



Facility Name & ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328 Report Period Beginning: 09/01/2016 Ending: 08/31/2017

**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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	136	2	4,851	4,989	8
9	SNF/PED					9
10	ICF	13,859	8,593	83	22,535	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,995	8,595	4,934	27,524	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 83.79%

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

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

NONE

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

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

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

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

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 90 and days of care provided 3,621

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 08/31/2017 Fiscal Year: 08/31/2017

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

Facility Name & ID Number **OAKVIEW HTS CONT C REHAB CTR** # **0026328** Report Period Beginning: **09/01/2016** Ending: **08/31/2017**

**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
	<b>A. General Services</b>										
1	Dietary	211,108	37,439	8,975	257,522		257,522		257,522		1
2	Food Purchase		206,304		206,304		206,304	(78)	206,226		2
3	Housekeeping	113,281	3,947		117,228		117,228		117,228		3
4	Laundry	41,375	4,598		45,973		45,973		45,973		4
5	Heat and Other Utilities			131,850	131,850		131,850	90	131,940		5
6	Maintenance	70,085	46,799	16,427	133,311		133,311	2,124	135,435		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>435,849</b>	<b>299,087</b>	<b>157,252</b>	<b>892,188</b>		<b>892,188</b>	<b>2,136</b>	<b>894,324</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,350	26,350		26,350		26,350		9
10	Nursing and Medical Records	1,432,689	160,356	2,551	1,595,596		1,595,596		1,595,596		10
10a	Therapy		5,716	628,100	633,816		633,816		633,816		10a
11	Activities	44,220	3,640	2,141	50,001		50,001		50,001		11
12	Social Services	31,628	43	2,171	33,842		33,842		33,842		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,508,537</b>	<b>169,755</b>	<b>661,313</b>	<b>2,339,605</b>		<b>2,339,605</b>		<b>2,339,605</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	92,321			92,321		92,321		92,321		17
18	Directors Fees										18
19	Professional Services			102,673	102,673		102,673	(55,274)	47,399		19
20	Dues, Fees, Subscriptions & Promotions			15,916	15,916		15,916	(5,103)	10,813		20
21	Clerical & General Office Expenses	152,240	13,181	370,162	535,583		535,583	(95,492)	440,091		21
22	Employee Benefits & Payroll Taxes			373,547	373,547		373,547	44,043	417,590		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,429	8,429		8,429	(8,249)	180		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,846	71,846		71,846	9,174	81,020		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>244,561</b>	<b>13,181</b>	<b>942,573</b>	<b>1,200,315</b>		<b>1,200,315</b>	<b>(110,901)</b>	<b>1,089,414</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,188,947</b>	<b>482,023</b>	<b>1,761,138</b>	<b>4,432,108</b>		<b>4,432,108</b>	<b>(108,765)</b>	<b>4,323,343</b>		<b>29</b>

\*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 HTS CONT C REHAB CTR**

#0026328

Report Period Beginning:

09/01/2016

Ending:

08/31/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			185,722	185,722		185,722	10,618	196,340			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			191,255	191,255		191,255	8,212	199,467			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,773	49,773		49,773	1,025	50,798			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			426,750	426,750		426,750	19,855	446,605			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			177,889	177,889		177,889		177,889			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,348	194,348		194,348		194,348			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			372,237	372,237		372,237		372,237			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,188,947	482,023	2,560,125	5,231,095		5,231,095	(88,910)	5,142,185			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(78)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,408)	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	(6,751)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,103)	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	(68,720)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (82,060)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (82,060)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

OAKVIEW HTS CONT C REHAB CTR

ID# 0026328

Report Period Beginning: 09/01/2016

Ending: 08/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (2,052)	21	1
2	TRAVEL	(8,249)	24	2
3	LEGAL FEES	(58,419)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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	<b>Total</b>	(68,720)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016

Ending:

08/31/2017

## 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	(78)	0	0	0	0	0	0	0	0	0	0	(78)	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	(1,408)	1,498	0	0	0	0	0	0	0	0	0	90	5
6	Maintenance	0	2,124	0	0	0	0	0	0	0	0	0	2,124	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,486)</b>	<b>3,622</b>	<b>0</b>	<b>2,136</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(58,419)	3,145	0	0	0	0	0	0	0	0	0	(55,274)	19
20	Fees, Subscriptions & Promotions	(5,103)	0	0	0	0	0	0	0	0	0	0	(5,103)	20
21	Clerical & General Office Expenses	(2,052)	(93,440)	0	0	0	0	0	0	0	0	0	(95,492)	21
22	Employee Benefits & Payroll Taxes	0	44,043	0	0	0	0	0	0	0	0	0	44,043	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,249)	0	0	0	0	0	0	0	0	0	0	(8,249)	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	9,174	0	0	0	0	0	0	0	0	0	9,174	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(73,823)</b>	<b>(37,078)</b>	<b>0</b>	<b>(110,901)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(75,309)</b>	<b>(33,456)</b>	<b>0</b>	<b>(108,765)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016 Ending:

08/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	10,618	0	0	0	0	0	0	0	0	0	10,618	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,751)	14,963	0	0	0	0	0	0	0	0	0	8,212	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	1,025	0	0	0	0	0	0	0	0	0	1,025	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,751)</b>	<b>26,606</b>	<b>0</b>	<b>19,855</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(82,060)</b>	<b>(6,850)</b>	<b>0</b>	<b>(88,910)</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE P6 Suup		GENERAL BAPT NH OF CAMPBELL	CAMPBELL, MO	GEN BAPT HCARE	PIGGOTT, AR	MGMT
		GENERAL BAPT NH OF PIGGOTT	PIGGOTT, AR	OAKVIEW VILLA	MT CARMEL, IL	SUPP LIVING
				MAGNOLIA MANOR	PIGGOTT, AR	ASST LIVING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	General Baptist Nursing Home Board		\$ 1,498	\$ 1,498	1	
2	V	6 Maintenance		General Baptist Nursing Home Board		2,124	2,124	2	
3	V	19 Professional Services		General Baptist Nursing Home Board		3,145	3,145	3	
4	V	21 Mgmt Fees	335,464	General Baptist Nursing Home Board			(335,464)	4	
5	V	21 Supplies		General Baptist Nursing Home Board		242,024	242,024	5	
6	V	22 Employee Benefits		General Baptist Nursing Home Board		44,043	44,043	6	
7	V	26 Insurance		General Baptist Nursing Home Board		9,174	9,174	7	
8	V	30 Depreciation		General Baptist Nursing Home Board		10,618	10,618	8	
9	V	32 Interest Expense		General Baptist Nursing Home Board		14,963	14,963	9	
10	V	35 Rental & Leasing		General Baptist Nursing Home Board		1,025	1,025	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 335,464			\$ 328,614	\$ *	(6,850)	14

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

Facility Name & ID Number

OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016

Ending:

08/31/2017

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Carol Blanton, President	BOD						1
2	Jim Poole, Vice President	BOD						2
3	Tracy Robison, Secretary	BOD						3
4	Kevin Smith, Board Member	BOD						4
5	Clydus Gray, Board Member	BOD						5
6	James McGee, Board Member	BOD						6
7	Trea McCandless, Board Member	BOD						7
8	Darrell McCrillis, Board Member	BOD						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OAKVIEW HTS CONT C REHAB CTR # 0026328 Report Period Beginning: 09/01/2016 Ending: 08/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016

Ending: 8/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	Oakview Heights (OH)	Direct Costs	14,815,828		\$ 982,041	\$ 662,417	4,957,726	\$ 328,614	1
2	Oakview Villa (OV)	Direct Costs	14,815,828		982,041	662,417	807,733	53,539	2
3	Campbell (CB)	Direct Costs	14,815,828		982,041	662,417	4,605,420	305,262	3
4	Piggott (PG)	Direct Costs	14,815,828		982,041	662,417	3,383,315	224,257	4
5	Magnolia Manor (MM)	Direct Costs	14,815,828		982,041	662,417	1,061,635	70,369	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				\$ 4,910,205	\$ 3,312,083		\$ 982,041	25

Facility Name & ID Number

OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016

Ending:

08/31/2017

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	GERSHMAN MORTGAGE		X	MORTGAGE REFINANCED	\$21,505.00	08/2013	\$ 6,007,277	\$ 5,676,890	08/2053	3.0000	\$ 171,500	1								
2	DE LAGE LANDEN FIN		X	PATIENT TRANSPORT VAN	\$844.00	02/2015	44,472	22,944	01/2020	5.2300	1,448	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	FNB OF PARAGOULD		X	LINE OF CREDIT	\$1,500.00	02/2016	500,000	187,251	02/2017	5.0000	18,307	6								
7	GEN BAPTIST NH BOARD	X		LOAN		01/2006	376,498	1,245,931	ON DEM	NONE		7								
8												8								
9	<b>TOTAL Facility Related</b>				\$23,849.00		\$ 6,928,247	\$ 7,133,016			\$ 191,255	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 6,928,247	\$ 7,133,016			\$ 191,255	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 31,400      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 2016 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 2017 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:

2012		<b>8</b>
2013		<b>9</b>
2014		<b>10</b>
2015		<b>11</b>
2016		<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME OAKVIEW HTS CONT C REHAB 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 2016 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 2016.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016 Ending:

08/31/2017

**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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>RESIDENT USE</u>	<u>352,863</u>	<u>1981</u>	<u>\$ 89,216</u>	<u>1</u>
2	<u>RESIDENT USE</u>	<u>270,630</u>	<u>1994</u>	<u>60,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>623,493</b>		<b>\$ 149,216</b>	<b>3</b>

## 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		1,045,662	5
6			2006	1,109,737	27,743	40	27,743		327,492	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		47,818	12
13	Roof		1996	11,450	382	30	382		7,952	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		18,748	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		8,125	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		15			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

Facility Name &amp; ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning:

09/01/2016 Ending: 08/31/2017

## 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		15			380	41
42	North-Side Heaters	2001	6,090		7			6,090	42
43	Water Heaters	2001	15,196		7			15,196	43
44	Land Improvements	2005	316,403	21,094	15	21,094		254,881	44
45	Pole Barn	2007	12,485	832	15	832		8,809	45
46	Shelter House	2008	10,188	679	15	679		6,396	46
47	Land Improvements - Paving	2008	14,053	937	15	937		8,432	47
48	Reseal Parking Lot	2008	5,218	348	15	348		3,131	48
49	Silverline Windows	2009	8,092	540	15	540		4,406	49
50	Purf Pipe in Parking Lot	2009	4,110	274	15	274		2,237	50
51	Parking Lot Repavement	2009	12,469	831	15	831		6,615	51
52	Sidewalk	2011	5,556	370	15	370		2,192	52
53	Breezeway	2011	9,748	650	15	650		3,737	53
54	Sewer Replacement	2012	39,848	2,657	15	2,657		12,619	54
55	Water Heater	2012	8,600	573	15	573		2,675	55
56	HVAC	2013	6,665	171	39	171		655	56
57	Parking Lot Repavement	2014	15,645	1,565	10	1,565		4,498	57
58	Roof	2014	11,580	386	30	386		1,110	58
59	Water Heater	2015	7,900	790	10	790		1,942	59
60	Roof	2015	9,658	322	30	322		791	60
61	Vinyl Flooring Patient Rooms	2016	4,885	698	7	698		1,367	61
62	A/c Unit	2016	5,652	565	10	565		1,060	62
63	Vinyl Flooring/Wall Base Office/Lobby	2016	673	96	7	96		172	63
64	Vinyl Flooring/Wall Base Admin Office	2016	673	96	7	96		164	64
65	Bathroom Remodel (Tile Work and Vanity Hardware)	2016	970	97	10	97		141	65
66	Land Drainage Improvement	2016	840	84	10	84		94	66
67	Concrete Pad	2017	6,352	225	20	225		225	67
68	Water Pipe Replacement	2017	8,335	197	30	197		197	68
69	Vinyl Flooring Hallways, Lobby and Common Areas	2017	10,493	874	7	874		874	69
70	TOTAL (lines 4 thru 69)		\$ 6,183,985	\$ 154,244		\$ 154,244	\$	\$ 2,745,250	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 6,183,985	\$ 154,244		\$ 154,244	\$	\$ 2,745,250	1
2	Lobby Door Replacement	2017	2,430	159	7	159		159	2
3	Vinyl Flooring Pat 'Rooms (Continuation of Floor Replacement)	2017	1,755	115	7	115		115	3
4	Water Heater	2017	11,448	286	15	286		286	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	TOTAL (lines 1 thru 33)		\$ 6,199,618	\$ 154,804		\$ 154,804	\$	\$ 2,745,810	34

\*\*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	\$ 100,260	\$ 16,540	\$ 16,540	\$	7	\$ 62,154	71
72	Current Year Purchases	22,132	1,830	1,830		7	1,830	72
73	Fully Depreciated Assets	720,231	3,654	3,654		7	720,231	73
74								74
75	<b>TOTALS</b>	\$ 842,623	\$ 22,024	\$ 22,024	\$		\$ 784,215	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	Donated Van	2009	2,700				5	2,700	77
78	FACILITY USE	Ford E-250	2015	44,472	8,894	8,894		5	22,607	78
79										79
80	<b>TOTALS</b>			\$ 51,646	\$ 8,894	\$ 8,894	\$		\$ 29,781	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)	\$ 7,243,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 185,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,722	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)	\$ 3,559,806	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	<b>TOTALS</b>	\$	\$	\$	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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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	<b>TOTAL</b>		\$	\$	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.

**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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	3,879	\$ 256,003	\$	3,879	\$ 256,003	1
2	Licensed Speech and Language Development Therapist		hrs		1,425	94,053		1,425	94,053	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,213	278,044	5,716	4,213	283,760	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	<b>TOTAL</b>			\$	9,517	\$ 628,100	\$ 5,716	9,517	\$ 633,816	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **08/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 653,601	\$ 672,564	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,329,154	1,560,323	3
4	Supply Inventory (priced at )	5,680	9,566	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,321	17,080	6
7	Other Prepaid Expenses	500	500	7
8	Accounts Receivable (owners or related parties)	332,145		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,335,401	\$ 2,260,033	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216	179,216	13
14	Buildings, at Historical Cost	6,199,617	8,390,149	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	894,270	1,065,984	16
17	Accumulated Depreciation (book methods)	(3,559,806)	(4,465,426)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,683,297	\$ 5,169,923	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,018,698	\$ 7,429,956	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 295,018	\$ 326,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,433,182	1,433,182	29
30	Accrued Salaries Payable	61,831	69,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,941	4,944	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,192	19,769	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	ADV BILLING SEC DEPOSITS RES TR	128,992	205,599	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,937,156	\$ 2,059,389	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,699,834	7,897,080	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,699,834	\$ 7,897,080	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,636,990	\$ 9,956,469	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,618,292)	\$ (2,526,513)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,018,698	\$ 7,429,956	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,910,066)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,910,066)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>42,384</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Related Party Contribution</b>	<b>249,363</b>	<b>15</b>
<b>16</b>	Other (describe) <b>Prior Period Adjustment</b>	<b>27</b>	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>291,774</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,618,292)</b>	<b>24</b> *

\* 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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,218,599	1
2	Discounts and Allowances for all Levels	(1,409,032)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,809,567	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,293,647	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,293,647	8
<b>C. Other Operating Revenue</b>			
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	78	14
15	Telephone, Television and Radio	1,408	15
16	Rental of Facility Space		16
17	Sale of Drugs	125,234	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,194	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 158,914	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,548	24
25	Interest and Other Investment Income***	6,751	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,299	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISC INCOME</b>	2,052	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,052	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,273,479	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	892,188	31
32	Health Care	2,339,605	32
33	General Administration	1,200,315	33
<b>B. Capital Expense</b>			
34	Ownership	426,750	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	177,889	35
36	Provider Participation Fee	194,348	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,231,095	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	42,384	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 42,384	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,475,290	44
45	Private Pay - Net Inpatient Revenue	1,628,980	45
46	Medicare - Net Inpatient Revenue	571,968	46
47	Other-(specify) <u>Manage Care/Hospice</u>	133,329	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,809,567	49

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

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

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

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

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

# **0026328**

Report Period Beginning: **09/01/2016**

Ending: **08/31/2017**

**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	2,560	2,570	\$ 69,313	\$ 26.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,864	17,933	435,512	24.29	3
4	Licensed Practical Nurses	16,139	16,201	291,003	17.96	4
5	CNAs & Orderlies	56,984	57,203	614,248	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,487	4,504	44,220	9.82	10
11	Social Service Workers	2,083	2,091	31,628	15.13	11
12	Dietician					12
13	Food Service Supervisor	2,071	2,079	34,134	16.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,317	20,395	176,974	8.68	15
16	Dishwashers					16
17	Maintenance Workers	4,503	4,520	70,085	15.51	17
18	Housekeepers	13,251	13,302	113,281	8.52	18
19	Laundry	4,873	4,892	41,375	8.46	19
20	Administrator	2,174	2,182	92,321	42.31	20
21	Assistant Administrator	2,073	2,081	67,360	32.37	21
22	Other Administrative	2,285	2,294	50,720	22.11	22
23	Office Manager					23
24	Clerical	1,874	1,881	34,160	18.16	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	1,733	1,740	22,613	13.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,271	155,868	\$ 2,188,947 *	\$ 14.04	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 \$ 1,975	93-3	35
36	Medical Director	MONTHLY 26,350	9-3	36
37	Medical Records Consultant	MONTHLY 2,485	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)	\$ 30,810		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



Facility Name &amp; ID Number OAKVIEW HTS CONT C REHAB CTR

# 0026328

Report Period Beginning: 09/01/2016

Ending: 08/31/2017

**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 \$4,850
- (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. \$ 32,241 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. \$ 194,348  
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. \$ 78
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: Watler Accounting Certified Public Accountants, P.C.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees

**OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER 04-5179  
LEGAL INVOICE LIST  
AUGUST 31 2017**

VendorName	InvoiceNumber	InvoiceDate	InvAmount	Allowable	Non-Allowable	Description
Duane Morris LLP	2224905	09/20/16	2,520.00		2,520.00	General (Various) Legal Svcs
Duane Morris LLP	2243997	11/14/16	684.50		684.50	General (Various) Legal Svcs
Duane Morris LLP	2256651	12/22/16	1,448.00		1,448.00	General (Various) Legal Svcs
Duane Morris LLP	2264723	01/20/17	23,103.00		23,103.00	General (Various) Legal Svcs
Duane Morris LLP	2272044	02/10/17	12,403.00		12,403.00	General (Various) Legal Svcs
Duane Morris LLP	2296256	04/24/17	3,340.00		3,340.00	General (Various) Legal Svcs
Duane Morris LLP	2301389	05/08/17	2,349.50		2,349.50	General (Various) Legal Svcs
Duane Morris LLP	2301386	05/08/17	3,538.50		3,538.50	General (Various) Legal Svcs
Duane Morris LLP	2301385	05/08/17	1,132.00		1,132.00	General (Various) Legal Svcs
Duane Morris LLP	2314083	06/15/17	1,556.50		1,556.50	General (Various) Legal Svcs
Duane Morris LLP	2324190	07/19/17	1,162.00		1,162.00	General (Various) Legal Svcs
Duane Morris LLP	2331100	08/10/17	1,977.50		1,977.50	General (Various) Legal Svcs
Lashly & Baer, P.C.	285029	02/01/17	725.17		725.17	General (Various) Legal Svcs
Lashly & Baer, P.C.	295219	02/10/17	2,479.50		2,479.50	General (Various) Legal Svcs
			58,419.17		58,419.17	

