



Facility Name & ID Number Oakview Home

# 0036228 Report Period Beginning: 10/01/07 Ending: 09/30/08

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 \_\_\_\_\_

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,650</u>			<u>5,650</u>
14	TOTALS	<u>5,650</u>			<u>5,650</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.48%

D. How many bed-hold days during this year were paid by the Department? 33 (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 06/07/90

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

YES  Date 06/07/90 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 09/30/2008

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

Facility Name & ID Number Oakview Home # 0036228 Report Period Beginning: 10/01/07 Ending: 09/30/08

**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
	<b>A. General Services</b>										
1	Dietary	50,435		1,369	51,804		51,804		51,804		1
2	Food Purchase		30,673		30,673		30,673		30,673		2
3	Housekeeping	32,297	6,178		38,475		38,475	80	38,555		3
4	Laundry	13,289	1,414		14,703		14,703		14,703		4
5	Heat and Other Utilities			17,903	17,903		17,903	2,030	19,933		5
6	Maintenance			21,030	21,030		21,030	13,996	35,026		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	96,021	38,265	40,302	174,588		174,588	16,106	190,694		8
	<b>B. Health Care and Programs</b>										
9	Medical Director		7,704	1,800	9,504		9,504	13	9,517		9
10	Nursing and Medical Records	144,440	3,178	19,955	167,573		167,573	(1,336)	166,237		10
10a	Therapy										10a
11	Activities	13,289	6,406		19,695		19,695		19,695		11
12	Social Services										12
13	CNA Training	5,460			5,460		5,460		5,460		13
14	Program Transportation			3,287	3,287		3,287	740	4,027		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	163,189	17,288	25,042	205,519		205,519	(583)	204,936		16
	<b>C. General Administration</b>										
17	Administrative	35,827		122,688	158,515		158,515	(72,132)	86,383		17
18	Directors Fees							417	417		18
19	Professional Services			3,638	3,638		3,638	2,437	6,075		19
20	Dues, Fees, Subscriptions & Promotions			1,467	1,467		1,467	507	1,974		20
21	Clerical & General Office Expenses	13,289	625	3,648	17,562		17,562	17,185	34,747		21
22	Employee Benefits & Payroll Taxes			67,188	67,188		67,188	16,677	83,865		22
23	Inservice Training & Education			(54)	(54)		(54)	399	345		23
24	Travel and Seminar							704	704		24
25	Other Admin. Staff Transportation			1,408	1,408		1,408	7,087	8,495		25
26	Insurance-Prop.Liab.Malpractice			7,004	7,004		7,004	2,218	9,222		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	49,116	625	206,987	256,728		256,728	(24,501)	232,227		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	308,326	56,178	272,331	636,835		636,835	(8,978)	627,857		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.

Facility Name & ID Number Oakview Home #0036228 Report Period Beginning: 10/01/07 Ending: 09/30/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			12,239	12,239	12,239	12,002	24,241			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			3,135	3,135	3,135	8,565	11,700			32
33	Real Estate Taxes			6,068	6,068	6,068	2,064	8,132			33
34	Rent-Facility & Grounds			45,900	45,900	45,900		45,900			34
35	Rent-Equipment & Vehicles			552	552	552	515	1,067			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			67,894	67,894	67,894	23,146	91,040			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			40,258	40,258	40,258		40,258			42
43	Other (specify):* <b>IL Repl Tax</b>			1,351	1,351	1,351	(1,351)				43
44	<b>TOTAL Special Cost Centers</b>			41,609	41,609	41,609	(1,351)	40,258			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	308,326	56,178	381,834	746,338	746,338	12,817	759,155			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

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**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				4
5	Telephone, TV & Radio in Resident Rooms				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				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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,351)	43-3		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,351)		\$	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 <b>Schedule VIII</b>	14,168		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 14,168		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 12,817		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	51
					52

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ID# 0036228  
 Report Period Beginning: 10/01/07  
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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	<b>Total</b>	0	49





Facility Name & ID Number Oakview Home

# 0036228

Report Period Beginning:

10/01/07

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**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
See Schedule VII C		See Attached Schedule		Health Services Consu	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long-Term Care
				Developmental Founda	Champaign, IL	Long-Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

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	See Schedule VIII	\$			\$	\$	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.

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Facility Name & ID Number Oakview Home

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Report Period Beginning: 10/01/07

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**VII. RELATED PARTIES (continued)**

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Oakview Home

#

0036228

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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	Alan Ryle	Chairman	Administrative	0.50	All related party wages are allocations from HSC. See attached allocation spreadsheet and explanation. These individuals receive no compensation from entities other than HSC.			Administrative	\$ 1,065	17-7	1
2	Lynn Ryle	Director	Administrative	0.50				Administrative	1,065	17-7	2
3											
4	Alan Ryle	Chairman	Directors Fees	0.50				Directors Fees	209	18-7	4
5	Lynn Ryle	Director	Directors Fees	0.50				Directors Fees	208	18-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,547		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

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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

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

Name of Related Organization Health Services Consultants, Inc.  
 Street Address P.O. Box 3037  
 City / State / Zip Code Champaign, IL 61826  
 Phone Number ( 217) 398-0754  
 Fax Number ( 217) 398-0944

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		<b>Reverse expenses for actual amounts paid and accrued to</b>			\$	\$		(11,230)	1
2		<b>HSC for services provided in order to allocate HSC's</b>						0	2
3		<b>actual expenses</b>						(122,688)	3
4									4
5	3	Housekeeping	Beds 368	207	1,843		16	80	5
6	5	Heat & Utilities	Beds 368	207	46,689		16	2,030	6
7	6	Maintenance	Beds 368	207	297,809	253,009	16	13,996	7
8	9	Medical Director	Beds 368	207	294		16	13	8
9	10	Nursing	Beds 368	207	299,354	299,079	16	9,894	9
10	11	Activities	Beds 368	207	0		16	0	10
11	12	Social	Beds 368	207	0		16	0	11
12	13	Nurse Training	Beds 368	207	0		16	0	12
13	14	Program Transportation	Beds 368	207	17,012		16	740	13
14	17	Administrative	Beds 368	207	988,951	987,681	16	50,556	14
15	18	Director Fees	Beds 368	207	9,600		16	417	15
16	19	Professional Fees	Beds 368	207	56,043		16	2,437	16
17	20	Dues & Subscriptions	Beds 368	207	11,663		16	507	17
18	21	Clerical	Beds 368	207	387,703	293,496	16	17,185	18
19	22	P/R Taxes & Benefits	Beds 368	207	568,646		16	16,677	19
20	23	Inservice	Beds 368	207	9,170		16	399	20
21	24	Travel & Seminar	Beds 368	207	16,184		16	704	21
22	25	Administrative Transportation	Beds 368	207	163,005		16	7,087	22
23	26	Insurance	Beds 368	207	51,024		16	2,218	23
24	30	Depreciation	Beds 368	207	276,038		16	12,002	24
25	TOTALS				\$ 3,201,028	\$ 1,833,265		\$ 3,024	25

SEE ACCOUNTANTS' COMPILATION REPORT

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# 0036228

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Ending: 09/30/08

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

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

Name of Related Organization Health Services Consultants, Inc.  
 Street Address P.O. Box 3037  
 City / State / Zip Code Champaign, IL 61826  
 Phone Number ( 217) 398-0754  
 Fax Number ( 217) 398-0944

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	32	Interest	Beds	368	207	\$ 196,996	\$ 16	\$ 8,565	1
2	33	Real Estate Tax	Beds	368	207	47,480	16	2,064	2
3	34	Building Lease	Beds	368	207		16		3
4	35	Equipment Lease	Beds	368	207	11,846	16	515	4
5	N/A	Salaries and Wages	Outside Consulting			1,082,815	1,082,815		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					\$ 4,540,165	\$ 2,916,080	\$ 14,168	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Ford E250 Van		x	Vehicle-Patient Transp.	\$1,234.00	1/25/05	\$ 38,273	\$	01/10/08	6.7400	\$ 90	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Busey Bank		x	Working Capital	N/A	N/A	N/A	N/A	N/A	5.0000	3,045	6								
7	Schedule VIII Allocation		x								8,565	7								
8												8								
9	<b>TOTAL Facility Related</b>				\$1,234.00		\$ 38,273	\$			\$ 11,700	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 38,273	\$			\$ 11,700	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 4,751	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 6,677	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,926	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 4,142	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 6,068	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	5,753	8
	2004	6,228	9
	2005	6,423	10
	2006	6,619	11
	2007	6,677	12
<b>\$5,523 (estimated 2008 tax) x 9/12 = \$4,142</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oakview Home COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036228

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>05-05-20-206-037</u>	<u>Facility</u>	\$ <u>6,061.00</u>	\$ <u>6,061.00</u>
2. <u>05-05-20-206-036</u>	<u>Facility</u>	\$ <u>616.00</u>	\$ <u>616.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>6,677.00</u>	\$ <u>6,677.00</u>

**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   x   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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

Facility Name & ID Number Oakview Home

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,600 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).

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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: \_\_\_\_\_ 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				\$	1
2					2
3	TOTALS			\$	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Leasehold Improvements		1994	12,790	328	39	328		4,487	9
10		Leasehold Improvements		1995	1,824	68	27	68		915	10
11		Drywall Repair		1997	1,651	61	27	61		730	11
12		New A/C Unit		2001	1,400	52	27	52		394	12
13		Water Main		2002	3,000	111	27	111		707	13
14		Vinyl Tile		2004	1,757	351	5	351		1,521	14
15		Underlayment, Tile		2004	627	125	5	125		531	15
16		Water Heater		2005	650	24	27.5	24		67	16
17		Sidewalk Repair		2006	550	37	15	37		92	17
18		Roof		2006	9,355	340	27.5	340		737	18
19		Oak Paneling		2007	509	73	7	73		103	19
20		Tile Flooring for Bedroom		2007	4,435	847	5	847		1,257	20
21		Fire Alarm System		2008	1,390	38	27.5	38		38	21
22		Tile Flooring for Two Bedrooms		2008	1,333	78	5	78		78	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

\*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

Facility Name & ID Number Oakview Home

# 0036228

Report Period Beginning:

10/01/07

Ending:

09/30/08

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								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)	\$ 41,271	\$ 2,533		\$ 2,533	\$	\$ 11,657	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 Home # 0036228 Report Period Beginning: 10/01/07 Ending: 09/30/08

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	\$ 7,586	\$ 1,886	\$ 1,886	\$		\$ 3,967	71
72	Current Year Purchases	1,352	165	165			165	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 8,938	\$ 2,051	\$ 2,051	\$		\$ 4,132	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	Patient Transportation	2005 Ford E250 Van	2005	\$ 38,273	\$ 7,655	\$ 7,655	\$	5	\$ 27,496	76
77										77
78										78
79										79
80	TOTALS			\$ 38,273	\$ 7,655	\$ 7,655	\$		\$ 27,496	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)	\$ 88,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,239	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,239	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)	\$ 43,285	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

Facility Name & ID Number Oakview Home

# 0036228

Report Period Beginning: 10/01/07

Ending: 09/30/08

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Milestone Midwest, Inc.

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>1990</u>	<u>15</u>	<u>06/07/90</u>	\$ <u>45,900</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	<b>TOTAL</b>		<b>16</b>		\$ <b>45,900</b>			<b>7</b>

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>N/A-month to</u>	\$ _____
13.	<u>Month Lease</u>	\$ _____
14.	_____	\$ _____

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: N/A \*

**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: \$ 552

Description: Office Equipment

(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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		1,820		1,820
4	Clinical Wages (b)		3,640		3,640
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,460	\$	\$ 5,460
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,460		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>5</b>

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 Home# 0036228Report Period Beginning: 10/01/07

Ending:

09/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 09/30/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>2,133</u> )	217,873		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			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>	\$ 218,023	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	41,271		15
16	Equipment, at Historical Cost	47,211		16
17	Accumulated Depreciation (book methods)	(43,285)		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>	\$ 45,197	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 263,220	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,903		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,142		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,045	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 12,045	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 251,175	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 263,220	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 244,666	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 244,666	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(7,570)	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)	\$ (7,570)	17
<b>B. Transfers (Itemize):</b>			
18	Transfers (to) from The Residential Developers, Inc.	14,079	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 14,079	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 251,175	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Home

# 0036228

Report Period Beginning: 10/01/07

Ending: 09/30/08

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 738,768	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 738,768	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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		13
14	Non-Patient Meals		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 738,768	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	174,588	31
32	Health Care	205,519	32
33	General Administration	256,728	33
<b>B. Capital Expense</b>			
34	Ownership	67,894	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	40,258	36
<b>D. Other Expenses (specify):</b>			
37	<u>IL Repl Tax</u>	1,351	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 746,338	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(7,570)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (7,570)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax Return is on a 12/31 fiscal year and is on the cash basis.

\*\*\* 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 Home

# 0036228

Report Period Beginning: 10/01/07

Ending: 09/30/08

**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	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees	600	600	5,460	9.10	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,460	1,460	13,289	9.10	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,040	2,197	30,502	13.88	14
15	Cook Helpers/Assistants	2,190	2,190	19,933	9.10	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,897	3,022	32,297	10.69	18
19	Laundry	1,460	1,460	13,289	9.10	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,065	2,340	35,827	15.31	22
23	Office Manager					23
24	Clerical	1,460	1,460	13,289	9.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,230	1,380	24,069	17.44	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	12,127	13,225	120,371	9.10	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,529	29,334	\$ 308,326 *	\$ 10.51	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	\$ 1,369	1-3	35
36	Medical Director	1,800	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	7,852	10-3	38
39	Pharmacist Consultant	240	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	4,963	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,000	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychologist	1,148	10-3	47
48	Dentist Consultant	1,026	10-3	48
49	TOTAL (lines 35 - 48)	\$ 21,398		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Home

# 0036228

Report Period Beginning: 10/01/07

Ending: 09/30/08

**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		
Christine Bouldin	Other Admin	0	\$ 27,804	Workers' Compensation Insurance	\$ 9,913	IDPH License Fee	\$		
Wendy Zawodniak	QMRP/Admin	0	8,023	Unemployment Compensation Insurance	7,093	Advertising: Employee Recruitment	122		
				FICA Taxes	23,587	Health Care Worker Background Check	368		
				Employee Health Insurance	16,195	(Indicate # of checks performed <u>23</u> )			
				Employee Meals	5,751	Patient Background Checks	1		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	961		
				Other	4,649	Schedule VIII Allocation	507		
				Schedule VIII Allocation	16,677				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 35,827			Less: Public Relations Expense	( )		
(List each licensed administrator separately.)						Non-allowable advertising	( )		
						Yellow page advertising	( )		
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	
Management & Support Staff Fee			\$ 122,688	None			Out-of-State Travel	\$	
							In-State Travel		
							Schedule VIII Allocation	704	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 122,688	TOTAL (agree to Schedule V, line 22, col.8)			\$ 83,865	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
Martin, Hood, Friese & Associates	Accounting	\$ 973							
Thomas, Mamer & Haughey	Legal	494							
Various	Other Prof. Services	2,171							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,638	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)								\$ 704	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Oakview Home

Report Period Beginning: 10/01/07 Ending:

**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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

