

		FOR BHF USE			

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2010)

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 MT CARMEL 62863

Number City 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:

☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☒	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: TIFFANY CLARK Telephone Number: (870) 598-1020

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 9/1/2009 to 8/31/2010 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)	TIFFANY CLARK	
	(Title)	CFO	
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 VILLAReport Period Beginning: 9/1/2009 Ending: 8/31/2010

III. STATISTICAL DATA

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

Date of change in certified units 3/15/2005

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	22	Single Unit Apartment	22	8,030	1
2	8	Double Unit Apartment	8	2,920	2
3		Other		2,920	3
4	30	TOTALS	30	13,870	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	3,228	1,722		4,950	5
6	Double Unit		4,384		4,384	6
7	Other					7
8	TOTALS	3,228	6,106		9,334	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 67.30%

D. Indicate the number of paid bed-hold days the SLF had during this year

122 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 ☒

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES ☐ NO ☒G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 8/31/2010 Fiscal Year: 8/31/2010

* 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 therequired 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 therequired 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 facilitymake all of the required payments of interest and principle? N/A

If no, explain. _____

Facility Name: OAKVIEW VILLA

Report Period Beginning:

9/1/2009

Ending:

8/31/2010

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	104,843	96,322	1,814	202,979		202,979	1
2	Housekeeping, Laundry and Maintenance	30,269	28,854	5,153	64,276		64,276	2
3	Heat and Other Utilities			50,088	50,088	(3,066)	47,022	3
4	Other (specify):							4
5	TOTAL General Services	135,112	125,176	57,055	317,343	(3,066)	314,277	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	177,968	2,062		180,030		180,030	6
7	Activities and Social Services	14,678	1,972	137	16,787		16,787	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	192,646	4,034	137	196,817		196,817	9
	C. General Administration							
10	Administrative and Clerical	82,554	5,428	73,094	161,076		161,076	10
11	Marketing Materials, Promotions and Advertising			20,406	20,406		20,406	11
12	Employee Benefits and Payroll Taxes			118,938	118,938		118,938	12
13	Insurance-Property, Liability and Malpractice			32,584	32,584		32,584	13
14	Other (specify):							14
15	TOTAL General Administration	82,554	5,428	245,022	333,004		333,004	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	410,312	134,638	302,214	847,164	(3,066)	844,098	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			74,638	74,638		74,638	17
18	Interest			132,718	132,718	(3)	132,715	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,279	1,279		1,279	21
22	Other (specify):							22
23	TOTAL Ownership			208,635	208,635	(3)	208,632	23
24	GRAND TOTAL (Sum of lines 16 and 23)	410,312	134,638	510,849	1,055,799	(3,069)	1,052,730	24

Facility Name: OAKVIEW VILLA

Report Period Beginning 9/1/2009 Ending: 8/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$ 15.60	1
2	Licensed Practical Nurses	1	19.58	2
3	Certified Nurse Assistants	7	9.00	3
4	Activity Director & Assistants	1	8.96	4
5	Social Service Workers			5
6	Head Cook	1	10.31	6
7	Cook Helpers/Assistants	5	8.36	7
8	Dishwashers			8
9	Maintenance Workers	1	15.78	9
10	Housekeepers	1	9.31	10
11	Laundry			11
12	Managers	1	28.80	12
13	Other Administrative	1	10.73	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	17

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES

Name 1	City 2
OAKVIEW HEIGHTS CONT CARE	MT CARMEL, IL
GENERAL BAPTIST NURSING HOME	CAMPBELL, MO

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
GEN BAPTIST N.H. BOARD, INC.	PIGGOTT, AR	MANAGEMENT

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: GEN BAPTIST NH BOARD, INC. If yes, what is the value of those services? \$ 44,052
(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES ☒ NO ☐
If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

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

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

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	NONE	\$	1
2			2
Total		\$	3

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	30		2005	3/1/2005	\$ 1,765,474	\$ 44,137	40	\$ 44,137	\$	\$ 242,753	1
2											2
3											3
4											4
5											5
6	Improvement Type										
6	LAND IMPROVEMENTS			3/1/2005	179,669	11,978	15	11,978		65,879	6
7	PLUMBING IMPROVEMENTS			10/16/2005	7,072	471	15	471		884	7
8	PATIO			8/10/2010	3,367	14	15	14		14	8
9	PLUMBING IMPROVEMENTS			1/5/2010	12,843	571	15	571		571	9
10	GUTTERS AND LANDSCAPING			5/15/2010	12,830	178	15	178		178	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,981,255	\$ 57,349		\$ 57,349	\$	\$ 310,279	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	\$ 17,289	\$ 17,289	\$	7	\$ 89,447	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 121,023	\$ 17,289	\$ 17,289	\$		\$ 89,447	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: 9/1/2009

Ending: 3/31/2010

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☐ NO
3	Original Building			/ /	\$			3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

9. Rental amount for movable equipment \$

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

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	GERSHMAN INVESTEMNT		X	MORTGAGE	4 /13 /04	\$ 2,592,475	\$ 2,250,515	4 /13 /44	5.8000	\$ 132,718	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,592,475	\$ 2,250,515			\$ 132,718	7
	B. Non-Facility Related										
8	GEN BAPTIST NH BOARD	X		LOAN	1/1/06	14,238	7,081	On deman	None		8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,606,713	\$ 2,257,596			\$ 132,718	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: 9/1/2009

Ending:

8/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 8/31/2010

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 49,812	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	64,888		3
4	Supply Inventory (priced at)	5,231		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,124		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)	\$ 147,055	\$	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	1,981,255		14
15	Leasehold Improvements, at Historical Cost	(310,278)		15
16	Equipment, at Historical Cost	121,023		16
17	Accumulated Depreciation (book methods)	(89,447)		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)	\$ 1,732,553	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,879,608	\$	25

*(See instructions.)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,029	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	7,081		29
30	Accrued Salaries Payable	23,138		30
31	Accrued Taxes Payable	2,504		31
32	Accrued Interest Payable	12,513		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	ADV BILLING, DEPOSITS	65,716		35
36	INTERCOMPANY	233,352		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 367,333	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,250,515		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)	\$ 2,250,515	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,617,848	\$	45
46	TOTAL EQUITY	\$ (738,240)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,879,608	\$	47

Facility Name: OAKVIEW VILLA

Report Period Beginning: 9/1/2009

Ending:

8/31/2010

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	\$ 816,234	1
2	Discounts and Allowances	(57,802)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 758,432	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	13,625	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 13,625	11
	C. Non-Operating Revenue		
12	Contributions	294	12
13	Interest and Other Investment Income	3	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 297	14
	D. Other Revenue (specify):		
15	CABLE TV INCOME	3,066	15
16	MISC INCOME	256	16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 3,322	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 775,676	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	317,343	19
20	Health Care/ Personal Care	196,817	20
21	General Administration	333,004	21
	B. Capital Expense		
22	Ownership	208,635	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,055,799	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ (280,123)	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ (280,123)	31

RELATED PARTY EXP	<u>-53,269</u>
UTILITIES	394
REPAIRS AND MAINTENANCE	176
ADMINISTRATIVE SALARY	22,108
PROFESSIONAL FEES	3,545
FEES, SUBSCRIPTIONS	112
OFFICE	10,192
TRAVEL & SEMINAR	1,219
EMPLOYEE BENEFITS	5,943
EQUIPMENT RENTAL	<u>363</u>
TOTAL	44,052