FOR BHF USE

LL2

Supportive Living Facility

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)

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.

I. Facility ID Number: 1000046

Facility Name: OAKVIEW VILLA

Address: 916 NORTH OAK STREET (Number) MT CARMEL (City) 62863 (Zip Code)

County: WABASH

Telephone Number: (618) 263-4092 **Fax #** (618) 263-4094

Federal Employer ID Number:

Date Current Owners were Certified: 3/15/2005

Type of Ownership:

X	VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: PEGGY COMPTON **Telephone Number:** (618) 263-4092
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 9/1/11 to 8/31/12 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) PEGGY COMPTON
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) CAMILLE LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P O BOX 1190; SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax (417) 865-0682

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

Facility Name OAKVIEW VILLA Report Period Beginning: 9/1/11 Ending: 8/31/12

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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		2,928	3
4	30	TOTALS	30	13,908	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	2,817	4,831		7,648	5
6	Double Unit	541	2,389		2,930	6
7	Other					7
8	TOTALS	3,358	7,220		10,578	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.06%

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.** _____ **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 8/31/12 Fiscal Year: 8/31/12
* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO **If yes, did the facility make all of the required payments of interest and principle?** N/A
If no, explain.

Facility Name: OAKVIEW VILLA **Report Period Beginning: 9/1/11 Ending: 8/31/12**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	91,221	87,956	2,164	181,341		181,341	1
2	Housekeeping, Laundry and Maintenance	28,372	18,572	7,576	54,520		54,520	2
3	Heat and Other Utilities			49,806	49,806	(3,135)	46,671	3
4	Other (specify):							4
5	**TOTAL General Services**	119,593	106,528	59,546	285,667	(3,135)	282,532	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	170,751	790		171,541		171,541	6
7	Activities and Social Services	21,896	1,138	80	23,114		23,114	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	192,647	1,928	80	194,655		194,655	9
	C. General Administration							
10	Administrative and Clerical	93,702	6,203	73,917	173,822		173,822	10
11	Marketing Materials, Promotions and Advertising			2,217	2,217		2,217	11
12	Employee Benefits and Payroll Taxes			94,116	94,116		94,116	12
13	Insurance-Property, Liability and Malpractice			11,874	11,874		11,874	13
14	Other (specify):							14
15	**TOTAL General Administration**	93,702	6,203	182,124	282,029		282,029	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	405,942	114,659	241,750	762,351	(3,135)	759,216	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			70,418	70,418	105	70,523	17
18	Interest			141,124	141,124	(2)	141,122	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			987	987		987	21
22	Other (specify):							22
23	**TOTAL Ownership**			212,529	212,529	103	212,632	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	405,942	114,659	454,279	974,880	(3,032)	971,848	24

Facility Name: OAKVIEW VILLA Report Period Beginning 9/1/11 Ending: 8/31/12

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 16.99	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7	9.52	3
4	Activity Director & Assistants	1	10.03	4
5	Social Service Workers			5
6	Head Cook	1	10.17	6
7	Cook Helpers/Assistants	4	8.84	7
8	Dishwashers			8
9	Maintenance Workers	1	13.21	9
10	Housekeepers			10
11	Laundry			11
12	Managers	1	24.87	12
13	Other Administrative	1	15.71	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	17	$ 11.80	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	NONE			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	1
2			2
	Total	$	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Business	5
OAKVIEW HEIGHTS CONT CARE		MT CARMEL, IL							
GENERAL BAPTIST NURSING HOME		CAMPBEL, MO							
MAGNOLIA MANOR ASST LIVING		PIGGOTT, AR							
GEN BAPTIST NRSG HOME OF PIGGOTT		PIGGOTT, AR							

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [X] NO [ ]
Name of related entity: GEN BAPTIST NURSING HOME BOARD If yes, what is the value of those services? $ 35,101
(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES [X] 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: 9/1/11 Ending: 8/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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			2005	3/1/2005	$ 1,765,474	$ 44,137	40	$ 44,137	$	$ 331,026	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	LAND IMPROVEMENTS			3/1/2005	179,669	11,978	15	11,978		89,834	6
7	PLUMBING IMPROVEMENTS			10/16/2005	7,072	471	15	471		1,827	7
8	PATIO			8/10/2010	3,367	225	15	225		462	8
9	PLUMBING IMPROVEMENTS			1/5/2010	12,843	856	15	856		2,283	9
10	GUTTERS AND LANDSCAPING			5/15/2010	12,830	855	15	855		1,889	10
11	BOILER			6/27/2012	9,493		15	105	105		11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 1,990,748	$ 58,522		$ 58,627	$ 105	$ 427,321	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	$ 138,398	$ 11,896	$ 11,896	$		$ 119,142	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 138,398	$ 11,896	$ 11,896	$		$ 119,142	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: 9/1/11 Ending: 8/31/12

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				$			7

8. Is movable equipment rental included in building rental? ☐ YES ☐ NO

9. Rental amount for movable equipment $

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related Long-Term										
1	GERSHMAN INVESTMENT		X	MORTGAGE	4/13/04	$ 2,592,475	$ 2,201,473	4/13/44	5.8000	$ 141,124	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 2,592,475	$ 2,201,473			$ 141,124	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 2,592,475	$ 2,201,473			$ 141,124	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:** 9/1/11 **Ending:** 8/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 8/31/12 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,036	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	139,165		3
4	Supply Inventory (priced at)	5,099		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,004		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)**	$ 169,304	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,000		13
14	Buildings, at Historical Cost	1,990,748		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	138,398		16
17	Accumulated Depreciation (book methods)	(546,464)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,612,682	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,781,986	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,135	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,801		30
31	Accrued Taxes Payable	4,288		31
32	Accrued Interest Payable	10,640		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	ADV BILLING, DEPOSITS	79,257		35
36	INTERCOMPANY	358,405		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 559,526	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,201,473		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 2,201,473	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 2,760,999	$	45
46	**TOTAL EQUITY**	$ (979,013)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,781,986	$	47

***(See instructions.)**

Facility Name: OAKVIEW VILLA **Report Period Beginning: 9/1/11 Ending: 8/31/12**

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

		1	
	Revenue	**Amount**	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 922,514	1
2	Discounts and Allowances	(58,535)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 863,979	3
	B. Other Operating Revenue		
4	Special Services		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	13,063	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 13,063	11
	C. Non-Operating Revenue		
12	Contributions	590	12
13	Interest and Other Investment Income	2	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 592	14
	D. Other Revenue (specify):		
15	**CABLE TV**	3,135	15
16	**MISC INCOME**	6,232	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 9,367	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 887,001	18

		2	
	Expenses	**Amount**	
	A. Operating Expenses		
19	General Services	285,667	19
20	Health Care/ Personal Care	194,655	20
21	General Administration	282,029	21
	B. Capital Expense		
22	Ownership	212,529	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 974,880	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (87,879)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (87,879)	31

RELATED PARTY EXP	$ (43,561)
HOUSEKEEPING	3
UTILITIES	280
REPAIRS AND MAINTENANC	52
ADMINISTRATIVE SALARY	14,145
PROFESSIONAL FEES	7,163
FEES, SUBSCRIPTIONS	202
OFFICE	8,932
TRAVEL & SEMINAR	1,525
INSURANCE	795
EMPLOYEE BENEFITS	-2,191
DEPRECIATION	1,075
INTEREST EXPENSE	2,845
EQUIPMENT RENTAL	275
TOTAL	$ 35,101