213	73720.000	Small Equipment Purchase	General & Administration	953	
C213	73815.000	Management Fees	General & Administration	400,000	
C213	73850.000	Purchased Services	General & Administration	5,258	
C213	73885.000	Resident Expense	General & Administration	46	
C213	73900.000	Miscellaneous	General & Administration	3,062	438,970
C223	73200.000	Payroll Taxes	General & Administration	163,127	
C223	73250.000	Workers Compensation	General & Administration	108,968	
C223	73280.000	Unemployment	General & Administration	47,621	
C223	73300.000	Group Insurance	General & Administration	28,087	
C223	73901.000	Employee Benefit	General & Administration	1,031	348,834
C243	65830.000	Education	Nursing Res. Care	0	
C243	67830.000	Education	Nursing Administration	662	
C243	69830.000	Education	Dietary	470	
C243	73750.000	Auto Expense	General & Administration	1,863	

C243	73820.000	Travel & Seminar	General & Administration	4,086	
C243	73825.000	Meals & Entertainment	General & Administration	2,600	
C243	73830.000	Education	General & Administration	553	
C243	73840.000	Mileage Reimbursement	General & Administration	1,399	11,633
C263	73523.000	MIP Insurance	General & Administration	32,365	
C263	73525.000	Property Insurance	General & Administration	8,921	
C263	73530.000	Insurance	General & Administration	29,997	
C263	73535.000	Auto Insurance	General & Administration	1,128	72,411
D303	73550.000	Depreciation	General & Administration	173,468	173,468
D323	73435.000	Interest	General & Administration	197,061	197,061
D353	72700.000	Equipment Rental	Plant & Maintenance	3,393	
D353	73700.000	Equipment Rental	General & Administration	4,898	
D353	73740.000	Copier Equipment	General & Administration	5,892	
D353	86910.000	Equipment Rental	Medical Supplies	236	14,419
E393	84050.000	Dental Consultant	Dental	1,000	
E393	85660.000	Legend Drugs	Pharmacy	157,968	
E393	85670.000	Supplies	Pharmacy	45	
E393	85690.000	Non-Legend Drugs	Pharmacy	14,388	
E393	88005.000	Laboratory - Med A	Laboratory	39,056	212,458
E402	74670.000	Supplies	Beauty Shop	21	21
E423	73585.000	Bed Tax Expense	General & Administration	212,638	212,638
FS01	40100.000	Room And Board	Medicare Part A	(732,883)	
FS01	40110.000	Less: Contractual Adjustment	Medicare Part A	(1,443,704)	
FS01	41100.000	Room And Board	Private Certified	(1,258,093)	
FS01	42100.000	Room And Board	Medicaid Certified	(2,221,145)	
FS01	43100.000	Room And Board	Managed Care Certified	(40,208)	
FS01	44100.000	Room And Board	Hospice Certified	(96,641)	
FS01	52100.000	Room And Board	Insurance	(13,340)	(5,806,014)
FS02	40900.000	Less: Contractual Adjustment	Medicare Part A	1,444,247	
FS02	41110.000	Less: Contractual Adjustment	Private Certified	350	
FS02	41900.000	Less: Contractual Adjustment	Private Certified	209	
FS02	42110.000	Less: Contractual Adjustment	Medicaid Certified	307,489	
FS02	42899.000	Prior Year Adjustment	Medicaid Certified	289,804	
FS02	42900.000	Less: Contractual Adjustment	Medicaid Certified	110	
FS02	43110.000	Less: Contractual Adjustment	Managed Care Certified	(59,033)	
FS02	43900.000	Less: Contractual Adjustment	Managed Care Certified	86,122	
FS02	44110.000	Less: Contractual Adjustment	Hospice Certified	8,868	
FS02	51900.000	Less: Contractual Adjustment	Medicaid Non-Certified	(601)	
FS02	52110.000	Less: Contractual Adjustment	Insurance	(26,551)	
FS02	52900.000	Less: Contractual Adjustment	Insurance	10,436	

FS02	73540.000	Bad Debt Expense	General & Administration	87,522	2,148,972
FS06	40400.000	Physical Therapy	Medicare Part A	(536,137)	
FS06	40450.000	Occupational Therapy	Medicare Part A	(574,611)	
FS06	40500.000	Speech Therapy	Medicare Part A	(168,596)	
FS06	41400.000	Physical Therapy	Private Certified	2,756	
FS06	41450.000	Occupational Therapy	Private Certified	3,503	
FS06	41500.000	Speech Therapy	Private Certified	6,510	
FS06	42400.000	Physical Therapy	Medicaid Certified	1,799	
FS06	43400.000	Physical Therapy	Managed Care Certified	(29,018)	
FS06	43450.000	Occupational Therapy	Managed Care Certified	(30,739)	
FS06	43500.000	Speech Therapy	Managed Care Certified	(11,946)	
FS06	44400.000	Physical Therapy	Hospice Certified	(0)	
FS06	52400.000	Physical Therapy	Insurance	(5,969)	
FS06	52450.000	Occupational Therapy	Insurance	(2,278)	
FS06	52500.000	Speech Therapy	Insurance	(3,322)	
FS06	56450.000	Occupational Therapy	Supported Living	(0)	
FS06	58400.000	Physical Therapy	Medicare Part B	(236,611)	
FS06	58450.000	Occupational Therapy	Medicare Part B	(248,161)	
FS06	58500.000	Speech Therapy	Medicare Part B	(111,014)	
FS06	58900.000	Less: Contractual Adjustment	Medicare Part B	279,610	(1,664,224)
FS14	59411.000	Employee/Guest Meals	Other Revenue	(396)	(396)
FS15	59912.000	Cable Income	Other Revenue	(1,145)	(1,145)
FS17	40250.000	Pharmacy	Medicare Part A	(131,159)	
FS17	43250.000	Pharmacy	Managed Care Certified	(13,734)	
FS17	55200.000	Medical Supplies	Residential Care	35	(144,859)
FS19	40850.000	LAB	Medicare Part A	(32,964)	
FS19	41850.000	LAB	Private Certified	131	
FS19	42850.000	LAB	Medicaid Certified	(297)	
FS19	43850.000	LAB	Managed Care Certified	(453)	
FS19	58850.000	LAB	Medicare Part B	(675)	(34,258)
FS20	40700.000	X-Ray	Medicare Part A	(232)	
FS20	43700.000	X-Ray	Managed Care Certified	(232)	(463)
FS24	59913.000	Donations	Other Revenue	(2,984)	(2,984)
FS25	59511.000	Interest Income	Other Revenue	(1,393)	
FS25	59914.000	Oil Lease Royalties	Other Revenue	(3,219)	
FS25	59916.000	Dividend Income	Other Revenue	(87)	(4,700)
FS28	59111.000	Barber/Beauty	Other Revenue	(59)	
FS28	59711.000	Discounts Earned	Other Revenue	(330)	
FS28	59911.000	Misc. Income	Other Revenue	(4,860)	(5,249)
BS01	10010.000	Cash - Landing	Cash	0	

BS01	10015.000	Cash - Payroll	Cash	(242)	
BS01	10020.000	Cash - Petty	Cash	450	
BS01	10021.000	Cash - Petty, Activities	Cash	200	
BS01	10031.000	Cash - Assistance Fund	Cash	9,806	
BS01	10035.000	Cash - Op Account	Cash	18,703	
BS01	10040.000	Cash - Tax & Insurance Escrow - Gershman	Cash	42,256	
BS01	10041.000	Cash - In FNB Patient Fund	Cash	5,521	
BS01	10045.000	Cash - On Hand Patient Fund	Cash	0	
BS01	10048.000	Cash - Gershman Bus Bank R.R.	Cash	499,936	576,629
BS03	10100.000	A/R - Private	A/R - Operations	113,590	
BS03	10200.000	A/R - Medicaid	A/R - Operations	727,614	
BS03	10300.000	A/R - Medicare Part A	A/R - Operations	195,692	
BS03	10400.000	A/R - Medicare Part B	A/R - Operations	152,152	
BS03	10500.000	A/R - Co-Insurance Part A	A/R - Operations	110,796	
BS03	10600.000	A/R - Co-Insurance Part B	A/R - Operations	31,361	
BS03	10700.000	A/R - Managed Care	A/R - Operations	93,456	
BS03	11000.000	A/R - Hospice	A/R - Operations	29,324	
BS03	12000.000	A/R - Allowance For Bad Debt	A/R - Operations	(200,000)	1,253,985
BS04	14100.000	Supplies - Medical	Inventory	7,562	
BS04	14200.000	Supplies - Dietary	Inventory	2,643	
BS04	14300.000	Supplies - Hskpg./Laundry	Inventory	690	
BS04	14900.000	Supplies - Other	Inventory	2,781	13,676
BS06	15200.000	Prepaid - Insurance	Prepaid Expenses	29,106	29,106
BS07	15100.000	Prepaid - Expenses	Prepaid Expenses	2,622	2,622
BS08	21580.000	Intercompany Account	Current Liabilities	468,380	468,380
BS13	16110.000	Land	Fixed Assets	149,216	149,216
BS14	16100.000	Building	Fixed Assets	5,657,260	
BS14	16105.000	Building Improvements	Fixed Assets	29,138	
BS14	16120.000	Land Improvement	Fixed Assets	458,712	6,145,111
BS16	16150.000	Automobile	Fixed Assets	75,194	
BS16	16200.000	Furniture, Fixture & Equipment	Fixed Assets	802,407	877,600
BS17	16140.000	Accum. Dep. - Land Improvement	Fixed Assets	(283,854)	
BS17	16500.000	Accum. Dep. - Building	Fixed Assets	(2,153,620)	
BS17	16505.000	Accum. Dep. - Building Improvements	Fixed Assets	(847)	
BS17	16550.000	Accum. Dep. - Automobile	Fixed Assets	(35,539)	
BS17	16600.000	Accum. Dep. - FF&E	Fixed Assets	(742,263)	(3,216,123)
BS26	20010.000	Accounts Payable	Current Liabilities	(598,013)	
BS26	20099.000	A/P Suspense	Current Liabilities	(23,376)	(621,389)
BS29	21540.000	Note Payable Line Of Credit - Loan # 80000615	Current Liabilities	(249,363)	
BS29	21550.000	Note Payable Line Of Credit - Loan # 80000623	Current Liabilities	(140,000)	

BS29	25200.000	Due To/From Parent Company	Long Term Liabilities	(1,058,565)	(1,447,928)
BS30	20200.000	Accrued Wages	Current Liabilities	(17,295)	
BS30	20205.000	Accrued Vacation	Current Liabilities	(36,815)	
BS30	20300.000	Employee Benefits	Current Liabilities	0	
BS30	20310.000	Garnishments	Current Liabilities	0	(54,110)
BS31	20110.000	Federal Withholding	Current Liabilities	(7,248)	
BS31	20120.000	State Withholding	Current Liabilities	(3,035)	
BS31	20130.000	FICA Liability - Social Security	Current Liabilities	(4,933)	
BS31	20135.000	FICA W/H - Social Security	Current Liabilities	(4,933)	
BS31	20140.000	FICA Liability - Medicare	Current Liabilities	(1,154)	
BS31	20145.000	FICA W/H - Medicare	Current Liabilities	(1,154)	
BS31	21000.000	Unemployment Liability	Current Liabilities	(8,471)	(30,928)
BS33	20240.000	Accrued Interest	Current Liabilities	(14,618)	(14,618)
BS36	20250.000	Accrued State Provider Tax	Current Liabilities	(8,370)	
BS36	21500.000	Advance Billing	Current Liabilities	0	
BS36	21510.000	Resident Refunds	Current Liabilities	0	
BS36	21530.000	Resident Trust	Current Liabilities	(5,521)	(13,891)
BS39	25100.000	Notes Payable - Gershman Mortgage	Long Term Liabilities	(5,847,032)	
BS39	25110.000	Notes Payable - Automobile	Long Term Liabilities	(39,861)	(5,886,893)
BS47	30100.000	Capital Investment	Equity	(1,322,373)	
BS47	30750.000	Prior Period Adjustment	Equity	52,383	
BS47	30800.000	Retained Earnings	Equity	3,289,821	2,019,832

TOTAL EXPENSES	0	0
NET (INCOME) LOSS		(250,277)