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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

Address: R R #4, 1320 WEST 9TH STREET (Number) MOUNT 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: MARK BREWSTER **Telephone Number:** (618) 263-4337
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 9/1/2011 to 8/31/2012 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) MARK BREWSTER
(Title) ADMINISTRATOR

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: 9/1/2011 Ending: 8/31/2012

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	32,940	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	32,940	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			4,190	4,190	8
9	SNF/PED					9
10	ICF	17,000	8,433	561	25,994	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,000	8,433	4,751	30,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.63%

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 4,190

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 8/31/12 Fiscal Year: 8/31/12

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	207,496	26,878	11,337	245,711		245,711		245,711			1
2	Food Purchase		191,141		191,141		191,141	(120)	191,021			2
3	Housekeeping	101,919	17,004		118,923		118,923	14	118,937			3
4	Laundry	59,986	11,917		71,903		71,903		71,903			4
5	Heat and Other Utilities			124,319	124,319		124,319	(3,239)	121,080			5
6	Maintenance	37,316	41,074	14,850	93,240		93,240	293	93,533			6
7	Other (specify):*											7
8	**TOTAL General Services**	406,717	288,014	150,506	845,237		845,237	(3,052)	842,185			8
	B. Health Care and Programs											
9	Medical Director			7,700	7,700		7,700		7,700			9
10	Nursing and Medical Records	1,509,551	151,722	2,456	1,663,729		1,663,729		1,663,729			10
10a	Therapy		2,728	713,308	716,036		716,036		716,036			10a
11	Activities	54,050	1,004	1,815	56,869		56,869		56,869			11
12	Social Services	29,159	143	1,815	31,117		31,117		31,117			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,592,760	155,597	727,094	2,475,451		2,475,451		2,475,451			16
	C. General Administration											
17	Administrative	76,665			76,665		76,665	79,514	156,179			17
18	Directors Fees											18
19	Professional Services			461,539	461,539		461,539	(229,868)	231,671			19
20	Dues, Fees, Subscriptions & Promotions			13,803	13,803		13,803	(1,932)	11,871			20
21	Clerical & General Office Expenses	83,559	18,759	19,298	121,616		121,616	46,275	167,891			21
22	Employee Benefits & Payroll Taxes			493,565	493,565		493,565		493,565			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,934	4,934		4,934	8,575	13,509			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,678	63,678		63,678	4,468	68,146			26
27	Other (specify):*							(12,314)	(12,314)			27
28	**TOTAL General Administration**	160,224	18,759	1,056,817	1,235,800		1,235,800	(105,282)	1,130,518			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,159,701	462,370	1,934,417	4,556,488		4,556,488	(108,334)	4,448,154			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: 9/1/2011 Ending: 8/31/2012

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			200,527	200,527		200,527	6,044	206,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			339,091	339,091		339,091	13,386	352,477			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,430	12,430		12,430	1,544	13,974			35
36	Other (specify):*											36
37	**TOTAL Ownership**			552,048	552,048		552,048	20,974	573,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			180,262	180,262		180,262		180,262			39
40	Barber and Beauty Shops	2,317	197		2,514		2,514		2,514			40
41	Coffee and Gift Shops							(119)	(119)			41
42	Provider Participation Fee			213,912	213,912		213,912		213,912			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	2,317	197	394,174	396,688		396,688	(119)	396,569			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,162,018	462,567	2,880,639	5,505,224		5,505,224	(87,479)	5,417,745			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: 9/1/2011 Ending: 8/31/2012

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	(120)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,812)	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	(2,603)	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	(1,217)	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	(5,903)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,655)		$	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)	(72,824)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (72,824)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (87,479)		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

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328

Report Period Beginning: 9/1/2011

Ending: 8/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (119)	41	1
2	MISC INCOME	(3,934)	21	2
3	NON-ALLOW IHCA DUES	(1,850)	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**	(5,903)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 **Report Period Beginning:** 9/1/2011 **Ending:** 8/31/2012

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	(120)	0	0	0	0	0	0	0	0	0	0	(120)	2
3	Housekeeping	0	14	0	0	0	0	0	0	0	0	0	14	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,812)	1,573	0	0	0	0	0	0	0	0	0	(3,239)	5
6	Maintenance	0	293	0	0	0	0	0	0	0	0	0	293	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,932)	1,880	0	0	0	0	0	0	0	0	0	(3,052)	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	79,514	0	0	0	0	0	0	0	0	0	79,514	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(229,868)	0	0	0	0	0	0	0	0	0	(229,868)	19
20	Fees, Subscriptions & Promotions	(3,067)	1,135	0	0	0	0	0	0	0	0	0	(1,932)	20
21	Clerical & General Office Expenses	(3,934)	50,209	0	0	0	0	0	0	0	0	0	46,275	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	8,575	0	0	0	0	0	0	0	0	0	8,575	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	4,468	0	0	0	0	0	0	0	0	0	4,468	26
27	Other (specify):*	0	(12,314)	0	0	0	0	0	0	0	0	0	(12,314)	27
28	**TOTAL General Administration**	(7,001)	(98,281)	0	0	0	0	0	0	0	0	0	(105,282)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,933)	(96,401)	0	0	0	0	0	0	0	0	0	(108,334)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 **Report Period Beginning:** 9/1/2011 **Ending:** 8/31/2012

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	6,044	0	0	0	0	0	0	0	0	0	6,044	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,603)	15,989	0	0	0	0	0	0	0	0	0	13,386	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	1,544	0	0	0	0	0	0	0	0	1,544	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,603)	22,033	1,544	0	0	0	0	0	0	0	0	20,974	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	(119)	0	0	0	0	0	0	0	0	0	0	(119)	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**	(119)	0	0	0	0	0	0	0	0	0	0	(119)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,655)	(74,368)	1,544	0	0	0	0	0	0	0	0	(87,479)	45

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENT # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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
				GEN BAPTIST NH PI	PIGGOTT, AR	NURSING HOME

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		$ 14	$ 14	1
2	V	5	UTILITIES		GENERAL BAPTIST N.H. BOARD, INC		1,573	1,573	2
3	V	6	REPAIR & MAINT		GENERAL BAPTIST N.H. BOARD, INC		293	293	3
4	V	17	ADMIN SALARIES		GENERAL BAPTIST N.H. BOARD, INC		79,514	79,514	4
5	V	19	PROFESSIONAL FEES	270,130	GENERAL BAPTIST N.H. BOARD, INC		40,262	(229,868)	5
6	V	20	FEES, SUBSCRIPTIONS		GENERAL BAPTIST N.H. BOARD, INC		1,135	1,135	6
7	V	21	OFFICE SALARIES		GENERAL BAPTIST N.H. BOARD, INC		47,648	47,648	7
8	V	21	OFFICE EXPENSE		GENERAL BAPTIST N.H. BOARD, INC		2,561	2,561	8
9	V	24	TRAVEL & SEMINAR		GENERAL BAPTIST N.H. BOARD, INC		8,575	8,575	9
10	V	26	INSURANCE		GENERAL BAPTIST N.H. BOARD, INC		4,468	4,468	10
11	V	27	EMPLOYEE BENEFITS		GENERAL BAPTIST N.H. BOARD, INC		(12,314)	(12,314)	11
12	V	30	DEPRECIATION		GENERAL BAPTIST N.H. BOARD, INC		6,044	6,044	12
13	V	32	INTEREST		GENERAL BAPTIST N.H. BOARD, INC		15,989	15,989	13
14	Total			$ 270,130			$ 195,762	$ * (74,368)	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: 9/1/2011 Ending: 8/31/2012

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		$ 1,544	$ 1,544	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			$			$ 1,544	$ * 1,544	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: 9/1/2011 Ending: 8/31/2012

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 CA # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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 & REHAB # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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: 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 CAMPBELL				$	$	4,421,693	$ 166,650	1
2		OAKVIEW HEIGHTS						5,235,094	197,306	2
3		OAKVIEW VILLA						931,319	35,101	3
4		MAGNOLIA MANOR						1,187,375	44,751	4
5		GENERAL BAPTIST NSG HOME PIGGOTT						1,272,799	47,971	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					$	$		$ 491,779	25

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	GERSHAM MORTGAGE		X	MORTGAGE		4/13/04	$ 6,098,158	$ 5,687,810	4/13/44	5.8000	$ 330,228	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FIRST BANK		X	LINE OF CREDIT	VARIOUS	9/1/2009	VAR	250,000	VAR	6.0000	5,896	6
7	GEN BAPTIST NH BOARD	X		LOAN	VARIOUS	1/2006	376,498	1,209,766	On demand	None		7
8	FIRST BANK		X	LINE OF CREDIT	VARIOUS	5/4/2012	VAR	115,734	VAR		2,921	8
9	TOTAL Facility Related						$ 6,474,656	$ 7,263,310			$ 339,045	9
	B. Non-Facility Related*											
10												10
11				MISC INTEREST TO VENDORS - ALLOWABLE FACILITY RELATED							46	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 46	14
15	TOTALS (line 9+line14)						$ 6,474,656	$ 7,263,310			$ 339,091	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 28,144 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: 9/1/2011 Ending: 8/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL COUNTY WABASH

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 CENTE # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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: 9/1/2011 Ending: 8/31/2012

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	$	30	$	$	$ 775,625	4
5				2005	3,461,500	86,538	40	86,538		612,975	5
6				2006	1,109,737	27,743	40	27,743		188,775	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		36,478	11
12	ROOF			1996	11,450	382	30	382		6,044	12
13	ELECTRICAL - NEW WIRING			1997	23,632	945	25	945		14,022	13
14	DRYWALL			1997	21,125	1,408	15	1,408		20,655	14
15	CARPET			1998	7,927		7			7,927	15
16	SIGN			1998	2,000	133	15	133		1,889	16
17	WALL PAPER			1998	2,435		7			2,435	17
18	PLASTIC COAT - ROOF - WING 5			1998	12,500	417	30	417		6,042	18
19	12 LAVATORY FAUCETS			1998	4,470	298	15	298		4,371	19
20	9 OVERHEAD LIGHTS			1998	921	62	15	62		900	20
21	EXIT SIGN			1998	449	30	15	30		440	21
22	OTHER MG-INCLUDING PLUMBING			1998	9,003	600	15	600		8,703	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		7,943	25
26	WALL PAPER			1999	4,135	276	15	276		3,699	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		10			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 CEN # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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		8,640	38
39	DITCH WORK	1997	700	47	15	47		696	39
40	RESEAL PARKING LOT	1999	3,336		5			3,336	40
41	LANDSCAPING	1999	976	65	15	65		873	41
42	LAND IMPROVEMENTS	2000	647	43	15	43		535	42
43	LAND IMPROVEMENTS	2001	380	25	15	25		293	43
44	LAND IMPROVEMENTS	2005	316,403	21,094	15	21,094		149,413	44
45	POLE BARN	2007	12,485	832	15	832		4,647	45
46	LAND IMPROVEMENTS - PAVING	2008	14,053	937	15	937		3,748	46
47	SHELTER HOUSE	2008	10,188	679	15	679		3,000	47
48	PURF PIPE IN PARKING LOT	2009	4,110	274	15	274		868	48
49	RESEAL PARKING LOT	2009	5,218	348	15	348		1,392	49
50	SILVERLINE WINDOWS	2009	8,092	539	15	539		1,708	50
51	PARKING LOT REPAVEMENT	2009	12,469	831	15	831		2,459	51
52	SIDEWALK	2011	5,556	340	15	340		340	52
53	BREEZEWAY	2011	9,748	487	15	487		487	53
54									54
55									55
56	GBNH BOARD ALLOCATION			1,481		1,481			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)		$ 6,045,214	$ 150,307		$ 150,307	$	$ 1,989,489	70

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RI # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	$ 396,750	$ 51,047	$ 51,047	$	VAR	$ 351,225	71
72	Current Year Purchases	1,918	114	114		VAR	114	72
73	Fully Depreciated Assets	337,810					337,810	73
74	GBNH BOARD ALLOC		4,563	4,563				74
75	TOTALS	$ 736,478	$ 55,724	$ 55,724	$		$ 689,149	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	1,800	78
79		ROUNDING								79
80	TOTALS			$ 30,722	$ 540	$ 540	$		$ 29,822	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)	$ 6,961,630	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 206,571	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 206,571	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)	$ 2,708,460	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 & REHABI# 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 13,974 Description: Water Soft $2,157; Copy Mach $2,632; Med Equip $7,641; GB Alloc $1,544
    (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 CENTEI # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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 # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	$	4,298	$ 296,079	$	4,298	$ 296,079	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,345	93,598		1,345	93,598	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,698	323,631	2,728	4,698	326,359	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			$	10,341	$ 713,308	$ 2,728	10,341	$ 716,036	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 & REHABI # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2012 (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	$ 144,210	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,126,350		3
4	Supply Inventory (priced at)	36,093		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,399		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)**	$ 1,354,052	$	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	6,045,214		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	767,200		16
17	Accumulated Depreciation (book methods)	(2,708,455)		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)**	$ 4,253,175	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,607,227	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 543,079	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,575,500		29
30	Accrued Salaries Payable	70,692		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,152		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	27,491		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/INTERCO	(212,079)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,036,205	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,687,810		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)**	$ 5,687,810	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,724,015	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,116,788)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,607,227	$	48

***(See instructions.)**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATIC # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,063,671)	1
2	Restatements (describe):		2
3	**PRIOR YEARS ADVANCE BILLING**	(52,381)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,116,052)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(736)	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)**	$ (736)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,116,788)	24 *

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & F # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,569,884	1
2	Discounts and Allowances for all Levels	(2,046,071)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,523,813	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,719,465	6
7	Oxygen	38	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,719,503	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	1,709	13
14	Non-Patient Meals	120	14
15	Telephone, Television and Radio	4,812	15
16	Rental of Facility Space		16
17	Sale of Drugs	189,053	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,860	19
20	Radiology and X-Ray	105	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 242,659	23
	D. Non-Operating Revenue		
24	Contributions	3,996	24
25	Interest and Other Investment Income***	2,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,599	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 119; MISC INC 3,934	4,053	28
28a	OIL LEASE ROYALTIES 6,361; GAIN ON FA 1,500	7,861	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,914	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,504,488	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	845,237	31
32	Health Care	2,475,451	32
33	General Administration	1,235,800	33
	B. Capital Expense		
34	Ownership	552,048	34
	C. Ancillary Expense		
35	Special Cost Centers	182,776	35
36	Provider Participation Fee	213,912	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,505,224	40
41	**Income before Income Taxes (line 30 minus line 40)****	(736)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (736)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,831,121	44
45	Private Pay - Net Inpatient Revenue	1,221,350	45
46	Medicare - Net Inpatient Revenue	566,570	46
47	Other-(specify) Other - Net Inpatient Revenue	90,219	47
48	Other-(specify) Bad debts/PY adjs/Mcr B C/A	(185,447)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,523,813	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 & REHABII # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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	1,857	2,077	$ 56,116	$ 27.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,402	11,139	218,087	19.58	3
4	Licensed Practical Nurses	22,622	23,924	394,559	16.49	4
5	CNAs & Orderlies	72,544	76,122	819,400	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,539	1,712	20,833	12.17	9
10	Activity Assistants	3,264	3,438	33,217	9.66	10
11	Social Service Workers	1,978	2,150	29,159	13.56	11
12	Dietician					12
13	Food Service Supervisor	2,130	2,194	25,132	11.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,880	21,056	182,364	8.66	15
16	Dishwashers					16
17	Maintenance Workers	2,538	2,626	37,316	14.21	17
18	Housekeepers	11,312	12,144	101,919	8.39	18
19	Laundry	5,649	6,965	59,986	8.61	19
20	Administrator	1,956	2,080	76,665	36.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,986	5,381	83,559	15.53	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	1,871	2,051	21,389	10.43	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTICIAN	260	260	2,317	8.91	33
34	TOTAL (lines 1 - 33)	164,788	175,319	$ 2,162,018 *	$ 12.33	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	$ 11,337	1-3	35
36	Medical Director	Monthly	7,700	9-3	36
37	Medical Records Consultant	Monthly	1,529	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	927	10-3	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	1,815	11-3	44
45	Social Service Consultant	Monthly	1,815	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,123		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: 9/1/2011 Ending: 8/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARK BREWSTER	ADMINISTRATOR	N/A	$ 76,665
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,665

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	78,828
Wilcox, McCorkle & Co, LTD	Auditing/Acctg/Consulting	9,500
BKD, LLP	Consulting/Cost Reports	32,033
Illinois Charity Bureau Fund		15
CTS	Network svcs	20,628
MDI Achive	Clin/Fin Software hosting	14,103
Technology Professionals	Software maint	65
GBNH Board	Management fees	270,130
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 461,539

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 234,826
Unemployment Compensation Insurance	37,229
FICA Taxes	165,062
Employee Health Insurance	41,900
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	14,548
TOTAL (agree to Schedule V, line 22, col.8)	$ 493,565

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	1,310
Health Care Worker Background Check	
(Indicate # of checks performed)	2,765
Patient Background Checks	
Dues & Sub 5,486/Nonallow IHCA (1,850)	3,636
Drug Testing	909
Advertising & Marketing	1,217
Licenses	2,116
GBNH Board Alloc	1,135
Less: Public Relations Expense	( )
Non-allowable advertising	(1,217)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,871

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,482
Seminar Expense	3,452
GBNH Board Alloc	8,575
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,509

**See instructions.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 9/1/2011 Ending: 8/31/2012

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: 9/1/2011 Ending: 8/31/2012

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. $ **37,419** 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. $ **213,912**
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. $ **120**

(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.