FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

Address: 1320 W 9TH STREET (Number) MT CARMEL (City) 62863 (Zip Code)

County: WABASH

Telephone Number: (618) 263-4337 **Fax #** (618) 262-7080

HFS ID Number:

Date of Initial License for Current Owners: 6/01/1981

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: TIFFANY CLARK **Telephone Number:** (870) 598-1020
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/2010 to 8/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) TIFFANY CLARK
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) CAMILLE B. LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,280	4,280	8
9	SNF/PED					9
10	ICF	18,019	8,555	487	27,061	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,019	8,555	4,767	31,341	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.41%

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)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/01/81

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 4,280

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 8/31/11 Fiscal Year: 8/31/11

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	235,139	35,715	14,064	284,918		284,918		284,918			1
2	Food Purchase		179,567		179,567		179,567	(33)	179,534			2
3	Housekeeping	168,031	20,538	475	189,044		189,044	352	189,396			3
4	Laundry	50,477	14,778		65,255		65,255		65,255			4
5	Heat and Other Utilities			136,552	136,552		136,552	(3,192)	133,360			5
6	Maintenance	58,293	73,495	24,607	156,395		156,395	435	156,830			6
7	Other (specify):*											7
8	TOTAL General Services	511,940	324,093	175,698	1,011,731		1,011,731	(2,438)	1,009,293			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,484,194	141,854	1,936	1,627,984		1,627,984		1,627,984			10
10a	Therapy		4,616	1,080,227	1,084,843		1,084,843		1,084,843			10a
11	Activities	60,417	1,693	3,763	65,873		65,873		65,873			11
12	Social Services	45,123	385	1,892	47,400		47,400		47,400			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,589,734	148,548	1,096,218	2,834,500		2,834,500		2,834,500			16
	C. General Administration											
17	Administrative	75,264			75,264		75,264	107,473	182,737			17
18	Directors Fees											18
19	Professional Services			516,847	516,847		516,847	(252,280)	264,567			19
20	Dues, Fees, Subscriptions & Promotions			40,349	40,349		40,349	(24,279)	16,070			20
21	Clerical & General Office Expenses	173,286	17,422	35,560	226,268		226,268	50,138	276,406			21
22	Employee Benefits & Payroll Taxes			580,203	580,203		580,203		580,203			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,116	18,116		18,116	9,360	27,476			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			83,203	83,203		83,203	6,762	89,965			26
27	Other (specify):*							78,842	78,842			27
28	TOTAL General Administration	248,550	17,422	1,274,278	1,540,250		1,540,250	(23,984)	1,516,266			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,350,224	490,063	2,546,194	5,386,481		5,386,481	(26,422)	5,360,059			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL #0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			229,500	229,500		229,500	6,745	236,245			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			339,494	339,494		339,494	24,242	363,736			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,596	37,596		37,596	2,287	39,883			35
36	Other (specify):*											36
37	**TOTAL Ownership**			606,590	606,590		606,590	33,274	639,864			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			175,506	175,506		175,506		175,506			39
40	Barber and Beauty Shops	3,102	608		3,710		3,710		3,710			40
41	Coffee and Gift Shops		4,176		4,176		4,176	(7,353)	(3,177)			41
42	Provider Participation Fee			46,572	46,572		46,572		46,572			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	3,102	4,784	222,078	229,964		229,964	(7,353)	222,611			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,353,326	494,847	3,374,862	6,223,035		6,223,035	(501)	6,222,534			45

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(33)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,876)	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	(3,703)	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	(22,784)	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	(27,999)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,395)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	59,894	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,894		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (501)		37

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

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

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

STATE OF ILLINOIS

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328

Report Period Beginning: 9/1/2010

Ending: 8/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (7,353)	41	1
2	MISC INCOME	(18,889)	21	2
3	NON-ALLOW IHCA DUES	(1,757)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 **Report Period Beginning:** 9/1/2010 **Ending:** 8/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(33)	0	0	0	0	0	0	0	0	0	0	(33)	2
3	Housekeeping	0	352	0	0	0	0	0	0	0	0	0	352	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,876)	2,684	0	0	0	0	0	0	0	0	0	(3,192)	5
6	Maintenance	0	435	0	0	0	0	0	0	0	0	0	435	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,909)	3,471	0	0	0	0	0	0	0	0	0	(2,438)	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	107,473	0	0	0	0	0	0	0	0	0	107,473	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(252,280)	0	0	0	0	0	0	0	0	0	(252,280)	19
20	Fees, Subscriptions & Promotions	(24,541)	262	0	0	0	0	0	0	0	0	0	(24,279)	20
21	Clerical & General Office Expenses	(18,889)	69,027	0	0	0	0	0	0	0	0	0	50,138	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,360	0	0	0	0	0	0	0	0	0	9,360	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	6,762	0	0	0	0	0	0	0	0	0	6,762	26
27	Other (specify):*	0	78,842	0	0	0	0	0	0	0	0	0	78,842	27
28	**TOTAL General Administration**	(43,430)	19,446	0	0	0	0	0	0	0	0	0	(23,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,339)	22,917	0	0	0	0	0	0	0	0	0	(26,422)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 **Report Period Beginning:** 9/1/2010 **Ending:** 8/31/2011

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	6,745	0	0	0	0	0	0	0	0	0	6,745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,703)	27,945	0	0	0	0	0	0	0	0	0	24,242	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,287	0	0	0	0	0	0	0	0	2,287	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,703)	34,690	2,287	0	0	0	0	0	0	0	0	33,274	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	(7,353)	0	0	0	0	0	0	0	0	0	0	(7,353)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(7,353)	0	0	0	0	0	0	0	0	0	0	(7,353)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,395)	57,607	2,287	0	0	0	0	0	0	0	0	(501)	45

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTE # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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		N/A		OAKVIEW VILLA	MT CARMEL, IL	SUPPORTIVE LIVI
				GEN BAPTIST NH BO	PIGGOTT, AR	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	HOUSEKEEPING	$	GENERAL BAPTIST N.H. BOARD, INC		$ 352	$ 352	1
2	V	5	UTILITIES		GENERAL BAPTIST N.H. BOARD, INC		2,684	2,684	2
3	V	6	REPAIR & MAINT		GENERAL BAPTIST N.H. BOARD, INC		435	435	3
4	V	17	ADMIN SALARIES		GENERAL BAPTIST N.H. BOARD, INC		107,473	107,473	4
5	V	19	PROFESSIONAL FEES	276,767	GENERAL BAPTIST N.H. BOARD, INC		24,487	(252,280)	5
6	V	20	FEES, SUBSCRIPTIONS		GENERAL BAPTIST N.H. BOARD, INC		262	262	6
7	V	21	OFFICE SALARIES		GENERAL BAPTIST N.H. BOARD, INC		62,056	62,056	7
8	V	21	OFFICE EXPENSE		GENERAL BAPTIST N.H. BOARD, INC		6,971	6,971	8
9	V	24	TRAVEL & SEMINAR		GENERAL BAPTIST N.H. BOARD, INC		9,360	9,360	9
10	V	26	INSURANCE		GENERAL BAPTIST N.H. BOARD, INC		6,762	6,762	10
11	V	27	EMPLOYEE BENEFITS		GENERAL BAPTIST N.H. BOARD, INC		78,842	78,842	11
12	V	30	DEPRECIATION		GENERAL BAPTIST N.H. BOARD, INC		6,745	6,745	12
13	V	32	INTEREST		GENERAL BAPTIST N.H. BOARD, INC		27,945	27,945	13
14	Total			$ 276,767			$ 334,374	$ * 57,607	14

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENT	$	GENERAL BAPTIST N.H. BOARD, INC		$ 2,287	$ 2,287	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,287	$ * 2,287	39

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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 [X] NO [ ]

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

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

	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		GENERAL BAPTIST NSG HOME				$	$	4,528,903	$ 248,997	1
2		OAKVIEW HEIGHTS						5,946,268	336,661	2
3		OAKVIEW VILLA						933,303	51,313	3
4		MAGNOLIA MANOR						1,169,192	64,282	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 701,253	25

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GERSHMAN MORTGAGE		X	MORTGAGE		4/13/04	$ 6,098,158	$ 5,742,578	4/13/44	5.8000	$ 334,034	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANK		X	LINE OF CREDIT	VARIOUS	9/1/2009	VAR	158,783	VAR	6.0000	5,460	6
7	GEN BAPTIST NH BOARD	X		LOAN	VARIOUS	1/2006	376,498	1,310,229	On demand	None		7
8												8
9	TOTAL Facility Related						$ 6,474,656	$ 7,211,590			$ 339,494	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,474,656	$ 7,211,590			$ 339,494	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 31,141 **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.)**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION C # 0026328 **Report Period Beginning:** 9/1/2010 **Ending:** 8/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2011 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:			
	2006		**8**
	2007		**9**
	2008		**10**
	2009		**11**
	2010		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	**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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILI 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,358 B. General Construction Type: Exterior Concrete/Sandstone Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (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. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CEN # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1981	1982	$ 775,625	$ 25,854	30	$ 25,854	$	$ 775,625	4
5				2005	3,461,500	86,538	40	86,538		526,437	5
6				2006	1,109,737	27,743	40	27,743		161,032	6
7											7
8											8
	Improvement Type**										
9	ROOF			1982	3,837		7			3,837	9
10	BUILDING IMPROVEMENTS			1994	2,914		10			2,914	10
11	ROOF			1996	68,042	2,268	30	2,268		34,210	11
12	ROOF			1996	11,450	382	30	382		5,662	12
13	ELECTRICAL - NEW WIRING			1997	23,632	946	25	946		13,077	13
14	DRYWALL			1997	21,125	1,408	15	1,408		19,247	14
15	CARPET			1998	7,927		7			7,927	15
16	SIGN			1998	2,000	133	15	133		1,756	16
17	WALL PAPER			1998	2,435		7			2,435	17
18	PLASTIC COAT - ROOF - WING 5			1998	12,500	417	30	417		5,625	18
19	12 LAVATORY FAUCETS			1998	4,470	298	15	298		4,073	19
20	9 OVERHEAD LIGHTS			1998	921	61	15	61		839	20
21	EXIT SIGN			1998	449	30	15	30		410	21
22	OTHER MG-INCLUDING PLUMBING			1998	9,003	600	15	600		8,103	22
23	CARPET, CURTAINS, BLINDS			1998	11,249		10			11,249	23
24	CARPET, CURTAINS, BLINDS			1998	19,656		10			19,656	24
25	FUEL TANK			1999	8,935	596	15	596		7,347	25
26	WALL PAPER			1999	4,135	276	15	276		3,423	26
27	KITCHEN			2000	4,230		10			4,230	27
28	BRITTINGTON AIR & WATER			2000	1,992		7			1,992	28
29	BUILDING HANDRAILS			2000	3,818		7			3,818	29
30	NORTH-SIDE HEATERS			2001	6,090		7			6,090	30
31	WATER HEATERS			2001	15,196		7			15,196	31
32	TILE - WING 7			2000	3,753		7			3,753	32
33	FIRE DOORS			2000	4,861	121	10	121		4,861	33
34	LAND IMPROVEMENTS			1982	14,363		10			14,363	34
35	GAZEBO			1997	3,495		10			3,495	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CE]# 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT REPAVEMENT	1997	$ 12,677	$	10	$	$	$ 12,677	37
38	LANDSCAPING	1997	8,836	589	15	589		8,051	38
39	DITCH WORK	1997	700	47	15	47		649	39
40	RESEAL PARKING LOT	1999	3,336		5			3,336	40
41	LANDSCAPING	1999	976	65	15	65		808	41
42	LAND IMPROVEMENTS	2000	647	43	15	43		492	42
43	LAND IMPROVEMENTS	2001	380	25	15	25		268	43
44	LAND IMPROVEMENTS	2005	316,403	21,094	15	21,094		128,319	44
45	POLE BARN	2007	12,485	832	15	832		3,815	45
46	LAND IMPROVEMENTS - PAVING	2008	14,053	937	15	937		2,811	46
47	SHELTER HOUSE	2008	10,188	679	15	679		2,321	47
48	PURF PIPE IN PARKING LOT	2009	4,110	274	15	274		594	48
49	RESEAL PARKING LOT	2009	5,218	348	15	348		1,044	49
50	SILVERLINE WINDOWS	2009	8,092	539	15	539		1,169	50
51	PARKING LOT REPAVEMENT	2009	12,469	831	15	831		1,628	51
52									52
53									53
54									54
55	GBNH BOARD ALLOCATION			1,745		1,745			55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,029,910	$ 175,719		$ 175,719	$	$ 1,840,664	70

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RE# 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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	$ 390,730	$ 53,477	$ 53,477	$	VAR	$ 306,978	71
72	Current Year Purchases	14,329	1,509	1,509		VAR	1,509	72
73	Fully Depreciated Assets	329,501					329,501	73
74	GBNH BOARD ALLOC		5,000	5,000				74
75	TOTALS	$ 734,560	$ 59,986	$ 59,986	$		$ 637,988	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	1986 MAZDA TRUCK	1992	$ 4,474	$	$	$	5	$ 4,474	76
77	FACILITY USE	1996 CHEVY VAN	1995	23,548				5	23,548	77
78	FACILITY USE	VAN - DONATED	2009	2,700	540	540		5	1,260	78
79		ROUNDING							(1)	79
80	TOTALS			$ 30,722	$ 540	$ 540	$		$ 29,281	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,944,408	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 236,245	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,245	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,507,933	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 39,883 Description: Water Soft 3,541; Misc Eq 266; Postage Mach 297; Copy Mach 7,029; Med Eq 26,463; GB Alloc 2,287
    (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 HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

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.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION C # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	5,254	$ 447,771	$	5,254	$ 447,771	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,844	183,313		2,844	183,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,220	449,143	4,616	5,220	453,759	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	13,318	$ 1,080,227	$ 4,616	13,318	$ 1,084,843	14

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 **Report Period Beginning:** 9/1/2010 **Ending:** 8/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2011 (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	$ 438,558	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	823,786		3
4	Supply Inventory (priced at)	44,573		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,600		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,319,517	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216		13
14	Buildings, at Historical Cost	6,029,910		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	765,282		16
17	Accumulated Depreciation (book methods)	(2,507,928)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,436,480	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,755,997	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 620,641	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,469,012		29
30	Accrued Salaries Payable	158,825		30
31	Accrued Taxes Payable (excluding real estate taxes)	800		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	27,720		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED PROVIDER TAX	8,370		36
37	ADV BILL/RES TRUST/SEC DEP/INTER	(208,278)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,077,090	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,742,578		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)**	$ 5,742,578	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,819,668	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,063,671)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,755,997	$	48

***(See instructions.)**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATIO # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,674,025)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,674,025)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(389,648)	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)**	$ (389,648)	17
	B. Transfers (Itemize):		
18	**ROUNDING**	2	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,063,671)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & R # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,604,290	1
2	Discounts and Allowances for all Levels	(2,063,015)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,541,275	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,995,828	6
7	Oxygen	219	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,996,047	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	4,836	13
14	Non-Patient Meals	33	14
15	Telephone, Television and Radio	5,876	15
16	Rental of Facility Space		16
17	Sale of Drugs	203,156	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,051	19
20	Radiology and X-Ray	4,060	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 257,012	23
	D. Non-Operating Revenue		
24	Contributions	2,868	24
25	Interest and Other Investment Income***	3,703	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,571	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	7,353	28
28a	MISC INC 18,889; OIL LEASE ROYALTIES 6,240	25,129	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,482	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,833,387	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,011,731	31
32	Health Care	2,834,500	32
33	General Administration	1,540,250	33
	B. Capital Expense		
34	Ownership	606,590	34
	C. Ancillary Expense		
35	Special Cost Centers	183,392	35
36	Provider Participation Fee	46,572	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,223,035	40
41	**Income before Income Taxes (line 30 minus line 40)****	(389,648)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (389,648)	43

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

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

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,064	$ 53,283	$ 25.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,645	12,145	235,447	19.39	3
4	Licensed Practical Nurses	25,478	26,510	435,330	16.42	4
5	CNAs & Orderlies	68,053	70,053	738,591	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,129	2,289	25,849	11.29	9
10	Activity Assistants	3,907	3,993	34,568	8.66	10
11	Social Service Workers	3,449	3,718	45,123	12.14	11
12	Dietician					12
13	Food Service Supervisor	2,046	2,110	21,276	10.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,140	26,018	213,863	8.22	15
16	Dishwashers					16
17	Maintenance Workers	4,411	4,619	58,293	12.62	17
18	Housekeepers	18,692	19,309	168,031	8.70	18
19	Laundry	5,803	6,201	50,477	8.14	19
20	Administrator	2,040	2,231	75,264	33.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,460	12,046	173,286	14.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,301	2,383	21,543	9.04	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTICIAN	288	320	3,102	9.69	33
34	TOTAL (lines 1 - 33)	188,858	196,009	$ 2,353,326 *	$ 12.01	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,064	1-3	35
36	Medical Director	Monthly	8,400	9-3	36
37	Medical Records Consultant	Monthly	1,475	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,516	11-3	44
45	Social Service Consultant	Monthly	1,892	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,347		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GAY EDMONDS	ADMINISTRATOR	N/A	$ 72,732
MARK BREWSTER	ADMINISTRATOR	N/A	2,532
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,264

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Vocollect Healthcare Systems	Accunurse Charting Syst	$ 36,237
Duane Morris LLP/John Farrar	Legal - attached	94,851
Lashly & Baer	Legal - HUD - attached	544
Wilcox, McCorkle & Co, LTD	Auditing/Acctg/Consulting	9,350
BKD, LLP	Consulting/Cost Reports	30,790
Healthlink, Inc	Admin fees for proc claims	122
Rehav Care Group	Therapy admin fees	546
Architecture & Design Group	Architect fees - sunroom	8,276
MDI Achive	Clin/Fin Software hosting	12,892
Techology Professionals	Software maint/comp svcs	6,484
CTS	Network svcs	39,988
GBNH Board	Management fees	276,767
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 516,847

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 263,706
Unemployment Compensation Insurance	19,773
FICA Taxes	175,044
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hospital and Employee Benefits	121,680
TOTAL (agree to Schedule V, line 22, col.8)	$ 580,203

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,060
Health Care Worker Background Check (Indicate # of checks performed 72)	
Background Checks	2,974
Dues & Sub 8,739/Non-allow IHCA (1,757)	6,982
Drug Testing	652
Advertising and Promotion	22,784
Licenses	2,140
GBNH Board Alloc	262
Less: Public Relations Expense	( )
Non-allowable advertising	(22,784)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,070

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,602
Seminar Expense	9,514
GBNH Board Alloc	9,360
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,476

**See instructions.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION # 0026328 Report Period Beginning: 9/1/2010 Ending: 8/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC - $4,968**

(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. $ **29,971** 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. $ **46,572**
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. $ **33**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
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?
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **WILCOX, MCCORKLE & COMPANY, LTD**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.