

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

I. IDPH License ID Number: 0026328

Facility Name: OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

Address: R R #4, 1320 WEST 9TH STREET MOUNT CARMEL 62863
 Number City Zip Code

County: WABASH

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

HFS ID Number: 371104153001

Date of Initial License for Current Owners: 06/01/81

Type of Ownership:

<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	

In the event there are further questions about this report, please contact:
Name: ROY BIGGERSTAFF **Telephone Number:** (618) 263-4337

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/2006 to 08/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>ROY BIGGERSTAFF</u>	
	(Title) <u>ADMINISTRATOR</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>JAMIE L. MCCORKLE</u> <u>CPA</u>	
	(Firm Name & Address) <u>WILCOX, MCCORKLE AND COMPANY, LTD.</u> <u>328 MARKET STREET, MT. CARMEL, IL 62863</u>	
	(Telephone) <u>(618) 262-5446</u> Fax # <u>(618) 262-8921</u>	

**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**

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER # 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

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 9/30/02

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	683	527	3,282	4,492	8
9	SNF/PED					9
10	ICF	16,819	9,052		25,871	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,502	9,579	3,282	30,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.43%

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

0 (Do not include bed-hold 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 6/01/81

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 20 and days of care provided 3,282

Medicare Intermediary ADMINASTAR FEDERAL (INDIANAPOLIS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 8/31/07 Fiscal Year: 8/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAR # 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	226,894	23,682	11,716	262,292		262,292		262,292		1
2	Food Purchase		127,321		127,321		127,321	(7,263)	120,058		2
3	Housekeeping	114,084	27,684		141,768		141,768		141,768		3
4	Laundry	25,190	6,619	50	31,859		31,859		31,859		4
5	Heat and Other Utilities			137,073	137,073		137,073		137,073		5
6	Maintenance	44,936	22,688	38,909	106,533		106,533		106,533		6
7	Other (specify):*										7
8	TOTAL General Services	411,104	207,994	187,748	806,846		806,846	(7,263)	799,583		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,225,444	104,639	55,811	1,385,894		1,385,894		1,385,894		10
10a	Therapy		3,091	358,718	361,809		361,809		361,809		10a
11	Activities	54,762	1,122	1,661	57,545		57,545		57,545		11
12	Social Services	46,211		3,266	49,477		49,477		49,477		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,326,417	108,852	419,456	1,854,725		1,854,725		1,854,725		16
	C. General Administration										
17	Administrative	140,225			140,225		140,225		140,225		17
18	Directors Fees			5,142	5,142		5,142		5,142		18
19	Professional Services			40,351	40,351		40,351		40,351		19
20	Dues, Fees, Subscriptions & Promotions			48,834	48,834		48,834		48,834		20
21	Clerical & General Office Expenses	97,988	14,406	64,003	176,397		176,397		176,397		21
22	Employee Benefits & Payroll Taxes			360,595	360,595		360,595		360,595		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,525	12,525		12,525		12,525		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			101,259	101,259		101,259		101,259		26
27	Other (specify):* CABLE TV			3,697	3,697		3,697	(3,697)			27
28	TOTAL General Administration	238,213	14,406	636,406	889,025		889,025	(3,697)	885,328		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,975,734	331,252	1,243,610	3,550,596		3,550,596	(10,960)	3,539,636		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			245,980	245,980	245,980		245,980			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			350,249	350,249	350,249	(142)	350,107			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			6,963	6,963	6,963		6,963			35
36	Other (specify):*										36
37	TOTAL Ownership			603,192	603,192	603,192	(142)	603,050			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			49,275	49,275	49,275		49,275			42
43	Other (specify):* BAD DEBT			50,000	50,000	50,000	(50,000)				43
44	TOTAL Special Cost Centers			99,275	99,275	99,275	(50,000)	49,275			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,975,734	331,252	1,946,077	4,253,063	4,253,063	(61,102)	4,191,961			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	7,263	2		4
5	Telephone, TV & Radio in Resident Rooms	3,697	27		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	142	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	50,000	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 61,102		\$	30

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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 61,102		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS Page 5A
OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION CENTER

ID# 0026328
 Report Period Beginning: 09/01/2006
 Ending: 08/31/2007

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL

0026328

Report Period Beginning:

09/01/2006

Ending:

08/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	7,263	0	0	0	0	0	0	0	0	0	0	7,263	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	7,263	0	0	0	0	0	0	0	0	0	0	7,263	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	3,697	0	0	0	0	0	0	0	0	0	0	3,697	27
28	TOTAL General Administration	3,697	0	0	0	0	0	0	0	0	0	0	3,697	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	10,960	0	0	0	0	0	0	0	0	0	0	10,960	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII # 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	142	0	0	0	0	0	0	0	0	0	0	142	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	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	142	0	142	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):*	50,000	0	0	0	0	0	0	0	0	0	0	50,000	43
44	TOTAL Special Cost Centers	50,000	0	50,000	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	61,102	0	61,102	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE	NONE	N/A		OAKVIEW VILLA	MT. CARMEL	SUPPORTIVE LIVI

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	N/A		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CAI # 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHAB # 0026328 Report Period Beginning: 09/01/2006 Ending: 8/31/2007

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 NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	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	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									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10						
		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		4/31/04	\$ 6,098,158	\$ 5,920,846	4/13/44	5.8000	\$ 345,485	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	FIRST BANK		X	LINE OF CREDIT	VARIOUS	12/5/06	250,000	138,977	12/05/07	7.7500	4,764	6					
7	GEN BAPTIST NH BOARD	X		LOAN	VARIOUS	01/2007	376,498	376,498	01/2008	NONE		7					
8												8					
9	TOTAL Facility Related						\$ 6,724,656	\$ 6,436,321			\$ 350,249	9					
B. Non-Facility Related*																	
10	INTEREST INCOME										(142)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (142)	14					
15	TOTALS (line 9+line14)						\$ 6,724,656	\$ 6,436,321			\$ 350,107	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 42,699 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL COUNTY WABASH

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Concrete/Sandstone Frame STEEL Number of Stories ONE

C. Does the Operating Entity? (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. (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 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENT USE</u>	<u>352,863</u>	<u>1981</u>	<u>\$ 89,216</u>	1
2	<u>RESIDENT USE</u>	<u>270,630</u>	<u>1994</u>	<u>60,000</u>	2
3	TOTALS	623,493		\$ 149,216	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	\$ 25,854	30	\$ 25,854		\$ 672,208	4
5				2005	3,461,501	86,538	40	86,538		180,286	5
6				2006	1,109,737	27,743	40	27,743		50,058	6
7											7
8											8
		Improvement Type**									
9		ROOF		1982	3,837		7			3,837	9
10		BUILDING IMPROVEMENTS		1994	2,914		10			2,914	10
11		ROOF		1996	68,042	2,268	30	2,268		25,138	11
12		ROOF		1996	11,450	382	30	382		4,135	12
13		ELECTRICAL - NEW WIRING		1997	23,632	945	25	945		9,295	13
14		DRYWALL		1997	21,125	1,408	15	1,408		13,614	14
15		CARPET		1998	7,927		7			7,927	15
16		SIGN		1998	2,000	133	15	133		1,222	16
17		WALL PAPER		1998	2,435		7			2,435	17
18		PLASTIC COAT-ROOF-WING 5		1998	12,500	417	30	417		3,958	18
19		12 LAVATORY FAUCETS		1998	4,470	298	15	298		2,881	19
20		9 OVERHEAD LIGHTS		1998	921	61	15	61		594	20
21		EXIT SIGN		1998	449	30	15	30		290	21
22		OTHER MG-INCLUDING PLUMBING		1998	9,003	600	15	600		5,702	22
23		CARPET, CURTAINS, BLINDS		1998	11,249	1,125	10	1,125		10,030	23
24		CARPET, CURTAINS, BLINDS		1998	19,656	1,966	10	1,966		17,526	24
25		FUEL TANK		1999	8,935	596	15	596		4,964	25
26		WALL PAPER		1999	4,135	276	15	276		2,320	26
27		KITCHEN		2000	4,230	423	10	423		3,138	27
28		BRITTINGTON AIR & WATER		2000	1,992	261	7	261		1,992	28
29		BUILDING HANDRAILS		2000	3,818	318	7	318		3,818	29
30		NORTH-SIDE HEATERS		2001	6,090	870	7	870		5,727	30
31		WATER HEATERS		2001	15,196	2,171	7	2,171		13,025	31
32		TILE-WING 7		2000	3,753	536	7	536		3,577	32
33		FIRE DOORS		2000	4,861	486	10	486		3,281	33
34		LAND IMPROVEMENTS		1982	14,363		10			14,363	34
35		GAZEBO		1997	3,495	349	10	349		3,466	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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PARKING LOT REPAVEMENT	1997	\$ 12,677	\$ 1,268	10	\$ 1,268	\$	\$ 12,571	37
38	LANDSCAPING	1997	8,836	589	15	589		5,695	38
39	DITCH WORK	1997	700	47	15	47		463	39
40	RESEAL PARKING LOT	1999	3,336		5			3,336	40
41	LANDSCAPING	1999	976	65	15	65		548	41
42	LAND IMPROVEMENTS	2000	647	43	15	43		320	42
43	LAND IMPROVEMENTS	2001	380	25	15	25		167	43
44	LAND IMPROVEMENTS	2005	316,403	21,094	15	21,094		43,945	44
45	POLE BARN	2007	12,485	485	15	485		485	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,975,781	\$ 179,670		\$ 179,670	\$	\$ 1,141,251	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & RE# 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 502,773	\$ 64,129	\$ 64,129	\$		\$ 424,699	71
72	Current Year Purchases	18,916	874	874			874	72
73	Fully Depreciated Assets	153,679						73
74								74
75	TOTALS	\$ 675,368	\$ 65,003	\$ 65,003	\$		\$ 425,573	75

D. Vehicle Depreciation (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	1986 MAZDA TRUCK	1992	\$ 4,474	\$	\$	\$	5	\$ 4,474	76
77	FACILITY USE	1996 CHEVY VAN	1995	23,548				5	23,548	77
78	FACILITY USE	1998 FORD PICKUP	2002	9,799	1,307	1,307		5	9,799	78
79										79
80	TOTALS			\$ 37,821	\$ 1,307	\$ 1,307	\$		\$ 37,821	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)		\$ 6,838,186	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 245,980	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 245,980	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)		\$ 1,604,645	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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: *

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			\$ <u>N/A</u>	\$ <u> </u>	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	10a-3	hrs	\$		\$ 151,957	\$		\$ 151,957	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			57,982			57,982	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			148,779	3,091		151,870	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 358,718	\$ 3,091		\$ 361,809	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABII# 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/2007 (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	\$ 287,192	\$ 377,627	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	476,885	476,885	3
4	Supply Inventory (priced at)	24,144	31,780	4
5	Short-Term Investments			5
6	Prepaid Insurance	35,462	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)	\$ 823,683	\$ 927,377	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	5,975,781	7,920,924	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	713,189	822,060	16
17	Accumulated Depreciation (book methods)	(1,604,645)	(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)	\$ 5,233,541	\$ 7,138,385	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,057,224	\$ 8,065,762	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 250,812	\$ 260,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	658,944	714,901	29
30	Accrued Salaries Payable	70,701	81,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,381	39,429	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	26,817	39,779	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		8,370	8,370	36
37		848	848	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,050,873	\$ 1,145,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,920,746	8,030,719	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)	\$ 5,920,746	\$ 8,030,719	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,971,619	\$ 9,176,128	46
47	TOTAL EQUITY(page 18, line 24)	\$ (914,395)	\$ (1,110,366)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,057,224	\$ 8,065,762	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (641,197)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (641,197)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(273,198)	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)	\$ (273,198)	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)	\$ (914,395)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & F # 0026328 Report Period Beginning: 09/01/2006

Ending: 08/31/2007

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,961,244	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,961,244	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	8,736	13
14	Non-Patient Meals	9,743	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,479	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	142	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 142	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,979,865	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	806,846	31
32	Health Care	1,854,725	32
33	General Administration	889,025	33
B. Capital Expense			
34	Ownership	603,192	34
C. Ancillary Expense			
35	Special Cost Centers	50,000	35
36	Provider Participation Fee	49,275	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,253,063	40
41	Income before Income Taxes (line 30 minus line 40)**	(273,198)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (273,198)	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **OAKVIEW HEIGHTS CONTINUOUS CARE & REHABIL**

0026328

Report Period Beginning: **09/01/2006**

Ending:

08/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,922	1,961	\$ 52,955	\$ 27.00	1
2	Assistant Director of Nursing	2,527	2,565	25,648	10.00	2
3	Registered Nurses	9,958	10,177	186,041	18.28	3
4	Licensed Practical Nurses	26,053	26,521	435,475	16.42	4
5	CNAs & Orderlies	55,894	57,007	513,062	9.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,992	3,031	22,063	7.28	9
10	Activity Assistants	2,601	2,899	32,699	11.28	10
11	Social Service Workers	6,074	6,161	46,211	7.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,019	2,049	29,715	14.50	14
15	Cook Helpers/Assistants	25,664	26,116	197,179	7.55	15
16	Dishwashers					16
17	Maintenance Workers	3,720	3,798	44,936	11.83	17
18	Housekeepers	14,241	14,533	114,084	7.85	18
19	Laundry	3,276	3,368	25,190	7.48	19
20	Administrator	2,986	3,025	95,279	31.50	20
21	Assistant Administrator	4,248	4,326	44,946	10.39	21
22	Other Administrative	822	861	12,263	14.24	22
23	Office Manager					23
24	Clerical	12,115	12,249	97,988	8.00	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,112	180,647	\$ 1,975,734 *	\$ 10.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 11,716	1:3	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	148,779	10a:3	40
41	Occupational Therapy Consultant	151,957	10a:3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	57,982	10a:3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 370,434		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	25	\$ 1,514	10:3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	25	\$ 1,514		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
SCOTT COLE	ADMINISTRATOR	N/A	\$ 62,229	Workers' Compensation Insurance	\$ 102,298	IDPH License Fee	\$ 2,577			
ROY BIGGERSTAFF	ADMINISTRATOR	N/A	31,626	Unemployment Compensation Insurance	27,138	Advertising: Employee Recruitment	1,132			
TRACY COLE	ASST ADMIN	N/A	46,370	FICA Taxes	151,144	Health Care Worker Background Check	3,281			
				Employee Health Insurance	72,764	(Indicate # of checks performed)				
				Employee Meals		Other Advertising	33,901			
				Illinois Municipal Retirement Fund (IMRF)*		Various Dues & Fees	7,943			
				Employee Education	7,251					
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 140,225							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$				
							Out-of-State Travel	\$		
							In-State Travel	12,525		
							Seminar Expense			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 360,595	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 48,834
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
WILCOX, MCCORKLE & CO	AUDITING	\$ 8,350				\$	Out-of-State Travel	\$		
WILCOX, MCCORKLE & CO	CONSULTING	7,535								
DUANE MORRIS LLP	LEGAL	18,339					In-State Travel	12,525		
ROBERTSON, PRIVETT, SCHERE	ACCOUNTING	1,500								
MICHIGAN PEER REVIEW ORGANIZATION		1,240								
JOHN FARRAR	LEGAL	133					Seminar Expense			
MISCELLANEOUS	DATA PROCESSING, ETC	3,254								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,351					TOTAL		\$ 12,525

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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9													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OAKVIEW HEIGHTS CONTINUOUS CARE & REHABILITATION # 0026328 Report Period Beginning: 09/01/2006 Ending: 08/31/2007

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. LIFE SERVICES NETWORK OF ILLINOIS
- (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. \$ _____ Line 10:2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,275
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? YES Indicate the amount. \$ _____
- (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? NONE
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NO
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: WILCOX, MCCORKLE & COMPANY, LTD. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT