

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2008  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2008)**

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><b>I.</b></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 ) 263-4092</u> Fax # <u>( 618 ) 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>  Email Address: <u>oakvilla@hotmail.com</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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>09/01/2007</u> to <u>08/31/2008</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">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">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 &amp; 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>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>	
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Facility Name OAKVIEW VILLA

Report Period Beginning: 09/01/2007 Ending: 08/31/2008

**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	8,052	1
2	8	Double Unit Apartment	8	2,928	2
3		Other			3
4	30	TOTALS	30	10,980	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	3,034	3,846		6,880	5
6	Double Unit		2,928		2,928	6
7	Other					7
8	TOTALS	3,034	6,774		9,808	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.33%

**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)

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**H. ACCOUNTING BASIS**

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 08/31/2008 Fiscal Year: 08/31/2008

\* 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:

09/01/2007

Ending:

08/31/2008

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	75,947	67,702	3,623	147,272		147,272	1
2	Housekeeping, Laundry and Maintenance	6,437	9,307	25,819	41,563		41,563	2
3	Heat and Other Utilities			40,893	40,893		40,893	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>82,384</b>	<b>77,009</b>	<b>70,335</b>	<b>229,728</b>		<b>229,728</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	142,647	753	9,289	152,689		152,689	6
7	Activities and Social Services	16,050	1,317		17,367		17,367	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>158,697</b>	<b>2,070</b>	<b>9,289</b>	<b>170,056</b>		<b>170,056</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	76,168	13,205	19,948	109,321		109,321	10
11	Marketing Materials, Promotions and Advertising			18,662	18,662		18,662	11
12	Employee Benefits and Payroll Taxes			42,418	42,418		42,418	12
13	Insurance-Property, Liability and Malpractice			14,662	14,662		14,662	13
14	Other (specify): CABLE TV			2,964	2,964		2,964	14
15	<b>TOTAL General Administration</b>	<b>76,168</b>	<b>13,205</b>	<b>98,654</b>	<b>188,027</b>		<b>188,027</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>317,249</b>	<b>92,284</b>	<b>178,278</b>	<b>587,811</b>		<b>587,811</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			72,102	72,102		72,102	17
18	Interest			172,311	172,311		172,311	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			100	100		100	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>244,513</b>	<b>244,513</b>		<b>244,513</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>317,249</b>	<b>92,284</b>	<b>422,791</b>	<b>832,324</b>		<b>832,324</b>	<b>24</b>

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2007 Ending: 08/31/2008

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	16.50	2
3	Certified Nurse Assistants	11	8.50	3
4	Activity Director & Assistants	1	9.00	4
5	Social Service Workers			5
6	Head Cook	1	9.15	6
7	Cook Helpers/Assistants	9	7.75	7
8	Dishwashers			8
9	Maintenance Workers	2	9.00	9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	26.69	13
14	Clerical	4	10.00	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>31</b>	<b>\$ 9.64</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	NONE	\$
2		
<b>Total</b>		<b>\$</b>

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).

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2007

Ending: 08/31/2008

## VIII. OWNERSHIP COSTS

A. Purchase price of land 30,000 Year land was acquired 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	\$	\$ 154,479	1
2											2
3											3
4											4
5											5
Improvement Type											
6		LAND IMPROVEMENTS		3/1/2005	179,669	11,978	15	11,978		41,923	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	\$	\$ 196,402	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	\$ 121,023	\$ 15,987	\$ 15,987	\$		\$ 54,869	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 121,023	\$ 15,987	\$ 15,987	\$		\$ 54,869	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: 09/01/2007

Ending: 8/31/2008

**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	<b>TOTAL</b>			\$			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				
	<b>A. Directly Facility Related Long-Term</b>										
1	GERSHMAN INVESTMENT		X	MORTGAGE	4/13/04	\$ 2,592,475	\$ 2,303,407	4/13/44	5.8000	\$ 172,311	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 2,592,475	\$ 2,303,407			\$ 172,311	7
	<b>B. Non-Facility Related</b>										
8	GEN BAPTIST NH BOARD	X		LOAN	1/1/06	376,498	14,238	on demand	none		8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,968,973	\$ 2,317,645			\$ 172,311	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.

Facility Name: OAKVIEW VILLA

Report Period Beginning: 09/01/2007

Ending:

08/31/2008

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 08/31/2008

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 65,710	\$ 299,131	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	35,536	780,626	3
4	Supply Inventory (priced at )	3,692	45,468	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,165	52,291	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 120,103	\$ 1,177,516	10
<b>B. Long-Term Assets</b>				
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	7,945,165	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	121,023	834,213	16
17	Accumulated Depreciation (book methods)	(251,271)	(2,089,316)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,844,895	\$ 6,869,278	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,964,998	\$ 8,046,794	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 3,251	\$ 264,273	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	71,455	1,002,525	29
30	Accrued Salaries Payable	12,926	99,540	30
31	Accrued Taxes Payable	1,767	11,933	31
32	Accrued Interest Payable	11,238	39,487	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
<b>Other Current Liabilities(specify):</b>				
35	Accrued Provider Tax		8,370	35
36	Security Deposits	11,600	11,600	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 112,237	\$ 1,437,728	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable	2,246,190	7,966,689	38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
<b>Other Long-Term Liabilities(specify):</b>				
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 2,246,190	\$ 7,966,689	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 2,358,427	\$ 9,404,417	45
46	<b>TOTAL EQUITY</b>	\$ (393,429)	\$ (1,357,623)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,964,998	\$ 8,046,794	47

\*(See instructions.)

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 727,556	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 727,556	3
<b>B. Other Operating Revenue</b>			
4	Special Services	55,911	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	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 55,911	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	500	12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 500	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)		17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 783,967	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	229,728	19
20	Health Care/ Personal Care	170,056	20
21	General Administration	188,027	21
<b>B. Capital Expense</b>			
22	Ownership	244,513	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 832,324	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (48,357)	29
30	<b>Income Taxes</b>		30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (48,357)	31