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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

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

County: 62863

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

HFS ID Number:

Date of Initial License for Current Owners:

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 09/01/2017 to 08/31/2018 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) 12/31/18 (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 HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17	475	4,727	5,219	8
9	SNF/PED					9
10	ICF	14,376	9,564		23,940	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,393	10,039	4,727	29,159	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.76%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 4,521

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: 08/31/2018 Fiscal Year: 08/31/2018

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	236,599	31,025	8,724	276,348		276,348		276,348			1
2	Food Purchase		238,200		238,200		238,200		238,200			2
3	Housekeeping	108,324	10,952	396	119,672		119,672		119,672			3
4	Laundry	31,581	5,291		36,872		36,872		36,872			4
5	Heat and Other Utilities			151,657	151,657		151,657	166	151,823			5
6	Maintenance	58,100	40,054	18,674	116,828		116,828	8,717	125,545			6
7	Other (specify):*											7
8	**TOTAL General Services**	434,604	325,522	179,451	939,577		939,577	8,883	948,460			8
	B. Health Care and Programs											
9	Medical Director			23,700	23,700		23,700		23,700			9
10	Nursing and Medical Records	1,470,802	155,665	2,348	1,628,815		1,628,815		1,628,815			10
10a	Therapy		3,374	703,455	706,829		706,829		706,829			10a
11	Activities	55,999	2,075	1,761	59,835		59,835		59,835			11
12	Social Services	34,193	139	3,261	37,593		37,593		37,593			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,560,994	161,253	734,525	2,456,772		2,456,772		2,456,772			16
	C. General Administration											
17	Administrative	67,689			67,689		67,689		67,689			17
18	Directors Fees											18
19	Professional Services			53,007	53,007		53,007	(10,930)	42,077			19
20	Dues, Fees, Subscriptions & Promotions			22,278	22,278		22,278	(4,809)	17,469			20
21	Clerical & General Office Expenses	129,902	14,506	652,168	796,576		796,576	(314,751)	481,825			21
22	Employee Benefits & Payroll Taxes			362,884	362,884		362,884	53,334	416,218			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,174	11,174		11,174	(11,174)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,904	72,904		72,904	7,331	80,235			26
27	Other (specify):*											27
28	**TOTAL General Administration**	197,591	14,506	1,174,415	1,386,512		1,386,512	(280,999)	1,105,513			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,193,189	501,281	2,088,391	4,782,861		4,782,861	(272,116)	4,510,745			29

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL|#0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			185,686	185,686		185,686		185,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,822	174,822		174,822	(5,501)	169,321			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,256	49,256		49,256	797	50,053			35
36	Other (specify):*											36
37	**TOTAL Ownership**			409,764	409,764		409,764	(4,704)	405,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			174,497	174,497		174,497		174,497			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,307	194,307		194,307		194,307			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			368,804	368,804		368,804		368,804			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,193,189	501,281	2,866,959	5,561,429		5,561,429	(276,820)	5,284,609			45

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAI # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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				4
5	Telephone, TV & Radio in Resident Rooms	(1,740)	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	(5,501)	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	(4,809)	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	(35,627)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,677)		$	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)	(229,143)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (229,143)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (276,820)		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

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328

Report Period Beginning: 09/01/2017

Ending: 08/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (10,670)	21	1
2	TRAVEL	(11,174)	24	2
3	LEGAL FEES	(13,783)	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**	(35,627)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,740)	1,906	0	0	0	0	0	0	0	0	0	166	5
6	Maintenance	0	8,717	0	0	0	0	0	0	0	0	0	8,717	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,740)	10,623	0	0	0	0	0	0	0	0	0	8,883	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	(13,783)	2,853	0	0	0	0	0	0	0	0	0	(10,930)	19
20	Fees, Subscriptions & Promotions	(4,809)	0	0	0	0	0	0	0	0	0	0	(4,809)	20
21	Clerical & General Office Expenses	(10,670)	(304,081)	0	0	0	0	0	0	0	0	0	(314,751)	21
22	Employee Benefits & Payroll Taxes	0	53,334	0	0	0	0	0	0	0	0	0	53,334	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,174)	0	0	0	0	0	0	0	0	0	0	(11,174)	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	7,331	0	0	0	0	0	0	0	0	0	7,331	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(40,436)	(240,563)	0	0	0	0	0	0	0	0	0	(280,999)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,176)	(229,940)	0	0	0	0	0	0	0	0	0	(272,116)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,501)	0	0	0	0	0	0	0	0	0	0	(5,501)	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	797	0	0	0	0	0	0	0	0	0	797	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,501)	797	0	0	0	0	0	0	0	0	0	(4,704)	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)**	(47,677)	(229,143)	0	0	0	0	0	0	0	0	0	(276,820)	45

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTE # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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
		GENERAL BAPT NH OF LINN	LINN, MO	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	Utilities	$	General Baptist Nursing Home Board		$ 1,906	$ 1,906	1
2	V	6	Maintenance		General Baptist Nursing Home Board		8,717	8,717	2
3	V	19	Professional Services		General Baptist Nursing Home Board		2,853	2,853	3
4	V	21	Mgmt Fees	622,138	General Baptist Nursing Home Board			(622,138)	4
5	V	21	Supplies		General Baptist Nursing Home Board		318,057	318,057	5
6	V	22	Employee Benefits		General Baptist Nursing Home Board		53,334	53,334	6
7	V	26	Insurance		General Baptist Nursing Home Board		7,331	7,331	7
8	V	35	Rental & Leasing		General Baptist Nursing Home Board		797	797	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 622,138			$ 392,995	$ * (229,143)	14

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

VII. RELATED PARTIES

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAI # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 09/01/2017 Ending: 8/31/2018

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	16,918,148		$ 1,339,580	$ 891,565	4,963,307	$ 392,995	1
2		Oakview Villa (OV)	Direct Costs	16,918,148		1,339,580	891,565	793,502	62,830	2
3		Linn (LN)	Direct Costs	16,918,148		1,339,580	891,565	2,639,934	209,030	3
4		Campbell (CB)	Direct Costs	16,918,148		1,339,580	891,565	4,380,403	346,841	4
5		Piggott (PG)	Direct Costs	16,918,148		1,339,580	891,565	3,051,279	241,600	5
6		Magnolia Manor (MM)	Direct Costs	16,918,148		1,339,580	891,565	1,089,723	86,284	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					$ 8,037,478	$ 5,349,393		$ 1,339,580	25

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	$ 5,587,919	08/2053	3.0000	$ 169,090	1
2	DE LAGE LANDEN FIN		X	PATIENT TRANSPORT VAN	$844.00	02/2015	44,472	13,598	01/2020	5.2300	782	2
3												3
4												4
5												5
	Working Capital											
6	FNB OF PARAGOULD		X	LINE OF CREDIT	$1,500.00	02/2016	250,000	44,828	02/2017	5.0000	4,950	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		$ 6,678,247	$ 6,892,276			$ 174,822	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,678,247	$ 6,892,276			$ 174,822	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 28,771 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION C # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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 worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2018 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:		
2013		8
2014		9
2015		10
2016		11
2017		12

	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

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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL COUNTY 62863

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTEI # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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 HEIGHTS CONTINUOUS CARE & REHABILITATION CEN # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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		1,132,199	5
6				2006	1,109,737	27,743	40	27,743		355,235	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		50,086	12
13	Roof			1996	11,450	382	30	382		8,334	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		19,693	17
18	Landscaping			1997	8,837		15			8,837	18
19	Drywall			1997	21,125		15			21,125	19
20	12 Lavatory+Faucets			1998	4,470		15			4,470	20
21	9 Overhead Lights			1998	921		15			921	21
22	Exit Sign			1998	449		15			449	22
23	Other MG- Including Plumbing			1998	9,003		15			9,003	23
24	Wall Paper			1998	2,435		7			2,435	24
25	Plastic Coat-Roof-Wing 5			1998	12,500	417	30	417		8,542	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 HEIGHTS CONTINUOUS CARE & REHABILITATION CE# 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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		15			380	41
42	North-Side Heaters	2001	6,090		7			6,090	42
43	Water Heaters	2001	15,196		7			15,196	43
44	Land Improvements	2005	316,403	21,094	15	21,094		275,974	44
45	Pole Barn	2007	12,485	832	15	832		9,641	45
46	Shelter House	2008	10,188	679	15	679		7,075	46
47	Land Improvements - Paving	2008	14,053	937	15	937		9,369	47
48	Reseal Parking Lot	2008	5,218	348	15	348		3,479	48
49	Silverline Windows	2009	8,092	540	15	540		4,945	49
50	Purf Pipe in Parking Lot	2009	4,110	274	15	274		2,511	50
51	Parking Lot Repavement	2009	12,469	831	15	831		7,447	51
52	Sidewalk	2011	5,556	370	15	370		2,562	52
53	Breezeway	2011	9,748	650	15	650		4,387	53
54	Sewer Replacement	2012	39,848	2,657	15	2,657		15,275	54
55	Water Heater	2012	8,600	573	15	573		3,249	55
56	HVAC	2013	6,665	171	39	171		826	56
57	Parking Lot Repavement	2014	15,645	1,565	10	1,565		6,063	57
58	Roof	2014	11,580	386	30	386		1,496	58
59	Water Heater	2015	7,900	790	10	790		2,732	59
60	Roof	2015	9,658	322	30	322		1,113	60
61	Vinyl Flooring Patient Rooms	2016	4,885	698	7	698		2,065	61
62	A/c Unit	2016	5,652	565	10	565		1,625	62
63	Vinyl Flooring/Wall Base Office/Lobby	2016	673	96	7	96		268	63
64	Vinyl Flooring/Wall Base Admin Office	2016	673	96	7	96		260	64
65	Bathroom Remodel (Tile Work and Vanity Hardware)	2016	970	97	10	97		239	65
66	Land Drainage Improvement	2016	840	84	10	84		179	66
67	Concrete Pad	2017	6,352	318	20	318		542	67
68	Water Pipe Replacement	2017	8,335	278	30	278		475	68
69	Vinyl Flooring Hallways, Lobby and Common Areas	2017	10,493	1,499	7	1,499		2,373	69
70	TOTAL (lines 4 thru 69)		$ 6,183,985	$ 155,043		$ 155,043	$	$ 2,900,292	70

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CE # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	
1	Totals from Page 12A, Carried Forward		$ 6,183,985	$ 155,043		$ 155,043	$	$ 2,900,292	1
2	Lobby Door Replacement	2017	2,430	347		347		506	2
3	Vinyl Flooring Pat 'Rooms (Continuation of Floor Replacement)	2017	1,755	251		251		366	3
4	Water Heater	2017	11,448	763		763		1,049	4
5	Pavement Maintenance	2018	6,840	42		42		42	5
6	Carpet Common Area	2018	639	11		11		11	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,207,097	$ 156,457		$ 156,457	$	$ 2,902,266	34

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RI# 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	$ 91,671	$ 14,511	$ 14,511	$	7	$ 49,679	71
72	Current Year Purchases	45,109	3,919	3,919		7	3,919	72
73	Fully Depreciated Assets	750,953	1,904	1,904		7	750,953	73
74								74
75	TOTALS	$ 887,733	$ 20,334	$ 20,334	$		$ 804,551	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	8,895	8,895		5	31,501	78
79										79
80	TOTALS			$ 51,646	$ 8,895	$ 8,895	$		$ 38,675	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)	$ 7,295,692	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 185,686	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 185,686	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)	$ 3,745,492	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABI # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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 HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION C# 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	$	3,377	$ 276,604	$	3,377	$ 276,604	1
2	Licensed Speech and Language Development Therapist		hrs		742	62,732		742	62,732	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,528	364,119	3,374	4,528	367,493	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			$	8,647	$ 703,455	$ 3,374	8,647	$ 706,829	14

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/2018 (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	$ 662,045	$ 688,166	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,600,588	1,773,541	3
4	Supply Inventory (priced at)	5,680	9,566	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,983	25,039	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	139,538		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,429,834	$ 2,496,312	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	6,207,097	8,403,175	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	939,379	1,131,562	16
17	Accumulated Depreciation (book methods)	(3,745,492)	(4,732,925)	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)**	$ 3,550,200	$ 4,981,028	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,980,034	$ 7,477,340	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 274,903	$ 289,369	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,290,759	1,290,759	29
30	Accrued Salaries Payable	113,013	127,416	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,592	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	14,192	19,769	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ADV BILLING SEC DEPOSITS RES TR	132,572	210,496	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,825,439	$ 1,939,401	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,601,517	7,764,327	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)**	$ 5,601,517	$ 7,764,327	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,426,956	$ 9,703,728	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,446,922)	$ (2,226,388)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,980,034	$ 7,477,340	48

***(See instructions.)**

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATIO # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,618,290)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,618,290)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	171,368	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)**	$ 171,368	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)**	$ (1,446,922)	24 *

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & R # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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	$ 5,749,055	1
2	Discounts and Allowances for all Levels	(1,758,431)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,990,624	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,565,317	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,565,317	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		14
15	Telephone, Television and Radio	1,740	15
16	Rental of Facility Space		16
17	Sale of Drugs	129,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,400	19
20	Radiology and X-Ray	105	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,342	23
	D. Non-Operating Revenue		
24	Contributions	2,343	24
25	Interest and Other Investment Income***	5,501	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,844	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	10,670	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,670	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,732,797	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	939,577	31
32	Health Care	2,456,772	32
33	General Administration	1,386,512	33
	B. Capital Expense		
34	Ownership	409,764	34
	C. Ancillary Expense		
35	Special Cost Centers	174,497	35
36	Provider Participation Fee	194,307	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,561,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	171,368	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 171,368	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,781,360	44
45	Private Pay - Net Inpatient Revenue	1,355,494	45
46	Medicare - Net Inpatient Revenue	752,306	46
47	Other-(specify) Manage Care/Hospice	101,464	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,990,624	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 HEIGHTS CONTINUOUS CARE & REHABII # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,148	2,156	$ 65,927	$ 30.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,045	15,103	378,091	25.03	3
4	Licensed Practical Nurses	17,835	17,904	358,237	20.01	4
5	CNAs & Orderlies	53,945	54,152	645,358	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,231	5,251	55,999	10.66	10
11	Social Service Workers	2,210	2,218	34,193	15.42	11
12	Dietician					12
13	Food Service Supervisor	2,028	2,036	33,187	16.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,296	23,386	203,412	8.70	15
16	Dishwashers					16
17	Maintenance Workers	4,393	4,410	58,100	13.17	17
18	Housekeepers	12,709	12,758	108,324	8.49	18
19	Laundry	3,781	3,796	31,581	8.32	19
20	Administrator	2,248	2,257	67,689	29.99	20
21	Assistant Administrator	2,283	2,292	69,120	30.16	21
22	Other Administrative			0		22
23	Office Manager					23
24	Clerical	4,760	4,778	60,782	12.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,773	1,780	23,189	13.03	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,685	154,277	$ 2,193,189 *	$ 14.22	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 900	39-3	35
36	Medical Director	MONTHLY	23,700	9-3	36
37	Medical Records Consultant	MONTHLY	2,048	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)		$ 26,648		49

C. CONTRACT NURSES

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RE # 0026328 Report Period Beginning: 09/01/2017 Ending: 08/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Matt Militoni	ADMINISTRATOR	N/A	$ 67,689
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,689

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	$ 13,783
WATLER ACCOUNTING	ACCTING	13,045
MDI	SOFTWARE	26,179
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 53,007

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,492
Unemployment Compensation Insurance	32,218
FICA Taxes	163,960
Employee Health Insurance	72,732
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	4,482
GBHC BD ALLOC PAY TAXES & OTH BENE	53,334
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,218

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	807
Health Care Worker Background Check	2,270
(Indicate # of checks performed 65)	
Patient Background Checks	
Dues & Subscriptions	8,124
Drug Testing	2,186
Advertising	4,809
Licenses	4,082
Less: Public Relations Expense	( )
Non-allowable advertising	(4,809)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,469

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)	$

* Attach copy of IMRF notifications

**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 $5,955**

(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. $ **24,230** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **194,307**
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? **NO** Indicate the amount. $ **N/A**

(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 2018

VendorName	InvoiceNumber	InvoiceDate	InvAmount	Allowable	Non-Allowable	Description
Duane Morris LLP	2339691	09/11/17	1,594.50		1,594.50	General (Various) Legal Svcs
Duane Morris LLP	2352875	10/16/17	148.00		148.00	General (Various) Legal Svcs
Duane Morris LLP	2364216	11/17/17	992.50		992.50	General (Various) Legal Svcs
Duane Morris LLP	2368626	12/06/17	1,288.50		1,288.50	General (Various) Legal Svcs
Duane Morris LLP	2377511	01/09/18	1,039.00		1,039.00	General (Various) Legal Svcs
Duane Morris LLP	2398536	03/19/18	4,860.00		4,860.00	General (Various) Legal Svcs
Duane Morris LLP	2398538	03/19/18	846.88		846.88	General (Various) Legal Svcs
Duane Morris LLP	2399913	03/23/18	1,179.00		1,179.00	General (Various) Legal Svcs
Duane Morris LLP	2410922	04/19/18	77.50		77.50	General (Various) Legal Svcs
Duane Morris LLP	2410921	04/19/18	655.00		655.00	General (Various) Legal Svcs
Duane Morris LLP	2417078	05/03/18	798.50		798.50	General (Various) Legal Svcs
Duane Morris LLP	2437774	07/03/18	303.50		303.50	General (Various) Legal Svcs
			13,782.88		13,782.88	

OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER 04-5179
TRIAL BALANCE (GROUPING)
AUGUST 31 2018

Sub1	Account Number	Account Description		Adjusted Amount	TOTAL
MEDICAID GROUPING					
A11	69100.000	Wages - Supervisor	Dietary	33,187.28	
A11	69110.000	Wages - Regular	Dietary	191,286.97	
A11	69150.000	Wages - Vacation/Holiday/Sick	Dietary	12,125.13	236,599.38
A12	69660.000	Chemicals	Dietary	2,344.19	
A12	69670.000	Supplies (Non-Food)	Dietary	23,439.83	
A12	69720.000	Small Equipment Purchase	Dietary	434.01	
A12	69730.000	Equipment Repair & Maintenance	Dietary	4,806.99	31,025.02
A13	69810.000	Dues & Subscriptions	Dietary	150.00	
A13	69850.000	Purchased Services	Dietary	8,574.34	8,724.34
A22	69680.000	Food Supplements	Dietary	3,245.61	
A22	69690.000	Raw Food	Dietary	234,954.25	238,199.86
A31	71100.000	Wages - Supervisor	Housekeeping	28.88	
A31	71110.000	Wages - Regular	Housekeeping	103,717.10	
A31	71150.000	Wages - Vacation/Holiday/Sick	Housekeeping	4,578.38	108,324.36
A32	71660.000	Chemicals	Housekeeping	201.44	
A32	71670.000	Supplies	Housekeeping	9,612.28	
A32	71720.000	Small Equipment Purchase	Housekeeping	1,138.01	10,951.73
A33	71850.000	Purchased Services	Housekeeping	396.00	396.00
A41	70110.000	Wages - Regular	Laundry	28,989.43	
A41	70150.000	Wages - Vacation/Holiday/Sick	Laundry	2,591.70	31,581.13
A42	70660.000	Chemicals	Laundry	405.40	
A42	70670.000	Supplies	Laundry	2,093.15	
A42	70690.000	Linen	Laundry	2,405.07	
A42	70720.000	Small Equipment Purchase	Laundry	281.66	
A42	70730.000	Equipment Repair & Maintenance	Laundry	106.05	5,291.33
A53	72510.000	Gas	Plant & Maintenance	4,671.07	
A53	72520.000	Electricity	Plant & Maintenance	117,146.31	
A53	72525.000	Cable Television	Plant & Maintenance	7,138.97	
A53	72530.000	Water	Plant & Maintenance	4,040.47	
A53	72535.000	Sewer	Plant & Maintenance	18,659.99	151,656.81
A61	72110.000	Wages - Regular	Plant & Maintenance	54,845.70	
A61	72150.000	Wages - Vacation/Holiday/Sick	Plant & Maintenance	3,254.50	58,100.20
A62	72660.000	Building Repair & Maintenance	Plant & Maintenance	14,218.97	
A62	72667.000	Vehicle Repair & Maintenance	Plant & Maintenance	576.15	
A62	72670.000	Supplies	Plant & Maintenance	11,674.93	
A62	72690.000	Grounds Maintenance	Plant & Maintenance	2,362.29	
A62	72695.000	Grounds Landscaping	Plant & Maintenance	160.00	
A62	72720.000	Small Equipment Purchase	Plant & Maintenance	470.29	
A62	72730.000	Repair & Maintenance	Plant & Maintenance	10,591.19	40,053.82
A63	72540.000	Trash Removal	Plant & Maintenance	7,851.67	
A63	72550.000	Service Contracts	Plant & Maintenance	6,824.01	
A63	72675.000	Pest Control	Plant & Maintenance	3,641.50	
A63	72850.000	Purchased Services	Plant & Maintenance	357.00	18,674.18
B101	63050.000	Wages - Medical Records	Nursing Medicare Dist.	23,189.34	
B101	63100.000	Wages - R.N.	Nursing Medicare Dist.	66,426.34	
B101	63150.000	Wages - Vacation/Holiday/Sick	Nursing Medicare Dist.	4,550.81	
B101	64100.000	Wages - R.N.	Nursing Non Distinct	274,831.54	
B101	64110.000	Wages - L.P.N.	Nursing Non Distinct	320,580.73	
B101	64120.000	Wages - Aides	Nursing Non Distinct	642,587.14	
B101	64150.000	Wages - Vacation/Holiday/Sick	Nursing Non Distinct	72,709.40	
B101	67100.000	Wages - DON	Nursing Administration	60,022.57	
B101	67150.000	Wages - Vacation/Holiday/Sick	Nursing Administration	5,904.04	1,470,801.91
B102	64600.000	Supplies (Non-Medical)	Nursing Non Distinct	14,246.87	
B102	67720.000	Small Equipment Purchased	Nursing Administration	2,694.30	
B102	86900.000	Non-Billable Non-Distinct	Medical Supplies	7,156.74	
B102	86905.000	Blood Sugar Testing	Medical Supplies	1,415.70	
B102	86915.000	Nursing Supplies	Medical Supplies	86,441.92	
B102	86920.000	Briefs	Medical Supplies	24,230.14	
B102	86925.000	Small Equipment Purchase	Medical Supplies	3,127.08	
B102	86930.000	Oxygen	Medical Supplies	16,351.88	155,664.63
B103	64810.000	Dues & Subscriptions	Nursing Non Distinct	100.00	
B103	64850.000	Medical Records Consultant	Nursing Non Distinct	2,048.00	
B103	66820.000	Travel & Seminars	Nursing Assisted Living	75.60	
B103	67810.000	Dues and Subscriptions	Nursing Administration	100.00	
B103	67850.000	Purchased Services	Nursing Administration	24.00	2,347.60
B10a2	80670.000	Supplies	Physical Therapy	3,374.26	3,374.26
B10a3	80950.000	Purchased Services/part A	Physical Therapy	214,346.71	
B10a3	80951.000	Purchased Services/part B	Physical Therapy	144,894.96	
B10a3	80952.000	Purchased Services Insurance	Physical Therapy	4,747.77	
B10a3	80953.000	Purchased Services Private Pay	Physical Therapy	129.95	
B10a3	81950.000	Purchased Services/ Part A	Occupational Therapy	152,279.67	
B10a3	81951.000	Purchased Services/part B	Occupational Therapy	118,621.40	
B10a3	81952.000	Purchased Services Insurance	Occupational Therapy	3,726.06	
B10a3	81953.000	Purchased Services Private Pay	Occupational Therapy	1,976.62	
B10a3	82810.000	Dues & Subscriptions	Speech Therapy	100.00	
B10a3	82950.000	Purchased Services/part A	Speech Therapy	33,686.39	
B10a3	82951.000	Purchased Services/part B	Speech Therapy	28,945.73	703,455.26
B111	61100.000	Wages - Supervisor	Activities	29,676.25	
B111	61110.000	Wages - Regular	Activities	24,466.73	
B111	61150.000	Wages - Vacation/Holiday/Sick	Activities	1,855.65	55,998.63
B112	61650.000	Supplies	Activities	2,075.45	2,075.45
B113	61660.000	Entertainment	Activities	1,225.88	
B113	61850.000	Purchased Services	Activities	535.54	1,761.42
B121	62100.000	Wages - Supervisor	Social Services	31,643.01	
B121	62150.000	Wages - Vacation/Holiday/Sick	Social Services	2,550.00	34,193.01
B122	62650.000	Supplies	Social Services	139.13	139.13
B123	62850.000	Purchased Services	Social Services	3,153.16	
B123	62900.000	Other	Social Services	107.53	3,260.69
B93	83050.000	Medical Director	Medical Director	23,700.00	23,700.00
C171	73100.000	Wages - Administrator	General & Administration	67,689.17	67,689.17
C193	73430.000	Legal Fees	General & Administration	13,782.88	
C193	73440.000	Accounting Fees	General & Administration	13,045.00	
C193	73520.000	Software Maintenance	General & Administration	26,179.13	53,007.01
C203	73510.000	Advertising	General & Administration	4,809.25	
C203	73515.000	Adv. Help Wanted	General & Administration	806.67	
C203	73810.000	Dues & Subscriptions	General & Administration	8,124.33	
C203	73835.000	Back Ground Check	General & Administration	2,270.49	
C203	73845.000	Drug Testing	General & Administration	2,185.61	
C203	73870.000	Licenses	General & Administration	4,082.00	22,278.35
C211	73110.000	Wages - Regular	General & Administration	56,733.57	
C211	73150.000	Wages - Vacation/Holiday/Sick	General & Administration	4,048.15	
C211	75100.000	Wages	Operations	68,160.00	
C211	75110.000	Wages - Vac/Hol/Sick	Operations	960.00	129,901.72
C212	73670.000	Office Supplies	General & Administration	12,969.73	
C212	73860.000	Postage	General & Administration	621.31	
C212	73880.000	Printing	General & Administration	548.09	
C212	75670.000	Supplies	Operations	366.99	14,506.12
C213	65600.000	Supplies (Non-Medical)	Nursing Res. Care	1,257.87	
C213	72500.000	Telephone	Plant & Maintenance	24,165.80	
C213	73320.000	Employee Benefits	General & Administration	(150.00)	
C213	73400.000	Uniform Expense	General & Administration	(1,283.09)	
C213	73445.000	Late Fees	General & Administration	561.54	
C213	73455.000	Service Charge	General & Administration	40.23	
C213	73580.000	Taxes - General	General & Administration	397.52	
C213	73720.000	Small Equipment Purchase	General & Administration	1,595.46	
C213	73815.000	Management Fees	General & Administration	622,138.06	
C213	73850.000	Purchased Services	General & Administration	169.74	
C213	73885.000	Resident Expense	General & Administration	1,885.46	
C213	73900.000	Miscellaneous	General & Administration	1,389.78	652,168.37
C223	73200.000	Payroll Taxes	General & Administration	163,959.80	
C223	73250.000	Workers Compensation	General & Administration	89,492.28	
C223	73280.000	Unemployment	General & Administration	32,217.66	
C223	73300.000	Group Insurance	General & Administration	72,731.94	
C223	73901.000	Employee Benefit	General & Administration	4,482.58	362,884.26
C243	64830.000	Education	Nursing Non Distinct	67.00	
C243	67820.000	Travel & Seminar	Nursing Administration	100.44	
C243	67830.000	Education	Nursing Administration	955.52	
C243	73750.000	Auto Expense	General & Administration	3,143.62	
C243	73820.000	Travel & Seminar	General & Administration	3,681.41	
C243	73825.000	Meals & Entertainment	General & Administration	214.39	
C243	73830.000	Education	General & Administration	2,794.97	
C243	73840.000	Mileage Reimbursement	General & Administration	216.32	11,173.67
C263	73523.000	MIP Insurance	General & Administration	28,770.96	
C263	73525.000	Property Insurance	General & Administration	7,581.96	
C263	73530.000	Insurance	General & Administration	35,107.56	
C263	73535.000	Auto Insurance	General & Administration	1,443.60	72,904.08
D303	73550.000	Depreciation	General & Administration	185,685.82	185,685.82
D323	73435.000	Interest	General & Administration	174,822.45	174,822.45
D353	67700.000	Equipment Rental (Non-Medical)	Nursing Administration	4,959.02	
D353	69700.000	Equipment Rental	Dietary	152.00	
D353	73700.000	Equipment Rental	General & Administration	7,012.23	
D353	73740.000	Copier Equipment	General & Administration	5,409.54	
D353	86910.000	Equipment Rental	Medical Supplies	31,723.08	49,255.87
E393	84050.000	Dental Consultant	Dental	900.00	
E393	85660.000	Legend Drugs	Pharmacy	131,624.16	
E393	85670.000	Supplies	Pharmacy	11.67	
E393	85690.000	Non-Legend Drugs	Pharmacy	6,431.03	
E393	87005.000	Radiology - Med A	Radiology	1,893.29	
E393	88005.000	Laboratory - Med A	Laboratory	33,636.51	174,496.66
E423	73585.000	Bed Tax Expense	General & Administration	194,307.00	194,307.00
FS01	40100.000	Room And Board	Medicare Part A	(689,233.03)	
FS01	40110.000	Room And Board	Medicare Part A	(1,396,139.37)	
FS01	41100.000	Room And Board	Private Certified	(1,416,953.00)	
FS01	42100.000	Room And Board	Medicaid Certified	(2,102,646.00)	
FS01	43100.000	Room And Board	Managed Care Certified	(23,526.00)	
FS01	44100.000	Room And Board	Hospice Certified	(113,806.00)	
FS01	52100.000	Room And Board	Insurance	(6,752.00)	(5,749,055.40)
FS02	40200.000	Less: Contractual Adjustment	Medicare Part A	309.82	
FS02	40900.000	Less: Contractual Adjustment	Medicare Part A	1,332,757.08	
FS02	41110.000	Less: Contractual Adjustment	Private Certified	26,092.42	
FS02	41200.000	Less: Contractual Adjustment	Private Certified	(43.00)	
FS02	41900.000	Less: Contractual Adjustment	Private Certified	11,573.06	
FS02	42110.000	Less: Contractual Adjustment	Medicaid Certified	311,228.00	
FS02	42900.000	Less: Contractual Adjustment	Medicaid Certified	10,877.26	
FS02	43110.000	Less: Contractual Adjustment	Managed Care Certified	(47,997.83)	
FS02	43900.000	Less: Contractual Adjustment	Managed Care Certified	71,291.16	
FS02	44110.000	Less: Contractual Adjustment	Hospice Certified	11,923.58	
FS02	44900.000	Less: Contractual Adjustment	Hospice Certified	650.77	
FS02	51900.000	Less: Contractual Adjustment	Medicaid Non-Certified	(819.20)	
FS02	52110.000	Less: Contractual Adjustment	Insurance	(18,592.00)	
FS02	54600.000	Less: Contractual Adjustment	V/A Non-Certified	722.71	
FS02	55250.000	Less: Contractual Adjustment	Residential Care	14.14	
FS02	73540.000	Bad Debt Expense	General & Administration	48,439.93	1,758,427.90
FS06	40400.000	Physical Therapy	Medicare Part A	(519,701.00)	
FS06	40450.000	Occupational Therapy	Medicare Part A	(516,727.00)	
FS06	40500.000	Speech Therapy	Medicare Part A	(129,416.00)	
FS06	41400.000	Physical Therapy	Private Certified	(129.00)	
FS06	43400.000	Physical Therapy	Managed Care Certified	(25,340.00)	
FS06	43450.000	Occupational Therapy	Managed Care Certified	(29,594.00)	
FS06	43500.000	Speech Therapy	Managed Care Certified	(5,775.00)	
FS06	51250.000	Pharmacy	Medicaid Non-Certified	(326.59)	
FS06	56450.000	Occupational Therapy	Supported Living	(0.21)	
FS06	58400.000	Physical Therapy	Medicare Part B	(302,359.52)	
FS06	58450.000	Occupational Therapy	Medicare Part B	(247,409.59)	
FS06	58500.000	Speech Therapy	Medicare Part B	(60,651.96)	
FS06	58900.000	Less: Contractual Adjustment	Medicare Part B	272,113.14	(1,565,316.73)
FS15	59912.000	Cable Income	Other Revenue	(1,740.00)	(1,740.00)
FS17	40250.000	Pharmacy	Medicare Part A	(119,579.74)	
FS17	41250.000	Pharmacy	Private Certified	(1,717.64)	
FS17	42250.000	Pharmacy	Medicaid Certified	(245.29)	
FS17	43250.000	Pharmacy	Managed Care Certified	(7,553.93)	(129,096.60)
FS19	40850.000	LAB	Medicare Part A	(26,358.97)	
FS19	43850.000	LAB	Managed Care Certified	(742.65)	
FS19	51850.000	LAB	Medicaid Non-Certified	(298.80)	(27,400.42)
FS20	40700.000	X-Ray	Medicare Part A	(105.43)	(105.43)
FS24	59913.000	Donations	Other Revenue	(2,342.97)	(2,342.97)
FS25	59511.000	Interest Income	Other Revenue	(2,192.97)	
FS25	59914.000	Oil Lease Royalties	Other Revenue	(3,307.93)	(5,500.90)
FS28	59111.000	Barber/Beauty	Other Revenue	391.71	
FS28	59811.000	Adjustments	Other Revenue	(2,395.27)	
FS28	59911.000	Misc. Income	Other Revenue	(8,666.22)	(10,669.78)
BS01	10010.000	Cash - Landing	Cash	0.00	
BS01	10015.000	Cash - Payroll	Cash	(1,350.39)	
BS01	10020.000	Cash - Petty	Cash	580.00	
BS01	10021.000	Cash - Petty, Activities	Cash	200.00	
BS01	10031.000	Cash - Assistance Fund	Cash	9,698.21	
BS01	10035.000	Cash - Op Account	Cash	3,206.41	
BS01	10040.000	Cash - Tax & Insurance Escrow - Gershman	Cash	49,119.50	
BS01	10041.000	Cash - In FNB Patient Fund	Cash	5,684.19	
BS01	10048.000	Cash - Gershman Bus Bank R.R.	Cash	594,907.44	662,045.36
BS03	10100.000	A/R - Private	A/R - Operations	714,803.44	
BS03	10200.000	A/R - Medicaid	A/R - Operations	626,523.82	
BS03	10300.000	A/R - Medicare Part A	A/R - Operations	98,636.12	
BS03	10400.000	A/R - Medicare Part B	A/R - Operations	35,670.78	
BS03	10500.000	A/R - Co-Insurance Part A	A/R - Operations	58,256.83	
BS03	10600.000	A/R - Co-Insurance Part B	A/R - Operations	12,712.85	
BS03	10700.000	A/R - Managed Care	A/R - Operations	25,705.85	
BS03	11000.000	A/R - Hospice	A/R - Operations	41,848.69	
BS03	12000.000	A/R - Allowance For Bad Debt	A/R - Operations	(13,570.19)	1,600,588.19
BS04	14100.000	Supplies - Medical	Inventory	2,962.61	
BS04	14200.000	Supplies - Dietary	Inventory	1,981.75	
BS04	14300.000	Supplies - Hskpg./Laundry	Inventory	404.06	
BS04	14900.000	Supplies - Other	Inventory	331.93	5,680.35
BS06	15100.000	Prepaid - Expenses	Prepaid Expenses	(64.34)	
BS06	15200.000	Prepaid - Insurance	Prepaid Expenses	22,047.33	21,982.99
BS08	21580.000	Intercompany Account	Current Liabilities	139,538.02	139,538.02
BS13	16110.000	Land	Fixed Assets	149,216.41	149,216.41
BS14	16100.000	Building	Fixed Assets	5,657,260.25	
BS14	16105.000	Building Improvements	Fixed Assets	68,758.63	
BS14	16120.000	Land Improvement	Fixed Assets	481,078.41	6,207,097.29
BS16	16150.000	Automobile	Fixed Assets	51,645.50	
BS16	16200.000	Furniture, Fixture & Equipment	Fixed Assets	887,733.80	939,379.30
BS17	16140.000	Accum. Dep. - Land Improvement	Fixed Assets	(369,328.06)	
BS17	16500.000	Accum. Dep. - Building	Fixed Assets	(2,518,832.93)	
BS17	16505.000	Accum. Dep. - Building Improvements	Fixed Assets	(14,104.76)	
BS17	16550.000	Accum. Dep. - Automobile	Fixed Assets	(38,674.50)	
BS17	16600.000	Accum. Dep. - FF&E	Fixed Assets	(804,551.70)	(3,745,491.95)
BS26	20010.000	Accounts Payable	Current Liabilities	(274,902.71)	(274,902.71)
BS29	21550.000	Note Payable Line Of Credit - Loan # 80000623	Current Liabilities	(44,828.08)	
BS29	25200.000	Due To/From Parent Company	Long Term Liabilities	(1,245,930.61)	(1,290,758.69)
BS30	20200.000	Accrued Wages	Current Liabilities	(84,274.23)	
BS30	20205.000	Accrued Vacation	Current Liabilities	(28,961.76)	
BS30	20310.000	Garnishments	Current Liabilities	(175.02)	
BS30	21000.000	Unemployment Liability	Current Liabilities	397.90	(113,013.11)
BS33	20240.000	Accrued Interest	Current Liabilities	(14,192.22)	(14,192.22)
BS36	20250.000	Accrued State Provider Tax	Current Liabilities	(8,370.00)	
BS36	20315.000	Uniforms	Current Liabilities	1,981.10	
BS36	21500.000	Advance Billing	Current Liabilities	(122,619.23)	
BS36	21510.000	Resident Refunds	Current Liabilities	2,120.00	
BS36	21530.000	Resident Trust	Current Liabilities	(5,684.19)	(132,572.32)
BS39	25100.000	Notes Payable - Gershman Mortgage	Long Term Liabilities	(5,587,919.02)	
BS39	25110.000	Notes Payable - Automobile	Long Term Liabilities	(13,598.38)	(5,601,517.40)
BS47	30100.000	Capital Investment	Equity	(1,322,372.53)	
BS47	30700.000	Transfer To/From Board	Equity	(249,363.20)	
BS47	30750.000	Prior Period Adjustment	Equity	52,382.97	
BS47	30800.000	Retained Earnings	Equity	3,137,642.88	1,618,290.12
				0.00	0.00