		FOR BHF USE					

LL1

DEPARTMENT OF
FINANCIAL AND
FOR LC

I. **IDPH License ID Number:** 0046755

Facility Name: Oakview

Address: 2311 Veterans Drive (Number) Effingham (City) 62401 (Zip Cod

County: Effingham

Telephone Number: (217) 342-6400 **Fax #** (217) 342-6412

HFS ID Number:

Date of Initial License for Current Owners: 3/24/2005

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNME		
	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: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

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.

2018
STATE OF ILLINOIS
HEALTHCARE AND FAMILY SERVICES
STATISTICAL REPORT (COST REPORT)
ONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/17 to 6/30/18 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)	
	(Title)	
Paid Preparer	**(Signed)**	**(Date)**
	(Print Name and Title)	
	(Firm Name & Address)	**RSM US LLP** **20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173**
	(Telephone)	**(847) 517-7070** **Fax # (847) 517-7067**

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

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 N/A

	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		Skilled (SNF)		
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6	16	ICF/DD 16 or Less	16	5,840
7	16	TOTALS	16	5,840

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment	3	4	5
		Medicaid Recipient	Private Pay	Other	Total
8	SNF				
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS	5,307			5,307
14	TOTALS	5,307			5,307

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.87%

0046755 Report Period Beginning: 7/01/17 Ending: 6/30/18

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [X] NO [ ]

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 03/24/05

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 03/24/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Oakview #

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

	Operating Expenses	Costs Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	A. General Services	1	2	3	4
1	Dietary	57,267	5,034	450	62,751
2	Food Purchase		43,179		43,179
3	Housekeeping	14,939	3,692	-	18,631
4	Laundry	9,959	2,516	-	12,475
5	Heat and Other Utilities			13,465	13,465
6	Maintenance	-	11,366	4,503	15,869
7	Other (specify):*	-	-	-	
8	**TOTAL General Services**	82,165	65,787	18,418	166,370
	B. Health Care and Programs				
9	Medical Director	-	-	-	
10	Nursing and Medical Records	164,571	11,656	8,565	184,792
10a	Therapy	-	-	-	
11	Activities	-	980	-	980
12	Social Services	-	-	-	
13	CNA Training	-	-	-	
14	Program Transportation	-	7,456	-	7,456
15	Other (specify):*	-	-	-	
16	**TOTAL Health Care and Programs**	164,571	20,092	8,565	193,228
	C. General Administration				
17	Administrative	43,034	-	-	43,034
18	Directors Fees			-	
19	Professional Services			5,250	5,250
20	Dues, Fees, Subscriptions & Promotions			128	128
21	Clerical & General Office Expenses	27,727	2,430	2,586	32,743
22	Employee Benefits & Payroll Taxes			91,207	91,207
23	Inservice Training & Education			555	555
24	Travel and Seminar			390	390
25	Other Admin. Staff Transportation		974	-	974
26	Insurance-Prop.Liab.Malpractice			352	352
27	Other (specify):* **Indirect Costs**	-	-	23,416	23,416
28	**TOTAL General Administration**	70,761	3,404	123,884	198,049
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	317,497	89,283	150,867	557,647

***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 includ

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	62,751	-	62,751			1
(10,400)	32,779	-	32,779			2
	18,631	-	18,631			3
	12,475	-	12,475			4
	13,465	-	13,465			5
	15,869	-	15,869			6
		-				7
(10,400)	155,970		155,970			8
2,250	2,250	-	2,250			9
(2,250)	182,542	-	182,542			10
		-				10a
	980	-	980			11
		-				12
		-				13
	7,456	-	7,456			14
		-				15
	193,228		193,228			16
	43,034	-	43,034			17
		-				18
	5,250	-	5,250			19
158	286	-	286			20
(554)	32,189	-	32,189			21
10,400	101,607	-	101,607			22
	555	-	555			23
	390	-	390			24
	974	-	974			25
	352	-	352			26
	23,416	-	23,416			27
10,004	208,053	-	208,053			28
(396)	557,251		557,251			29

e a detailed explanation of each reclassification.

Facility Name & ID Number **Oakview**

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger			
	Capital Expense	**Salary/Wage**	**Supplies**	**Other**	**Total**
	D. Ownership	**1**	**2**	**3**	**4**
30	Depreciation			5,888	5,888
31	Amortization of Pre-Op. & Org.			-	
32	Interest			-	
33	Real Estate Taxes			-	
34	Rent-Facility & Grounds			1	1
35	Rent-Equipment & Vehicles			-	
36	Other (specify):*			-	
37	**TOTAL Ownership**			5,889	5,889
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	-	-	-	
39	Ancillary Service Centers	-	46	-	46
40	Barber and Beauty Shops	-	-	-	
41	Coffee and Gift Shops	-	-	-	
42	Provider Participation Fee			36,792	36,792
43	Other (specify):* **Non-Allowable Cos**	-	-	4	4
44	**TOTAL Special Cost Centers**		46	36,796	36,842
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	317,497	89,329	193,552	600,378

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	5,888	25,959	31,847			30
		-				31
		-				32
		-				33
	1	(1)				34
396	396	-	396			35
		-				36
396	6,285	25,958	32,243			37
		-				38
	46	-	46			39
		-				40
		-				41
	36,792	-	36,792			42
	4	(4)				43
	36,842	(4)	36,838			44
	600,378	25,954	626,332			45

0.

Facility Name & ID Number Oakview # 0046755 Rep

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjust**
In column 2 below, reference the line on which the particular cost was

	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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,600)	30		9
10	Interest and Other Investment Income				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)	43		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,604)		$	30

BHF USE ONLY									
48		49		50		51		52	

ed out of Schedule V, pages 3 or 4 via column 7.
; included. (See instructions.)

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)	38,558		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 38,558		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 25,954		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Oakview

ID# 0046755

Report Period Beginning: 7/01/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

Facility Name & ID Number Oakview

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defin

1 OWNERS		2 RELATED NURSI
Name	Ownership %	Name
Community Support Systems	100	N/A

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in 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 Or Name of Related O
1	V	30	Depreciation	$	Community Suppo
2	V	34	Rent	1	Community Suppo
3	V				
4	V				
5	V				
6	V				
7	V				
8	V				
9	V				
10	V				
11	V				
12	V				
13	V				
14	Total			$ 1	

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

ed in the instructions. Use Page 6-Supplemental as necessary.

NG HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
		Merchant	Effingham	CILA
		KC Home	Effingham	CILA
		Smith	Teutopolis	CILA
		DT Center	Teutopolis	Developmental
				Training
		Community Support	Teutopolis	Lessor
		Systems Foundation, I		

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:	
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
rt Systems Foundation, Inc.		$ 38,559	$ 38,559	1
rt Systems Foundation, Inc.			(1)	2
				3
				4
				5
				6
				7
				8
				9
				10
				11
				12
				13
		$ 38,559	$ * 38,558	14

VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their re must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest
1	Greg Bean	President	Administrative	0
2	Dan Holste	Vice President	Administrative	0
3	Larry Weber	Secretary	Administrative	0
4	Randy Jones	Treasurer	Administrative	0
5	Jeremy Nieman	Member	Administrative	0
6	Anita Seiler	Member	Administrative	0
7	James Rutledge	Member	Administrative	0
8	Barry Bright	Member	Administrative	0
9	Janet Clark	Member	Administrative	0
10	Ginger Robins	Member	Administrative	0
11	Angie Koester	Member	Administrative	0
12	Yvette Paddock	Member	Administrative	0
13				

* If the owner(s) of this facility or any other related parties listed above have receive of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE /

** This must include all forms of compensation paid by related entities and all FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES

Board of Directors.
elatives who receive any type of compensation from this home

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

ed compensation from other nursing homes, attach a schedule detailing the name(s)
AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

ocated to Schedule V of this report (i.e., management fees).
RMS OF COMPENSATION RECEIVED FROM THIS HOME,
ULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oakview #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1			`		
2					
3					
4		N/A			
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25	TOTALS				

0046755 Report Period Beginning: 7/01/17 Ending: 6/30/18

ce

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

5 Number of ıbunits Being ocated 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
					2
					3
					4
					5
					6
					7
					8
					9
					10
					11
					12
					13
					14
					15
					16
					17
					18
					19
					20
					21
					22
					23
					24
	$	$		$	25

Facility Name & ID Number Oakview #

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required
	A. Directly Facility Related				
	Long-Term				
1	N/A				
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	TOTAL Facility Related				
	B. Non-Facility Related*				
10					
11					
12					
13					
14	TOTAL Non-Facility Related				
15	TOTALS (line 9+line14)				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, cons (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated (See instructions.)**

necessary.)

5	6	7	8	9	10	
Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	Original	Balance				
	$	$			$	1
						2
						3
						4
						5
						6
						7
						8
	$	$			$	9
						10
						11
						12
						13
	$	$			$	14
	$	$			$	15

ch. V. $ N/A Line # N/A

equently, page 4, col. 7.

in column 2.

Facility Name & ID Number Oakview

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next work statement and bill must accompany**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment c

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the li

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other ge
(Describe appeal cost below. Attach copies of invoices to support the cost and a c

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**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	**N/A**	**8**
	2014		**9**
	2015		**10**
	2016		**11**
	2017		**12**

Facility is a not for profit entity and does not pay real estate tax.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Dec taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you mu application for real estate tax exemption unless the building This denial must be no more than four years old at**

sheet, "RE_Tax". The real estate tax the cost report.	$	1
2017 overs more than one year, detail below.)	$	2
	$	3
nes below.)	$	4
eneral operating costs on Schedule V, sections A, B or C. copy of the appeal filed with the county.)	$	5
Alloc Fr. Mgmt Co. real estate tax appeal board's decision.)	$	6
	$	7

		FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2017	$	13
	14	PLUS APPEAL COST FROM LINE 5	$	14
	15	LESS REFUND FROM LINE 6	$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	$	16

duct any overaccrual of

ust attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TA

FACILITY NAME Oakview

FACILITY IDPH LICENSE NUMBER 0046755

CONTACT PERSON REGARDING THIS REPORT Andrew Kistler

TELEPHONE (217) 705-4298 FAX #: (217) 705

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provi
cost that applies to the operation of the nursing home in Column D. Real estate ta
home property which is vacant, rented to other organizations, or used for purposes
entered in Column D. Do not include cost for any period other than calendar year

	(A) Tax Index Number	(B) Property Description	
1.	Facility is a not for profit entity		$
2.	and does not pay real estate tax.		$
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 prop
used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the c
(Generally the real estate tax cost must be allocated to the nursing home based upc

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this s
tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is
documentation . Facilities located in Cook County are required to provide
installment tax bill.

X STATEMENT

COUNTY Effingham

-4432

ded below. Enter only the portion of the
x applicable to any portion of the nursing
other than long term care must not be
2017.

(C) Total Tax	(D) Tax Applicable to Nursing Home
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$

erty, or property which is not directly

ost allocated to the nursing home.
on sq. ft. of space used.)

statement. Be sure to use the 2017

not considered acceptable tax bill
copies of their original **second**

Facility Name & ID Number Oakview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,200 B. General Construction Type: Exterior Bric

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Rel

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule

E. List all other business entities owned by this operating entity or related to the operating entity that are l
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, indepen
List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred: N/A 2. N

3. Current Period Amortization: N/A 4. D

Nature of Costs:
(Attach a complete schedule detailing the total amount of or

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet
1	Residential Care	63,000
2		
3	TOTALS	63,000

ck Frame Steel Number of Stories One

lated Organization. [ ] (c) Rent from Completely Unrelated Organization.

or Schedule XII-A. See instructions.)

t from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

XI-C or Schedule XII-B. See instructions.)

ocated on or adjacent to this nursing home's grounds
ident living facilities, CNA training facilities, etc.)
).

[ ] YES [X] NO

lumber of Years Over Which it is Being Amortized: N/A

ates Incurred: N/A

ganization and pre-operating costs.)

3 Year Acquired	4 Cost	
2004	$ 95,244	1
		2
	$ 95,244	3

Facility Name & ID Number Oakview

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	
4	16		2005	2005	$
5			2005	2005	
6					
7					
8					
	Improvement Type**				
9	Wall and window hangings, drapes, decorating			2005	
10	Telephone system upgrade			2005	
11					
12					
13	Landscaping Improvements			2005	
14	Fire Sprinklers			2005	
15	Elevator door restrictor			2013	
16					
17	Elevator Repair			2016	
18					
19	Sump Pump Drain - Mechanical Room			2017	
20	Flooring - Kitchen, Dining Room, 4 Bathrooms			2017	
21					
22	Reconcile to book				
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
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.

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation
1,113,035	$ -	40	$ 27,826	$ 27,826	$ 368,695
5,462		40	137	137	1,781
5,521		10			5,521
450		10	-		450
	-		-		
	-		-		
957	-	10	-		957
10,359	-	30	345	345	4,428
3,720	248	10	248		1,157
	-		-		
3,658	-	10	366	366	915
	-		-		
4,493	-	5	899	899	1,348
6,955	464	15	464		464
	-		-		
	3,614		-	(3,614)	
	-		-		
			-		
	-		-		
	-		-		
	-		-		
	-		-		

See Page 12A, Line 70 for total

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Facility Name & ID Number Oakview

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Improvement Type**	3 Year Constructed	
37			$
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
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55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70	TOTAL (lines 4 thru 69)		$

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

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation
	$		$	$	$
	-		-		
	-		-		
	-		-		
	-		-		
			-		
	-		-		
	-		-		
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	-		-		
	-		-		
	-		-		
	-		-		
	-		-		
	-		-		
	-		-		
1,154,610	$ 4,326		$ 30,285	$ 25,959	$ 385,716

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Facility Name & ID Number Oakview # 0046755

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Curre Depre
71	Purchased in Prior Years	$ 7,808	$
72	Current Year Purchases		
73	Fully Depreciated Assets	36,771	
74			
75	TOTALS	$ 44,579	$

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Curr Depr
76	Resident Use	2002 Ford Van	2005	$ 11,981	$
77					
78					
79					
80	TOTALS			$ 11,981	$

E. Summary of Care-Related Assets

		1 Referen
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Page
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12

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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

ent Book eciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
1,562	$ 1,562	$ -		$ 3,361	71
		-			72
		-		36,771	73
		-			74
1,562	$ 1,562	$		$ 40,132	75

rent Book reciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
-	$ -	$ -	5	$ 11,981	76
		-			77
		-			78
		-			79
	$	$		$ 11,981	80

ıce	2 Amount		
s 12B thru 12I, if applicable)	$ 1,306,414	81	
I, if applicable)	$ 5,888	82	
I, if applicable)	$ 31,847	83	**
I, if applicable)	$ 25,959	84	
I, if applicable)	$ 437,829	85	

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

STA
Facility Name & ID Number Oakview #

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, c
If NO, see instructions. ☐

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount
3	Original Building:				$ N/A
4	Additions				
5					
6					
7	TOTAL				$ **

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: N/A

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

15. Is Movable equipment rental included in building rental? ☐

16. Rental Amount for movable equipment: $ 396 Description: Copi

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17			$ N/A	$
18				
19				
20				
21	TOTAL		$	$

column 4?
YES ☐ NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		7

N/A
N/A

*

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.	/2019	$
13.	/2020	$
14.	/2021	$

YES ☐ NO
er
(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
	17
	18
	19
	20
	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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See inst

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

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

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PO
IN-HOUSE PROG
IN OTHER FACII
COMMUNITY CO
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS

		1	2	
		Facility		
		Drop-outs	Completed	
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)	$		

(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.

tructions.)

edule listing the facility name, address and cost per CNA trained in that facility.)

RTION:		3.	CLINICAL PORTION:
RAM	☐		IN-HOUSE PROGRAM ☐
LITY	☐		IN OTHER FACILITY ☐
OLLEGE	☐		HOURS PER CNA ____
	____		

(d)

3	4
Contract	Total
	$
	$

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	

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost
1	Licensed Occupational Therapist		hrs	$
2	Licensed Speech and Language Development Therapist		hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist	39(2)	hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program		hrs	
8	Habilitation		hrs	
9	Pharmacy		# of prescrpts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activitie
on this schedule.

4	5	6	7	8	
Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
	$	$		$	1
					2
					3
		46		46	4
					5
					6
					7
					8
					9
					10
					11
					12
					13
	$	$ 46		$ 46	14

fees should be detailed on
es should not be listed

STATE OF ILLIN

Facility Name & ID Number Oakview # 0046755

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/18

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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,244	13
14	Buildings, at Historical Cost		1,118,497	14
15	Leasehold Improvements, at Historical Cost		36,113	15
16	Equipment, at Historical Cost		56,560	16
17	Accumulated Depreciation (book methods)		(437,829)	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 (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 868,585	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 868,585	25

***(See instructions.)**

Report Period Beginning: 7/01/17 Ending: 6/30/18

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	**$**	**$**	**26**
27	Officer's Accounts Payable			**27**
28	Accounts Payable-Patient Deposits			**28**
29	Short-Term Notes Payable			**29**
30	Accrued Salaries Payable			**30**
31	Accrued Taxes Payable (excluding real estate taxes)			**31**
32	Accrued Real Estate Taxes(Sch.IX-B)			**32**
33	Accrued Interest Payable			**33**
34	Deferred Compensation			**34**
35	Federal and State Income Taxes			**35**
	Other Current Liabilities(specify):			
36				**36**
37				**37**
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	**$**	**$**	**38**
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			**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)**	**$**	**$**	**45**
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	**$**	**$**	**46**
47	**TOTAL EQUITY(page 18, line 24)**	**$ SEE SCH 17A**	**$ SEE SCH 17A**	**47**
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	**$ SEE SCH 17A**	**$ SEE SCH 17A**	**48**

Facility Name: **Oakview**
IDPH License ID Number: **0046755**
Fiscal Year End: **6/30/18**

Schedule 17A

NOTE: Oakview is a 16-bed DD facility that is part of Community Suppor
CSS combines all its programs in a single balance sheet; therefo
Statements of Equity for each program. For this reason, pages 17

t Systems (CSS), a multi-program organization.
e, it does not maintain separate Balance Sheets or
' & 18 have not been completed on this cost report.

Facility Name & ID Number Oakview #

XVI. STATEMENT OF CHANGES IN EQUITY

1	**Balance at Beginning of Year, as Previously Reported**	**$**
2	Restatements (describe):	
3		
4		
5		
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	**$**
	A. Additions (deductions):	
7	NET Income (Loss) (from page 19, line 43)	
8	Aquisitions of Pooled Companies	
9	Proceeds from Sale of Stock	
10	Stock Options Exercised	
11	Contributions and Grants	
12	Expenditures for Specific Purposes	
13	Dividends Paid or Other Distributions to Owners	**(**
14	Donated Property, Plant, and Equipment	
15	Other (describe)	
16	Other (describe)	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	**$**
	B. Transfers (Itemize):	
18		
19		
20		
21		
22		
23	**TOTAL Transfers (sum of lines 18-22)**	**$**
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	**$**

1 Total		
SEE SCH 17A	1	
	2	
	3	
	4	
	5	
	6	
25,442	7	
	8	
	9	
	10	
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)	13	
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	16	
25,442	17	
	18	
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	21	
	22	
	23	
25,442	24	*

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

STATE OF ILLINOI

Facility Name & ID Number Oakview # 0046755

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this sched
classifications of revenue and expense must be provided on this form, even if financial statem
Note: This schedule should show gross revenue and expenses. Do not net revenue

	I. Revenue	1 Amount		
	A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	$ 623,746	1	31
2	Discounts and Allowances for all Levels	( )	2	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 623,746	3	33
	B. Ancillary Revenue			
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy		6	35
7	Oxygen		7	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8	
	C. Other Operating Revenue			37
9	Payments for Education		9	38
10	Other Government Grants		10	39
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	41
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	42
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	44
22	Laundry		22	45
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23	46
	D. Non-Operating Revenue			47
24	Contributions	1,100	24	48
25	Interest and Other Investment Income***		25	49
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,100	26	
	E. Other Revenue (specify):**			*
27	**Settlement Income (Insurance, Legal, Etc.)**		27	**
28			28	
28a	**Interest Income**	974	28a	***
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 974	29	
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 625,820	30	****]

^ Ent

Report Period Beginning: 7/01/17 **Ending:** 6/30/18

ule to Schedules V and VI.) All required
ıents are attached.
ɜ against expense.

II. Expenses	2 Amount	
A. Operating Expenses		
General Services	166,370	31
Health Care	193,228	32
General Administration	198,049	33
B. Capital Expense		
Ownership	5,889	34
C. Ancillary Expense		
Special Cost Centers	50	35
Provider Participation Fee	36,792	36
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 600,378	40
Income before Income Taxes (line 30 minus line 40)**	25,442	41
Income Taxes		42
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 25,442	43

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	$ 623,746	44
Private Pay - Net Inpatient Revenue		45
Medicare - Net Inpatient Revenue		46
Other-(specify)		47
Other-(specify)		48
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 623,746	49

This must agree with page 4, line 45, column 4.
Does this agree with taxable income (loss) per Federal Income Tax Return? No^ **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.
tity is a cash basis taxpayer

STATE

Facility Name & ID Number Oakview # 004675

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			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	22	22	381	17.32	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	4,112	4,112	57,267	13.93	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,145	1,145	14,939	13.05	18
19	Laundry	763	763	9,959	13.05	19
20	Administrator	1,151	1,151	33,832	29.39	20
21	Assistant Administrator					21
22	Other Administrative	460	460	9,202	20.00	22
23	Office Manager					23
24	Clerical	800	800	27,727	34.66	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)	12,691	12,691	164,190	12.94	30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,144	21,144	$ 317,497 *	$ 15.02	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	23	$ 450	1(3)	35
36	Medical Director	9	2,250	9(7)	36
37	Medical Records Consultant				37
38	Nurse Consultant	259	5,965	10(3)	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) Psychologist	3	350	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	294	$ 9,015		49

C. CONTRACT NURSES

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

Facility Name & ID Number Oakview #

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Rodgers	Administrator		$ 33,832
Geri Buhnerkempe	Assist Administrator		9,202
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,034

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting	$ 5,250
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,250

D. Employee Benefits

Workers' Compensati	
Unemployment Comp	
FICA Taxes	
Employee Health Insu	
Employee Meals	
Illinois Municipal Ret	
Employee Retirement	
Employee Disability	
Employee Dental/Visi	
TOTAL (agree to Scl	
line 22, col.	

E. Schedule of Non-C

to Owners or Emp

Description
N/A
TOTAL

* Attach copy of IMRI

and Payroll Taxes

Description	Amount
ion Insurance	$ 9,509
ensation Insurance	
	24,268
urance	42,110
	10,400
irement Fund (IMRF)*	
	11,078
	124
on	4,118
hedule V, 8)	$ 101,607

ash Compensation Paid loyees

	Line #	Amount
		$
		$

F notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	128
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
INHAA	
Miscellaneous Dues & Subscriptions	
Miscellaneous License & Fees	158
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 286

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	390
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 390

**See instructions.

Facility Name & ID Number **Oakview** **#**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No** **(13)**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**
(14)

(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? **N/A** **(15)**

(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? **N/A** **(16)**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** 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.
N/A **(17)**

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,792** **(18)**
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? **Yes** If YES, attach an explanation of the allocation. **(19)**

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? **Yes**

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.

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,400** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Mark Kenter, CPA**

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

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.