

		FOR BHF USE			

LL2

Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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>OAKVIEW VILLA</u></p> <p>Address: <u>916 NORTH OAK STREET</u> <u>MT. CARMEL</u> <u>62863</u> <small>Number City Zip Code</small></p> <p>County: <u>WABASH</u></p> <p>Telephone Number: (<u>618</u>) <u>263-4092</u> Fax # (<u>618</u>) <u>263-4094</u></p> <p>Federal Employer ID Number: <u>37-1104153</u></p> <p>Date Current Owners were Certified: <u>03/15/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 <u>501(C)(3)</u></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 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>GAY EDMONDS</u> Telephone Number: <u>(618) 263-4092</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" 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 <u>501(C)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input 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>09/01/2006</u> to <u>08/31/2007</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%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>GAY EDMONDS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>JAMIE L. MCCORKLE CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>WILCOX, MCCORKLE, AND COMPANY, LTD. 328 MARKET STREET, MT. CARMEL, IL 62863</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(618) 262-5446</u> Fax <u>(618) 262-8921</u></td> <td></td> </tr> </table> <p align="center">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) <u>GAY EDMONDS</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>JAMIE L. MCCORKLE CPA</u>		(Firm Name & Address) <u>WILCOX, MCCORKLE, AND COMPANY, LTD. 328 MARKET STREET, MT. CARMEL, IL 62863</u>		(Telephone) <u>(618) 262-5446</u> Fax <u>(618) 262-8921</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input checked="" 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 <u>501(C)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input type="checkbox"/> "Sub-S" Corp.	_____																																								
	<input type="checkbox"/> Limited Liability Co.	_____																																								
	<input type="checkbox"/> Trust																																									
	<input type="checkbox"/> Other _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>GAY EDMONDS</u>																																									
	(Title) <u>ADMINISTRATOR</u>																																									
Paid Preparer	(Signed) _____	(Date) _____																																								
	(Print Name and Title) <u>JAMIE L. MCCORKLE CPA</u>																																									
	(Firm Name & Address) <u>WILCOX, MCCORKLE, AND COMPANY, LTD. 328 MARKET STREET, MT. CARMEL, IL 62863</u>																																									
	(Telephone) <u>(618) 262-5446</u> Fax <u>(618) 262-8921</u>																																									

Facility Name OAKVIEW VILLAReport Period Beginning: 9/1/2006 Ending: 8/31/2007

III. STATISTICAL DATA

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

Date of change in certified units 3/15/2005

	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	22	Single Unit Apartment	22	8,030	1
2	8	Double Unit Apartment	8	2,920	2
3		Other			3
4	30	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	3,715	3,251		6,966	5
6	Double Unit		2,920		2,920	6
7	Other					7
8	TOTALS	3,715	6,171		9,886	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.28%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

ACCRUAL MODIFIED CASH* CASH* I. Is your fiscal year identical to your tax year? YES NOTax Year: 08/31/2007 Fiscal Year: 08/31/2007

* 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. _____

Facility Name: OAKVIEW VILLA

Report Period Beginning:

9/1/2006

Ending:

8/31/2007

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	56,013	67,646	3,485	127,144		127,144	1
2	Housekeeping, Laundry and Maintenance		11,046	9,175	20,221		20,221	2
3	Heat and Other Utilities			29,441	29,441		29,441	3
4	Other (specify):							4
5	TOTAL General Services	56,013	78,692	42,101	176,806		176,806	5
B. Health Care and Programs								
6	Health Care/ Personal Care	124,172	1,264		125,436		125,436	6
7	Activities and Social Services	14,207	921	75	15,203		15,203	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	138,379	2,185	75	140,639		140,639	9
C. General Administration								
10	Administrative and Clerical	69,160	11,708	18,157	99,025		99,025	10
11	Marketing Materials, Promotions and Advertising			7,083	7,083		7,083	11
12	Employee Benefits and Payroll Taxes			16,139	16,139		16,139	12
13	Insurance-Property, Liability and Malpractice			47,401	47,401		47,401	13
14	Other (specify): CABLE TV			3,207	3,207		3,207	14
15	TOTAL General Administration	69,160	11,708	91,987	172,855		172,855	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	263,552	92,585	134,163	490,300		490,300	16
Capital Expenses								
D. Ownership								
17	Depreciation			71,668	71,668		71,668	17
18	Interest			137,929	137,929		137,929	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			209,597	209,597		209,597	23
24	GRAND TOTAL (Sum of lines 16 and 23)	263,552	92,585	343,760	699,897		699,897	24

Facility Name: OAKVIEW VILLA

Report Period Beginning 09/01/2006 Ending: 08/31/2007

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	1	15.63	2
3	Certified Nurse Assistants	6	7.78	3
4	Activity Director & Assistants	1	8.00	4
5	Social Service Workers			5
6	Head Cook	2	8.07	6
7	Cook Helpers/Assistants	4	7.53	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	25.67	13
14	Clerical	1	8.60	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16	\$	17

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	1	City	2
OAKVIEW HEIGHTS CONT CARE		MT. CARMEL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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).

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

	Amount of Fee	
1	NONE	\$
2		
Total		\$

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2006

Ending: 08/31/2007

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	\$	\$ 110,342	1
2											2
3											3
4											4
5											5
Improvement Type											
6		LAND IMPROVEMENTS		3/1/2005	179,669	11,978	15	11,978		29,945	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	\$	\$ 140,287	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	\$ 38,882	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 108,871	\$ 15,553	\$ 15,553	\$		\$ 38,882	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

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2006

Ending: 8/31/2007

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	GERSHMAN INVESTMENT		X	MORTGAGE	4 /13/04	\$ 2,592,475	\$ 2,309,299	4/13/44	5.8000	\$ 134,447	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,592,475	\$ 2,309,299			\$ 134,447	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,592,475	\$ 2,309,299			\$ 134,447	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

Page 7

Facility Name: OAKVIEW VILLA

Report Period Beginning: 9/1/2006

Ending:

8/31/2007

08/31/2007

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/07

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 90,435	\$ 377,627	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		476,885	3
4	Supply Inventory (priced at)	7,636	31,780	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,623	41,085	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)	\$ 103,694	\$ 927,377	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	7,920,924	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	108,871	822,060	16
17	Accumulated Depreciation (book methods)	(179,170)	(1,783,815)	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)	\$ 1,904,844	\$ 7,138,385	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,008,538	\$ 8,065,762	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 10,187	\$ 260,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	55,957	714,901	29
30	Accrued Salaries Payable	10,382	81,083	30
31	Accrued Taxes Payable	5,048	39,429	31
32	Accrued Interest Payable	12,962	39,779	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35			8,370	35
36			848	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 94,536	\$ 1,145,409	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	2,109,973	8,030,719	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)	\$ 2,109,973	\$ 8,030,719	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,204,509	\$ 9,176,128	45
46	TOTAL EQUITY	\$ (195,971)	\$ (1,110,366)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,008,538	\$ 8,065,762	47

*(See instructions.)

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2006

Ending:

08/31/2007

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	\$ 663,545	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 663,545	3
B. Other Operating Revenue			
4	Special Services	12,061	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)	\$ 12,061	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)	\$ 675,606	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	176,806	19
20	Health Care/ Personal Care	140,639	20
21	General Administration	172,855	21
B. Capital Expense			
22	Ownership	209,597	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)	\$ 699,897	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (24,291)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (24,291)	31