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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HTS CONT C & REH CTR

Address: 1320 WEST 9TH ST RR4 (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: 06/01/1981

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: Brett Millikin Telephone Number: 870-598-1020 OR 870-514-1271
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 09/01/2015 to 08/31/2016 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) 12/30/16 (Date)
	(Type or Print Name) Brett Millikin
	(Title) CFO
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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 HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	213		5,615	5,828	8
9	SNF/PED					9
10	ICF	16,275	6,508		22,783	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,488	6,508	5,615	28,611	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.86%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 06/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/81 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 3,607

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: 08/31/2016 Fiscal Year: 08/31/2016

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 **Report Period Beginning:** 09/01/2015 **Ending:** 08/31/2016

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	173,591	37,080	8,773	219,444		219,444		219,444			1
2	Food Purchase		164,683		164,683		164,683	(1,203)	163,480			2
3	Housekeeping	104,201	2,131	36	106,368		106,368		106,368			3
4	Laundry	42,012	5,966		47,978		47,978		47,978			4
5	Heat and Other Utilities			115,369	115,369		115,369	(86)	115,283			5
6	Maintenance	66,333	36,521	17,496	120,350		120,350	1,538	121,888			6
7	Other (specify):*											7
8	**TOTAL General Services**	386,137	246,381	141,674	774,192		774,192	249	774,441			8
	B. Health Care and Programs											
9	Medical Director			17,800	17,800		17,800		17,800			9
10	Nursing and Medical Records	1,536,394	118,991	1,924	1,657,309		1,657,309		1,657,309			10
10a	Therapy		2,847	591,532	594,379		594,379		594,379			10a
11	Activities	43,229	1,807	3,532	48,568		48,568		48,568			11
12	Social Services	31,650		2,057	33,707		33,707		33,707			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,611,273	123,645	616,845	2,351,763		2,351,763		2,351,763			16
	C. General Administration											
17	Administrative	93,139			93,139		93,139		93,139			17
18	Directors Fees											18
19	Professional Services			44,751	44,751		44,751	14,204	58,955			19
20	Dues, Fees, Subscriptions & Promotions			20,583	20,583		20,583	(4,252)	16,331			20
21	Clerical & General Office Expenses	164,633	12,623	281,139	458,395		458,395	(20,449)	437,946			21
22	Employee Benefits & Payroll Taxes			370,666	370,666		370,666	68,813	439,479			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,282	8,282		8,282	(8,282)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,785	76,785		76,785	20,129	96,914			26
27	Other (specify):*											27
28	**TOTAL General Administration**	257,772	12,623	802,206	1,072,601		1,072,601	70,163	1,142,764			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,255,182	382,649	1,560,725	4,198,556		4,198,556	70,412	4,268,968			29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			181,509	181,509		181,509	9,957	191,466			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198,470	198,470		198,470	13,564	212,034			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,669	21,669		21,669	1,364	23,033			35
36	Other (specify):*											36
37	TOTAL Ownership			401,648	401,648		401,648	24,885	426,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			197,470	197,470		197,470		197,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,706	197,706		197,706		197,706			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			395,176	395,176		395,176		395,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,255,182	382,649	2,357,549	4,995,380		4,995,380	95,297	5,090,677			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 HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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	(1,203)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,520)	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	(7,233)	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	(4,252)	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	(38,114)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (52,322)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,322)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAKVIEW HTS CONT C & REH CTR

ID# 0026328

Report Period Beginning: 09/01/2015

Ending: 08/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (12,039)	21	1
2	TRAVEL	(8,282)	24	2
3	LEGAL FEES	(17,793)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38,114)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,203)	0	0	0	0	0	0	0	0	0	0	(1,203)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,520)	1,434	0	0	0	0	0	0	0	0	0	(86)	5
6	Maintenance	0	1,538	0	0	0	0	0	0	0	0	0	1,538	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,723)	2,972	0	0	0	0	0	0	0	0	0	249	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,793)	31,997	0	0	0	0	0	0	0	0	0	14,204	19
20	Fees, Subscriptions & Promotions	(4,252)	0	0	0	0	0	0	0	0	0	0	(4,252)	20
21	Clerical & General Office Expenses	(12,039)	(8,410)	0	0	0	0	0	0	0	0	0	(20,449)	21
22	Employee Benefits & Payroll Taxes	0	68,813	0	0	0	0	0	0	0	0	0	68,813	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,282)	0	0	0	0	0	0	0	0	0	0	(8,282)	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	20,129	0	0	0	0	0	0	0	0	0	20,129	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(42,366)	112,529	0	0	0	0	0	0	0	0	0	70,163	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,089)	115,501	0	0	0	0	0	0	0	0	0	70,412	29

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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	9,957	0	0	0	0	0	0	0	0	0	9,957	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,233)	20,797	0	0	0	0	0	0	0	0	0	13,564	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,364	0	0	0	0	0	0	0	0	0	1,364	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,233)	32,118	0	0	0	0	0	0	0	0	0	24,885	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	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	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(52,322)	147,619	0	0	0	0	0	0	0	0	0	95,297	45

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

VII. RELATED PARTIES

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

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

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

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

1 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	5	Heat and Other Utilities	$	General Baptist Nursing Home Board		$ 1,434	$ 1,434	1
2	V	6	Maintenance		General Baptist Nursing Home Board		1,538	1,538	2
3	V	19	Professional Services		General Baptist Nursing Home Board		31,997	31,997	3
4	V	21	Mgmt Fees	245,030	General Baptist Nursing Home Board		223,214	(21,816)	4
5	V	21	Supplies		General Baptist Nursing Home Board		13,406	13,406	5
6	V	22	Employee Benefits & Payroll Taxes		General Baptist Nursing Home Board		68,813	68,813	6
7	V	26	Insurance		General Baptist Nursing Home Board		20,129	20,129	7
8	V	30	Depreciation		General Baptist Nursing Home Board		9,957	9,957	8
9	V	32	Interest Expense		General Baptist Nursing Home Board		20,797	20,797	9
10	V	35	Rental & Leasing		General Baptist Nursing Home Board		1,364	1,364	10
11	V								11
12	V								12
13	V								13
14	Total			$ 245,030			$ 392,649	$ * 147,619	14

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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

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

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 8/31/2016

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Oakview Heights (OH)	Direct Costs	14,230,177		$ 1,103,953	$ 627,574	5,061,328	$ 392,649	1
2		Oakview Villa (OV)	Direct Costs	14,230,177		1,103,953	627,574	750,043	58,187	2
3		Campbell (CB)	Direct Costs	14,230,177		1,103,953	627,574	4,234,194	328,482	3
4		Piggott (PG)	Direct Costs	14,230,177		1,103,953	627,574	3,160,552	245,190	4
5		Magnolia Manor (MM)	Direct Costs	14,230,177		1,103,953	627,574	1,024,060	79,445	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					$ 5,519,764	$ 3,137,871		$ 1,103,953	25

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GERSHMAN MORTGAGE		X	MORTGAGE REFINANCED	$21,505.00	08/2013	$ 6,007,277	$ 5,763,236	08/2053	3.0000	$ 174,265	1
2	DE LAGE LANDEN FIN		X	PATIENT TRANSPORT VAN	$844.00	02/2015	44,472	31,623	01/2020	5.2300	1,889	2
3												3
4												4
5												5
	Working Capital											
6	FNB OF PARAGOULD		X	LINE OF CREDIT	$1,500.00	02/2015	500,000	499,363	02/2017	5.0000	22,316	6
7	GEN BAPTIST NH BOARD	X		LOAN		01/2006	376,498	1,245,931	ON DEM	NONE		7
8												8
9	TOTAL Facility Related				$23,849.00		$ 6,928,247	$ 7,540,153			$ 198,470	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,928,247	$ 7,540,153			$ 198,470	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 31,868 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 HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:		
2011		8
2012		9
2013		10
2014		11
2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HTS CONT C & REH CTR COUNTY WABASH

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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 HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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		959,123	5
6				2006	1,109,737	27,743	40	27,743		299,747	6
7											7
8											8
	Improvement Type**										
9	Roof			1982	3,837		7			3,837	9
10	Land Improvements			1982	14,363		10			14,363	10
11	Building Imp.- Smith Consult.			1994	2,914		10			2,914	11
12	Roof			1996	68,042	2,268	30	2,268		45,550	12
13	Roof			1996	11,450	382	30	382		7,570	13
14	Parking Lot Repavement			1997	12,677		10			12,677	14
15	Ditch Work			1997	700		15			700	15
16	Gazebo			1997	3,495		10			3,495	16
17	Electrical-New Wing			1997	23,632	945	25	945		17,803	17
18	Landscaping			1997	8,837		15			8,837	18
19	Drywall			1997	21,125		15			21,125	19
20	12 Lavatory+Faucets			1998	4,470		15			4,470	20
21	9 Overhead Lights			1998	921		15			921	21
22	Exit Sign			1998	449		15			449	22
23	Other MG- Including Plumbing			1998	9,003		15			9,003	23
24	Wall Paper			1998	2,435		7			2,435	24
25	Plastic Coat-Roof-Wing 5			1998	12,500	417	30	417		7,708	25
26	Carpet			1998	7,927		7			7,927	26
27	Sign			1998	2,000		15			2,000	27
28	Carpet,Curtains, Blinds			1998	11,249		10			11,249	28
29	Carpet,Curtains, Blinds			1998	19,656		10			19,656	29
30	Landscaping			1999	976		15			976	30
31	Wall Paper			1999	4,135		15			4,135	31
32	Reseal Parking Lot			1999	3,336		5			3,336	32
33	Fuel Tank			1999	8,935		15			8,935	33
34	Land Improvements			2000	647		15			647	34
35	Kitchen			2000	4,231		10			4,231	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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	Building Handrails	2000	$ 3,818	$	7	$	$	$ 3,818	37
38	Brittington Air & Water	2000	1,992		7			1,992	38
39	Tile-Wing 7	2000	3,753		7			3,753	39
40	Fire Doors	2000	4,861		10			4,861	40
41	Land Improvements	2001	380	11	15	11		380	41
42	North-Side Heaters	2001	6,090		7			6,090	42
43	Water Heaters	2001	15,196		7			15,196	43
44	Land Improvements	2005	316,403	21,094	15	21,094		233,787	44
45	Pole Barn	2007	12,485	832	15	832		7,976	45
46	Shelter House	2008	10,188	679	15	679		5,717	46
47	Land Improvements - Paving	2008	14,053	937	15	937		7,495	47
48	Reseal Parking Lot	2008	5,218	348	15	348		2,783	48
49	Silverline Windows	2009	8,092	540	15	540		3,866	49
50	Purf Pipe in Parking Lot	2009	4,110	274	15	274		1,964	50
51	Parking Lot Repavement	2009	12,469	831	15	831		5,784	51
52	Sidewalk	2011	5,556	370	15	370		1,821	52
53	Breezeway	2011	9,748	650	15	650		3,087	53
54	Sewer Replacement	2012	39,848	2,657	15	2,657		9,962	54
55	Water Heater	2012	8,600	573	15	573		2,102	55
56	HVAC	2013	6,665	171	39	171		484	56
57	Parking Lot Repavement	2014	15,645	1,565	10	1,565		2,934	57
58	Roof	2014	11,580	386	30	386		724	58
59	Water Heater	2015	7,900	790	10	790		1,152	59
60	Roof	2015	9,658	322	30	322		470	60
61	Flooring	2016	4,885	669	7	669		669	61
62	A/c Unit	2016	5,652	495	10	495		495	62
63	Flooring	2016	673	76	7	76		76	63
64	Flooring	2016	673	68	7	68		68	64
65	Bathroom Remodel	2016	970	44	10	44		44	65
66	Land Drainage Improvement	2016	840	11	10	11		11	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,158,805	$ 152,684		$ 152,684	$	$ 2,591,004	70

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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	$ 108,748	$ 17,496	$ 17,496	$	7	$ 67,324	71
72	Current Year Purchases	18,085	1,211	1,211		7	1,211	72
73	Fully Depreciated Assets	693,659	1,224	1,224		7	693,659	73
74								74
75	TOTALS	$ 820,491	$ 19,931	$ 19,931	$		$ 762,193	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY USE	86 Mazda Truck-B2000	1992	$ 4,474	$	$	$	5	$ 4,474	76
77	FACILITY USE	Donated Van	2009	2,700				5	2,700	77
78	FACILITY USE	Ford E-250	2015	44,472	8,894	8,894		5	13,712	78
79								5		79
80	TOTALS			$ 51,646	$ 8,894	$ 8,894	$		$ 20,886	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,180,158	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,509	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,509	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,374,083	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	3,218	$ 263,622	$	3,218	$ 263,622	1
2	Licensed Speech and Language Development Therapist		hrs		1,181	99,819		1,181	99,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,836	228,092	2,847	2,836	230,939	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			$	7,235	$ 591,532	$ 2,847	7,235	$ 594,379	14

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/2016 (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	$ 520,788	$ 536,868	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,381,592	1,618,014	3
4	Supply Inventory (priced at)	11,317	15,847	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,633	10,462	6
7	Other Prepaid Expenses	3,022	3,022	7
8	Accounts Receivable (owners or related parties)	425,637		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,348,989	$ 2,184,213	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	149,216	179,216	13
14	Buildings, at Historical Cost	6,158,804	8,304,671	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,137	1,038,632	16
17	Accumulated Depreciation (book methods)	(3,374,084)	(4,202,785)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,806,073	$ 5,319,734	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,155,062	$ 7,503,947	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 348,282	$ 350,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,745,294	1,745,294	29
30	Accrued Salaries Payable	58,110	66,208	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,491	7,876	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,408	19,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ADV BILLING SEC DEPOSITS RES TR	97,684	162,946	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,270,269	$ 2,352,810	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,794,859	8,025,525	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,794,859	$ 8,025,525	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,065,128	$ 10,378,335	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,910,066)	$ (2,874,388)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,155,062	$ 7,503,947	48

*(See instructions.)

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,769,578)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,769,578)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,488)	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)**	$ (140,488)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,910,066)	24 *

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

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	$ 5,322,693	1
2	Discounts and Allowances for all Levels	(1,994,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,328,024	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,346,136	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,346,136	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,203	14
15	Telephone, Television and Radio	1,520	15
16	Rental of Facility Space		16
17	Sale of Drugs	126,259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,204	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,186	23
	D. Non-Operating Revenue		
24	Contributions	3,274	24
25	Interest and Other Investment Income***	7,233	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,507	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	MISC INCOME	12,039	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,039	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,854,892	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	774,192	31
32	Health Care	2,351,763	32
33	General Administration	1,072,601	33
	B. Capital Expense		
34	Ownership	401,648	34
	C. Ancillary Expense		
35	Special Cost Centers	197,470	35
36	Provider Participation Fee	197,706	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,995,380	40
41	**Income before Income Taxes (line 30 minus line 40)****	(140,488)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (140,488)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,304,223	44
45	Private Pay - Net Inpatient Revenue	1,166,920	45
46	Medicare - Net Inpatient Revenue	519,888	46
47	Other-(specify) Manage Care/Hospice	336,994	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,328,024	49

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

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

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

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

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,083	2,092	$ 67,893	$ 32.45	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	18,285	18,364	422,991	23.03	3
4	Licensed Practical Nurses	16,902	16,975	294,758	17.36	4
5	CNAs & Orderlies	68,458	68,754	732,462	10.65	5
6	CNA Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	4,179	4,197	43,229	10.30	10
11	Social Service Workers	2,085	2,094	31,650	15.11	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	19,915	20,001	173,591	8.68	15
16	Dishwashers		0			16
17	Maintenance Workers	4,212	4,230	66,333	15.68	17
18	Housekeepers	11,845	11,896	104,201	8.76	18
19	Laundry	4,805	4,826	42,012	8.71	19
20	Administrator	2,043	2,052	93,139	45.39	20
21	Assistant Administrator	2,342	2,352	57,930	24.63	21
22	Other Administrative	2,621	2,632	72,543	27.56	22
23	Office Manager		0			23
24	Clerical	2,072	2,081	34,160	16.42	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)		0			30
31	Medical Records	1,439	1,445	18,290	12.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,286	163,991	$ 2,255,182 *	$ 13.75	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	MONTHLY	17,800	9-3	36
37	Medical Records Consultant	MONTHLY	1,924	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,724		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number OAKVIEW HTS CONT C & REH CTR # 0026328 Report Period Beginning: 09/01/2015 Ending: 08/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SCOTTIE COLE	ADMINISTRATOR	N/A	$ 93,139
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 93,139

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
DUANE MORRIS LLP	LEGAL	$ 17,793
WILCOX & CO	ACCTING	4,725
MDI		22,233
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 44,751

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,997
Unemployment Compensation Insurance	40,714
FICA Taxes	169,388
Employee Health Insurance	51,623
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	944
GBHC BD ALLOC PAY TAXES & OTH BENE	68,813
TOTAL (agree to Schedule V, line 22, col.8)	$ 439,479

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	459
Health Care Worker Background Check	3,211
(Indicate # of checks performed 97)	
Patient Background Checks	
DRUG TESTING	447
LICENSES	4,095
DUES & SUBSCRIPTIONS	8,119
ADVERTISING & MARKETING	4,252
Less: Public Relations Expense	( )
Non-allowable advertising	(4,252)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,331

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL HEALTH CARE ASSOC $7,155**

(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. $ **31,622** 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. $ **197,706**
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. $ **1,203**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Watler Accounting Certified Public Accountants, P.C.**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER 04-5179
LEGAL INVOICE LIST
AUGUST 31 2016

VendorName	InvoiceNumber	InvoiceDate	InvAmount	Allowable	Non-Allowable	Description
Duane Morris LLP	2110778	09/18/15	612.00		612.00	General (Various) Legal Svcs
Duane Morris LLP	2129534	11/17/15	1,153.00		1,153.00	General (Various) Legal Svcs
Duane Morris LLP	2149556	01/25/16	1,108.00		1,108.00	General (Various) Legal Svcs
Duane Morris LLP	2206825	07/25/16	11,895.00		11,895.00	General (Various) Legal Svcs
Duane Morris LLP	2206826	07/25/16	1,259.50		1,259.50	General (Various) Legal Svcs
Duane Morris LLP	2215669	08/18/16	1,765.00		1,765.00	General (Various) Legal Svcs
			17,792.50		17,792.50	

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER 04-5179
TRIAL BALANCE (GROUPING)
AUGUST 31 2016

Sub1	Account Number	Account Description		Amount	TOTAL
MEDICAID GROUPING					
A11	66100.000	Wages - Supervisor	Dietary	24,935	
A11	66110.000	Wages - Regular	Dietary	142,931	
A11	66150.000	Wages - Vacation/Holiday/Sick	Dietary	5,725	173,591
A12	69670.000	Supplies (Non-Food)	Dietary	21,476	
A12	69735.000	Small Equipment Purchase	Dietary	316	
A12	69720.000	Equipment Repair & Maintenance	Dietary	5,298	27,090
A13	69850.000	Purchased Services	Dietary	8,773	8,773
A22	69680.000	Food Supplements	Dietary	13,522	
A22	69690.000	Raw Food	Dietary	151,161	164,683
A31	71100.000	Wages - Supervisor	Housekeeping	17,570	
A31	71110.000	Wages - Regular	Housekeeping	81,523	
A31	71150.000	Wages - Vacation/Holiday/Sick	Housekeeping	5,169	104,261
A32	71670.000	Supplies	Housekeeping	7,131	7,131
A33	71850.000	Purchased Services	Housekeeping	96	96
A41	70110.000	Wages - Regular	Laundry	39,061	
A41	70150.000	Wages - Vacation/Holiday/Sick	Laundry	2,950	42,012
A42	70660.000	Chemicals	Laundry	2,171	
A42	70670.000	Supplies	Laundry	1	
A42	70690.000	Linen	Laundry	3,565	
A42	70720.000	Small Equipment Purchase	Laundry	223	5,966
A53	72510.000	Gas	Plant & Maintenance	4,650	
A53	72520.000	Electricity	Plant & Maintenance	85,188	
A53	72525.000	Cable Television	Plant & Maintenance	7,653	
A53	72530.000	Water	Plant & Maintenance	11,824	
A53	72535.000	Sewer	Plant & Maintenance	6,675	115,369
A61	72110.000	Wages - Regular	Plant & Maintenance	62,296	
A61	72150.000	Wages - Vacation/Holiday/Sick	Plant & Maintenance	4,036	66,333
A62	72660.000	Building Repair & Maintenance	Plant & Maintenance	15,303	
A62	72667.000	Vehicle Repair & Maintenance	Plant & Maintenance	166	
A62	72670.000	Supplies	Plant & Maintenance	10,349	
A62	72680.000	Grounds Maintenance	Plant & Maintenance	3,173	
A62	72720.000	Small Equipment Purchase	Plant & Maintenance	1,476	
A62	72730.000	Repair & Maintenance	Plant & Maintenance	6,056	36,521
A63	72540.000	Trash Removal	Plant & Maintenance	6,813	
A63	72550.000	Service Contracts	Plant & Maintenance	5,657	
A63	72675.000	Pest Control	Plant & Maintenance	3,921	
A63	72830.000	Education	Plant & Maintenance	130	
A63	72900.000	Other	Plant & Maintenance	973	17,495
B101	63050.000	Wages - Medical Records	Nursing Medicare Dist	18,296	
B101	63100.000	Wages - R.N.	Nursing Medicare Dist	54,457	
B101	63150.000	Wages - Vacation/Holiday/Sick	Nursing Medicare Dist	2,343	
B101	64100.000	Wages - R.N.	Nursing Non Distinct	344,795	
B101	64110.000	Wages - L.P.N.	Nursing Non Distinct	277,531	
B101	64120.000	Wages - Aides	Nursing Non Distinct	689,653	
B101	64150.000	Wages - Vacation/Holiday/Sick	Nursing Non Distinct	81,437	
B101	67100.000	Wages - DON	Nursing Administration	66,080	
B101	67150.000	Wages - Vacation/Holiday/Sick	Nursing Administration	1,917	1,536,394
B102	64600.000	Supplies (Non-Medical)	Nursing Non Distinct	28,942	
B102	86900.000	Non-Billable Non-Distinct	Medical Supplies	14,345	
B102	86915.000	Nursing Supplies	Medical Supplies	26,615	
B102	86920.000	Briefs	Medical Supplies	31,622	
B102	86925.000	Small Equipment Purchase	Medical Supplies	1,750	
B102	86930.000	Oxygen	Medical Supplies	17,717	118,991
B103	64820.000	Medical Records Consultant	Nursing Non Distinct	1,924	1,924
B10a1	80670.000	Supplies	Physical Therapy	2,627	2,627
B10a3	80900.000	Purchased Services/part A	Physical Therapy	151,848	
B10a3	80951.000	Purchased Services/part B	Physical Therapy	74,766	
B10a3	80952.000	Purchased Services Insurance	Physical Therapy	1,218	
B10a3	80953.000	Purchased Services Private Pay	Physical Therapy	259	
B10a3	81900.000	Purchased Services/ Part A	Occupational Therapy	161,372	
B10a3	81951.000	Purchased Services/part B	Occupational Therapy	101,864	
B10a3	81953.000	Purchased Services Private Pay	Occupational Therapy	385	
B10a3	82900.000	Purchased Services Medicaid	Speech Therapy	557	
B10a3	82950.000	Purchased Services/part A	Speech Therapy	47,913	
B10a3	82951.000	Purchased Services/part B	Speech Therapy	51,326	
B10a3	82953.000	Purchased Services Private Pay	Speech Therapy	123	591,532
B111	61100.000	Wages - Supervisor	Activities	3,000	
B111	61110.000	Wages - Regular	Activities	38,512	
B111	61150.000	Wages - Vacation/Holiday/Sick	Activities	4,717	43,229
B112	61660.000	Supplies	Activities	1,367	1,367
B113	61660.000	Entertainment	Activities	575	
B113	61830.000	Education	Activities	500	
B113	61850.000	Purchased Services	Activities	2,057	3,532
B121	62100.000	Wages - Supervisor	Social Services	30,836	
B121	62150.000	Wages - Vacation/Holiday/Sick	Social Services	814	31,650
B122	62850.000	Purchased Services	Social Services	2,567	2,567
B131	83000.000	Medical Director	Medical Director	17,800	17,800
C171	73100.000	Wages - Administrator	General & Administration	63,749	63,749
C183	73430.000	Legal Fees	General & Administration		
C183	73440.000	Accounting Fees	General & Administration	4,725	
C183	73620.000	Software Maintenance	General & Administration	33,734	44,751
C203	73500.000	Advertising	General & Administration		
C203	73515.000	Ads- Help Wanted	General & Administration	459	
C203	73610.000	Dues & Subscriptions	General & Administration	8,119	
C203	73635.000	Back Ground Check	General & Administration	2,211	
C203	73645.000	Drug Testing	General & Administration	447	
C203	73655.000	Marketing	General & Administration	862	
C203	73670.000	Licenses	General & Administration	4,099	20,583
C211	73110.000	Wages - Regular	General & Administration	103,969	
C211	73150.000	Wages - Vacation/Holiday/Sick	General & Administration	3,054	
C211	75100.000	Wages	Operations	57,800	164,633
C212	73670.000	Office Supplies	General & Administration	11,864	
C212	73860.000	Postage	General & Administration	759	
C212	73880.000	Printing	General & Administration	50	12,623
C213	65600.000	Supplies (Non-Medical)	Nursing Res. Care	155	
C213	72500.000	Telephone/Internet	Plant & Maintenance	23,849	
C213	73400.000	Uniform Expense	General & Administration	1,918	
C213	73455.000	Service Charge	General & Administration	98	
C213	73460.000	Professional Fees	General & Administration	1,498	
C213	73580.000	Taxes - General	General & Administration	53	
C213	73815.000	Management Fees	General & Administration	245,030	
C213	73850.000	Purchased Services	General & Administration	6,887	
C213	73885.000	Resident Expense	General & Administration	22	
C213	73900.000	Miscellaneous	General & Administration	1,552	281,139
C223	73200.000	Payroll Taxes	General & Administration	169,388	
C223	73250.000	Workers Compensation	General & Administration	107,997	
C223	73280.000	Unemployment	General & Administration	40,714	
C223	73300.000	Group Insurance	General & Administration	51,623	
C223	73901.000	Employee Benefit	General & Administration	944	370,666
C243	64830.000	Education	Nursing Non Distinct	2,333	
C243	65830.000	Education	Nursing Res. Care	155	
C243	73750.000	Auto Expense	General & Administration	1,339	
C243	73820.000	Travel & Seminar	General & Administration	2,192	
C243	73825.000	Meals & Entertainment	General & Administration	703	
C243	73830.000	Education	General & Administration	1,441	
C243	73840.000	Mileage Reimbursement	General & Administration	119	8,282
C263	73523.000	MIP Insurance	General & Administration	31,868	
C263	73525.000	Property Insurance	General & Administration	6,789	
C263	73530.000	Insurance	General & Administration	35,458	
C263	73535.000	Auto Insurance	General & Administration	2,671	76,785
D303	73550.000	Depreciation	General & Administration	181,509	181,509
D323	73435.000	Interest	General & Administration	198,470	198,470
D353	72700.000	Equipment Rental	Plant & Maintenance	3,841	
D353	73700.000	Equipment Rental	General & Administration	6,506	
D353	73740.000	Copier Equipment	General & Administration	5,032	
D353	86910.000	Equipment Rental	Medical Supplies	6,289	21,669
E393	84050.000	Dental Consultant	Dental	850	
E393	85660.000	Legend Drugs	Pharmacy	130,588	
E393	85690.000	Non-Legend Drugs	Pharmacy	16,762	
E393	88005.000	Laboratory - Med A	Laboratory	49,271	197,470
E423	73585.000	Bed Tax Expense	General & Administration	197,706	197,706
FS01	40100.000	Room And Board	Medicare Part A	(543,835)	
FS01	40110.000	Less: Contractual Adjustment	Medicare Part A	(1,075,013)	
FS01	41100.000	Room And Board	Private Certified	(1,176,685)	
FS01	42100.000	Room And Board	Medicaid Certified	(2,220,035)	
FS01	43100.000	Room And Board	Managed Care Certified	(50,360)	
FS01	44100.000	Room And Board	Hospice Certified	(250,130)	
FS01	52100.000	Room And Board	Insurance	(6,635)	(5,322,693)
FS02	40900.000	Less: Contractual Adjustment	Medicare Part A	1,098,960	
FS02	41110.000	Less: Contractual Adjustment	Private Certified	9,730	
FS02	41900.000	Less: Contractual Adjustment	Private Certified	35	
FS02	42110.000	Less: Contractual Adjustment	Medicaid Certified	484,559	
FS02	42899.000	Prior Year Adjustment	Medicaid Certified	48,556	
FS02	42900.000	Less: Contractual Adjustment	Medicaid Certified	71,719	
FS02	43110.000	Less: Contractual Adjustment	Managed Care Certified	(81,360)	
FS02	43900.000	Less: Contractual Adjustment	Managed Care Certified	44,038	
FS02	44110.000	Less: Contractual Adjustment	Hospice Certified	18,938	
FS02	51900.000	Less: Contractual Adjustment	Medicaid Non-Certified	316	
FS02	52110.000	Less: Contractual Adjustment	Insurance	(3,952)	
FS02	52900.000	Less: Contractual Adjustment	Insurance	(7,852)	
FS02	73540.000	Bad Debt Expense	General & Administration	310,978	1,994,664
FS06	40400.000	Physical Therapy	Medicare Part A	(389,163)	
FS06	40450.000	Occupational Therapy	Medicare Part A	(428,036)	
FS06	40500.000	Speech Therapy	Medicare Part A	(141,164)	
FS06	41400.000	Physical Therapy	Private Certified	1,420	
FS06	41450.000	Occupational Therapy	Private Certified	601	
FS06	41500.000	Speech Therapy	Private Certified	(2,635)	
FS06	42400.000	Physical Therapy	Medicaid Certified	(26,033)	
FS06	42450.000	Occupational Therapy	Medicaid Certified	(27,465)	
FS06	42500.000	Speech Therapy	Medicaid Certified	(7,874)	
FS06	43400.000	Physical Therapy	Managed Care Certified	(12,426)	
FS06	43450.000	Occupational Therapy	Managed Care Certified	(17,253)	
FS06	43500.000	Speech Therapy	Managed Care Certified	(7,359)	
FS06	44450.000	Occupational Therapy	Hospice Certified	(0)	
FS06	52500.000	Speech Therapy	Insurance	7,852	
FS06	56450.000	Occupational Therapy	Supported Living	(0)	
FS06	58400.000	Physical Therapy	Medicare Part B	(163,804)	
FS06	58450.000	Occupational Therapy	Medicare Part B	(221,490)	
FS06	58500.000	Speech Therapy	Medicare Part B	(125,118)	
FS06	58900.000	Less: Contractual Adjustment	Medicare Part B	213,811	(1,346,136)
FS14	59411.000	Employee/Guest Meals	Other Revenue	(1,203)	(1,203)
FS15	59912.000	Cable Income	Other Revenue	(1,520)	(1,520)
FS17	40250.000	Pharmacy	Medicare Part A	(113,902)	
FS17	41250.000	Pharmacy	Private Certified	(1,113)	
FS17	42250.000	Pharmacy	Medicaid Certified	(6,553)	
FS17	43250.000	Pharmacy	Managed Care Certified	(4,824)	
FS17	55200.000	Medical Supplies	Residential Care	132	(126,259)
FS19	40850.000	LAB	Medicare Part A	(26,759)	
FS19	43850.000	LAB	Managed Care Certified	(2,176)	
FS19	58850.000	LAB	Medicare Part B	(268)	(29,204)
FS24	59913.000	Donations	Other Revenue	(3,274)	(3,274)
FS25	59511.000	Interest Income	Other Revenue	(2,514)	
FS25	59914.000	Oil Lease Royalties	Other Revenue	(4,719)	(7,233)
FS28	59911.000	Misc. Income	Other Revenue	(12,039)	(12,039)
BS01	10015.000	Cash - Payroll	Cash	124	
BS01	10020.000	Cash - Petty	Cash	450	
BS01	10021.000	Cash - Petty, Activities	Cash	200	
BS01	10031.000	Cash - Assistance Fund	Cash	9,780	
BS01	10035.000	Cash - Op Account	Cash	(72,430)	
BS01	10040.000	Cash - Tax & Insurance Escrow - Gershman	Cash	37,262	
BS01	10041.000	Cash - In FNB Patient Fund	Cash	5,567	
BS01	10048.000	Cash - Gershman Bus Bank R.R.	Cash	539,835	520,788
BS03	10100.000	A/R - Private	A/R - Operations	352,098	
BS03	10200.000	A/R - Medicaid	A/R - Operations	619,264	
BS03	10300.000	A/R - Medicare Part A	A/R - Operations	141,793	
BS03	10400.000	A/R - Medicare Part B	A/R - Operations	94,398	
BS03	10500.000	A/R - Co-Insurance Part A	A/R - Operations	106,679	
BS03	10600.000	A/R - Co-Insurance Part B	A/R - Operations	16,044	
BS03	10700.000	A/R - Managed Care	A/R - Operations	52,061	
BS03	11000.000	A/R - Hospice	A/R - Operations	55,652	
BS03	11100.000	A/R - Veterans Admin.	A/R - Operations	3,602	
BS03	12000.000	A/R - Allowance For Bad Debt	A/R - Operations	(60,000)	1,381,592
BS04	14100.000	Supplies - Medical	Inventory	5,994	
BS04	14200.000	Supplies - Dietary	Inventory	1,841	
BS04	14300.000	Supplies - Hskpg./Laundry	Inventory	1,236	
BS04	14900.000	Supplies - Other	Inventory	2,246	11,317
BS06	15200.000	Prepaid - Insurance	Prepaid Expenses	6,633	6,633
BS07	15100.000	Prepaid - Expenses	Prepaid Expenses	3,022	3,022
BS08	21580.000	Intercompany Account	Current Liabilities	425,637	425,637
BS13	16110.000	Land	Fixed Assets	149,216	149,216
BS14	16100.000	Building	Fixed Assets	5,657,260	
BS14	16105.000	Building Improvements	Fixed Assets	41,992	
BS14	16120.000	Land Improvement	Fixed Assets	459,552	6,158,804
BS16	16150.000	Automobile	Fixed Assets	51,646	
BS16	16200.000	Furniture, Fixture & Equipment	Fixed Assets	820,491	872,137
BS17	16140.000	Accum. Dep. - Land Improvement	Fixed Assets	(311,950)	
BS17	16500.000	Accum. Dep. - Building	Fixed Assets	(2,275,357)	
BS17	16505.000	Accum. Dep. - Building Improvements	Fixed Assets	(3,698)	
BS17	16550.000	Accum. Dep. - Automobile	Fixed Assets	(20,886)	
BS17	16600.000	Accum. Dep. - FF&E	Fixed Assets	(762,193)	(3,374,084)
BS26	20010.000	Accounts Payable	Current Liabilities	(348,282)	(348,282)
BS29	21540.000	Note Payable Line Of Credit - Loan # 80000615	Current Liabilities	(249,363)	
BS29	21550.000	Note Payable Line Of Credit - Loan # 80000623	Current Liabilities	(250,000)	
BS29	25200.000	Due To/From Parent Company	Long Term Liabilities	(1,245,931)	(1,745,294)
BS30	20200.000	Accrued Wages	Current Liabilities	(26,981)	
BS30	20205.000	Accrued Vacation	Current Liabilities	(31,129)	(58,110)
BS31	21000.000	Unemployment Liability	Current Liabilities	(6,491)	(6,491)
BS33	20240.000	Accrued Interest	Current Liabilities	(14,408)	(14,408)
BS36	20250.000	Accrued State Provider Tax	Current Liabilities	(8,370)	
BS36	21500.000	Advance Billing	Current Liabilities	(86,784)	
BS36	21510.000	Resident Refunds	Current Liabilities	3,037	
BS36	21530.000	Resident Trust	Current Liabilities	(5,567)	(97,684)
BS39	25100.000	Notes Payable - Gershman Mortgage	Long Term Liabilities	(5,763,236)	
BS39	25110.000	Notes Payable - Automobile	Long Term Liabilities	(31,623)	(5,794,859)
BS47	30100.000	Capital Investment	Equity	(1,322,373)	
BS47	30750.000	Prior Period Adjustment	Equity	52,383	
BS47	30800.000	Retained Earnings	Equity	3,039,568	1,769,578

TOTAL EXPENSES	(0)	0
NET (INCOME) LOSS		140,484