

Facility Name OAKVIEW VILLA

Report Period Beginning: 09/01/2005 Ending: 08/31/2006

III. STATISTICAL DATA

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

Date of change in certified units 03/15/2005

	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		Single Unit Apartment	22	8,030	1
2		Double Unit Apartment	8	2,920	2
3		Other			3
4		TOTALS	30	10,950	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	3,526	1,295		4,821	5
6	Double Unit		2,920		2,920	6
7	Other					7
8	TOTALS	3,526	4,215		7,741	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 70.69%

D. Indicate the number of paid bed-hold days the SLF had during this year
NONE Also, indicate the number of unpaid bed-hold days the SLF had during this year. NONE (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 08/31/2006 Fiscal Year: 08/31/2006

* 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? N/A

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? N/A

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? N/A

If no, explain. _____

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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	32,974	19,517	2,236	54,727		54,727	1
2	Housekeeping, Laundry and Maintenance	10,215		5,471	15,686		15,686	2
3	Heat and Other Utilities			17,869	17,869		17,869	3
4	Other (specify):							4
5	TOTAL General Services	43,189	19,517	25,576	88,282		88,282	5
B. Health Care and Programs								
6	Health Care/ Personal Care	145,927		35,040	180,967		180,967	6
7	Activities and Social Services	17,231			17,231		17,231	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	163,158		35,040	198,198		198,198	9
C. General Administration								
10	Administrative and Clerical	57,385	8,328	5,739	71,452		71,452	10
11	Marketing Materials, Promotions and Advertising			3,346	3,346		3,346	11
12	Employee Benefits and Payroll Taxes			25,260	25,260		25,260	12
13	Insurance-Property, Liability and Malpractice			55,869	55,869		55,869	13
14	Other (specify): CABLE TV			2,507	2,507		2,507	14
15	TOTAL General Administration	57,385	8,328	92,721	158,434		158,434	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	263,732	27,845	153,337	444,914		444,914	16
Capital Expenses								
D. Ownership								
17	Depreciation			71,668	71,668		71,668	17
18	Interest			146,439	146,439		146,439	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			218,107	218,107		218,107	23
24	GRAND TOTAL (Sum of lines 16 and 23)	263,732	27,845	371,444	663,021		663,021	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 15.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7	7.00	3
4	Activity Director & Assistants	1	7.00	4
5	Social Service Workers			5
6	Head Cook	2	7.00	6
7	Cook Helpers/Assistants	4	7.00	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	24.39	13
14	Clerical	1	7.00	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	17	\$	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	NONE			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	NONE	\$
2		
Total		\$

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 <u>1</u>	City <u>2</u>
OAKVIEW HEIGHTS CONT CARE	MT. CARMEL

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: N/A If yes, what is the value of those services? \$ N/A

(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).

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VIII. OWNERSHIP COSTS

A. Purchase price of land 30,000 Year land was acquired 7/1/1982

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	30		2005	3/1/2005	\$ 1,765,474	\$ 44,137	40	\$ 44,137	\$	\$ 66,205	1
2											2
3											3
4											4
5											5
Improvement Type											
6		LAND IMPROVEMENTS		3/1/2005	179,669	11,978	15	11,978		17,967	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)				\$ 1,945,143	\$ 56,115		\$ 56,115	\$	\$ 84,172	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	\$ 108,871	\$ 15,553	\$ 15,553	\$	7	\$ 23,329	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 108,871	\$ 15,553	\$ 15,553	\$		\$ 23,329	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

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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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Amount of Note					
			YES	NO		Date of Note	Original	Balance	Maturity Date			
		A. Directly Facility Related Long-Term										
1		GERSHMAN INVESTMENT		X	MORTGAGE	4 /13/04	\$ 2,592,475	\$ 2,325,326	4/13/44	5.8000	\$ 146,439	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 2,592,475	\$ 2,325,326			\$ 146,439	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 2,592,475	\$ 2,325,326			\$ 146,439	10

* 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

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/2006

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,469	\$ 286,714	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	143,322	438,057	3
4	Supply Inventory (priced at)		32,001	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,623	43,288	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 177,414	\$ 800,060	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000	179,216	13
14	Buildings, at Historical Cost	1,945,143	7,908,439	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	108,871	803,145	16
17	Accumulated Depreciation (book methods)	(107,501)	(1,466,167)	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)	\$ 1,976,513	\$ 7,424,633	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,153,927	\$ 8,224,693	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 281	\$ 182,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		431,603	29
30	Accrued Salaries Payable		72,049	30
31	Accrued Taxes Payable		69,871	31
32	Accrued Interest Payable		40,055	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	PROVIDER TAX PAYABLE		8,370	35
36	EMPLOYEE BENEFITS PAYABLE		3,163	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 281	\$ 807,425	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,325,326	8,230,145	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)	\$ 2,325,326	\$ 8,230,145	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,325,607	\$ 9,037,570	45
46	TOTAL EQUITY	\$ (171,680)	\$ (812,877)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,153,927	\$ 8,224,693	47

*(See instructions.)

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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	\$ 538,446	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 538,446	3
B. Other Operating Revenue			
4	Special Services	10,798	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)	\$ 10,798	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)	\$ 549,244	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	114,525	19
20	Health Care/ Personal Care	259,408	20
21	General Administration	289,088	21
B. Capital Expense			
22	Ownership		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)	\$ 663,021	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (113,777)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (113,777)	31