

		FOR BHF USE			

LL2

Supportive Living Facility

**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I.</p> <p>Facility Name: <u>Rantoul Estates LLC</u></p> <p>Address: <u>300 Twin Lake</u> <u>Rantoul Illinois</u> <u>61866</u> <small>Number City Zip Code</small></p> <p>County: <u>Champaign</u></p> <p>Telephone Number: (<u>217</u>) <u>322-5885</u> Fax # (<u>217</u>) <u>324-5851</u></p> <p>Federal Employer ID Number: <u>20-1863763</u></p> <p>Date Current Owners were Certified: <u>11/23/04</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Amy Eubank</u> Telephone Number: (<u>217</u>) <u>342-5885</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																																						

Facility Name Rantoul Estates LLC

Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	39	Single Unit Apartment	39	14,235	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	46	TOTALS	46	16,790	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	1,345	11,584		12,929	5
6	Double Unit		1,246		1,246	6
7	Other					7
8	TOTALS	1,345	12,830		14,175	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.43%

D. Indicate the number of paid bed-hold days the SLF had during this year 2 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: Dec Fiscal Year: Dec

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

Facility Name: Rantoul Estates LLC

Report Period Beginning:

01//01/05

Ending:

12/31/05

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	77,422	64,942		142,364		142,364	1
2	Housekeeping, Laundry and Maintenance	16,220	4,504	18,125	38,849		38,849	2
3	Heat and Other Utilities			56,701	56,701		56,701	3
4	Other (specify): Miscellaneous			13,009	13,009		13,009	4
5	TOTAL General Services	93,642	69,446	87,835	250,923		250,923	5
B. Health Care and Programs								
6	Health Care/ Personal Care	127,031	27	6,739	133,797		133,797	6
7	Activities and Social Services		2,265		2,265		2,265	7
8	Other (specify): Legal/Accounting			1,192	1,192		1,192	8
9	TOTAL Health Care and Programs	127,031	2,292	7,931	137,254		137,254	9
C. General Administration								
10	Administrative and Clerical	46,140	3,052	83,547	132,739		132,739	10
11	Marketing Materials, Promotions and Advertising			10,319	10,319		10,319	11
12	Employee Benefits and Payroll Taxes			31,317	31,317		31,317	12
13	Insurance-Property, Liability and Malpractice			56,597	56,597		56,597	13
14	Other (specify): Acquisitions			8,264	8,264		8,264	14
15	TOTAL General Administration	46,140	3,052	190,044	239,236		239,236	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	266,813	74,790	285,810	627,413		627,413	16
Capital Expenses								
D. Ownership								
17	Depreciation			285,839	285,839		285,839	17
18	Interest			266,180	266,180		266,180	18
19	Real Estate Taxes			39,467	39,467		39,467	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Amorization			30,207	30,207		30,207	22
23	TOTAL Ownership			621,693	621,693		621,693	23
24	GRAND TOTAL (Sum of lines 16 and 23)	266,813	74,790	907,503	1,249,106		1,249,106	24

Facility Name: Rantoul Estates LLC

Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	3	9.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	9.00	6
7	Cook Helpers/Assistants	2	7.50	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	8.00	10
11	Laundry			11
12	Managers	2	13.00	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	9	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	Wilkinson Corporation Managing Member	30%	5	20002	1
2					2
3					3
4					4
5					5
Total				\$ 20002	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	Oakshire Senior Living	\$ 50,006 1
2		
Total		\$ 50,006 3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	City
1 Brookstone Mattoon South	2 Mattoon

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
3 Wilkinson Corporation	4 Yakima, WA	5 Investment
Hartford Square	Hartford CT	Commercial Bldg

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: Wilkinson Corporation If yes, what is the value of those services? \$ 20,002

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Rantoul Estates LLC

Report Period Beginning:

01//01/05

Ending:

12/31/05

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	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	
1	46		2004		\$ 4,025,679	\$ 146,388	28	\$ 146,388	\$	\$ 152,487	1
2											2
3											3
4											4
5											5
Improvement Type											
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,025,679	\$ 146,388		\$ 146,388	\$	\$ 152,487	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21	Land Improvements	\$ 938,782	\$ 62,585	\$ 70,408	21
22	Furniture and Fixtures	205,869	76,865	86,865	22
23	Goodwill and Loan Fees	486,800	32,207	32,721	23
24	TOTALS (lines 21, 22 and 23)	\$ 1,631,451	\$ 171,657	\$ 189,994	24

Facility Name: Rantoul Estates LLC

Report Period Beginning: Jan-05

Ending: 12/31/ Dec-05

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? YES NO

	1	2	3	4	5	6	
	Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building		/ /	\$			3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	TOTAL			\$			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	GEMSA Loan Service		X	Mortgage	12/13/04	\$ 3,813,251	\$ 3,754,637	/ /	6.0000	\$ 243,562
2	Mike Dietzen		X	Note	12/13/04	244,199		/ /	12.0000	22,618
3	Fund II Notes	X		Note	12/13/04		154,983	/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,057,450	\$ 3,909,620			\$ 266,180
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 4,057,450	\$ 3,909,620			\$ 266,180

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

STATE OF ILLINOIS

Page 7

Facility Name: Rantoul Estates LLC

Report Period Beginning: 01//01/05

Ending:

12/31/05

12/31/05

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 34,251	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	16,512		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,762		6
7	Other Prepaid Expenses	84,666		7
8	Accounts Receivable (owners or related parties)	42,209		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 182,400	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,000		13
14	Buildings, at Historical Cost	4,025,679		14
15	Leasehold Improvements, at Historical Cost	938,782		15
16	Equipment, at Historical Cost	205,869		16
17	Accumulated Depreciation (book methods)	(338,638)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	486,800		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)	\$ 5,398,492	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,580,892	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,706	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,105		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,536		30
31	Accrued Taxes Payable	84,041		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 276,388	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,754,637		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 3,909,621	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,186,009	\$	45
46	TOTAL EQUITY	\$ 1,394,883	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,580,892	\$	47

*(See instructions.)

Facility Name: Rantoul Estates LLC

Report Period Beginning: 01//01/05

Ending:

12/31/05

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,000,138	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,000,138	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,000,138	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	250,923	19
20	Health Care/ Personal Care	137,254	20
21	General Administration	239,236	21
B. Capital Expense			
22	Ownership	621,693	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,249,106	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (248,968)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (248,968)	31