

		FOR BHF USE			

LL2

Supportive Living Facility

**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)**

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>I.</p> <p>Facility Name: <u>BETHE-ANNE EXTENDING LIVING</u></p> <p>Address: <u>1143 N. LAVEERGNE</u> <u>CHICAGO</u> <u>60651</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: (<u>773</u>) <u>287-2711</u> Fax # <u>773 287-2017</u></p> <p>Federal Employer ID Number: <u>36-4372019</u></p> <p>Date Current Owners were Certified: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input 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 _____</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>Linda Barnett</u> Telephone Number: (<u>773</u>) <u>473-7870</u></p>	<input 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 _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from _____ to _____ 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" style="width:100%"> <tr> <td rowspan="2" style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>WANDA LEWIS</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:20%">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</td> <td></td> </tr> </table> <p align="right">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>WANDA LEWIS</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	
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	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																																									

Facility Name BETHE-ANNE EXTENDING LVING

Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	76	Single Unit Apartment	76	27,740	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	78	TOTALS	78	28,470	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	13,870		326	14,196	5
6	Double Unit		210		210	6
7	Other					7
8	TOTALS	13,870	210	326	14,406	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 50.60%

D. Indicate the number of paid bed-hold days the SLF had during this year
 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 216 (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 NO

Tax Year: Fiscal Year: JUNE 30

* 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?

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? NO

If no, explain. NOT APPLICABLE

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? If yes, did the facility make all of the required payments of interest and principle?

If no, explain. NOT APPLICABLE

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			
A. General Services								
1	Dietary and Food Purchase	106,553	137,036		243,589		243,589	1
2	Housekeeping, Laundry and Maintenance	76,336	76,937		153,273		153,273	2
3	Heat and Other Utilities			146,063	146,063		146,063	3
4	Other (specify):Dietary Consultants/Security Contract	47,917		98,338	146,255		146,255	4
5	TOTAL General Services	230,806	213,972	244,401	689,179		689,179	5
B. Health Care and Programs								
6	Health Care/ Personal Care	189,393	1,269		190,662		190,662	6
7	Activities and Social Services	94,563	4,060	6,026	104,649		104,649	7
8	Other (specify):Nurse Consultants			23,700	23,700		23,700	8
9	TOTAL Health Care and Programs	283,956	5,329	29,726	319,011		319,011	9
C. General Administration								
10	Administrative and Clerical	136,020	17,750	108,938	262,708	(8,135)	254,573	10
11	Marketing Materials, Promotions and Advertising	3,186		9,307	12,493		12,493	11
12	Employee Benefits and Payroll Taxes			86,607	86,607		86,607	12
13	Insurance-Property, Liability and Malpractice			95,174	95,174		95,174	13
14	Other (specify):Drug Testing-Nurse Consultants			10,962	10,962	(1,344)	9,618	14
15	TOTAL General Administration	139,206	17,750	310,988	467,944	(9,480)	458,465	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	653,968	237,051	585,115	1,476,135	(9,480)	1,466,655	16
Capital Expenses								
D. Ownership								
17	Depreciation			292,492	292,492		292,492	17
18	Interest			46,809	46,809	(414)	46,395	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			84,115	84,115		84,115	20
21	Rent -- Equipment							21
22	Other (specify): Masonary & Tuckpointing			26,872	26,872		26,872	22
23	TOTAL Ownership			450,288	450,288	(414)	449,873	23
24	GRAND TOTAL (Sum of lines 16 and 23)	653,968	237,051	1,035,403	1,926,422	(9,894)	1,916,528	24

Facility Name: BETHE-ANNE EXTENDING LVING

Report Period Beginning 7/1/2004 Ending: 6/30/2005

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 29.64	1
2	Licensed Practical Nurses	1	11.00	2
3	Certified Nurse Assistants	13	10.07	3
4	Activity Director & Assistants	1	15.48	4
5	Social Service Workers	2	17.04	5
6	Head Cook	2	11.68	6
7	Cook Helpers/Assistants	18	8.45	7
8	Dishwashers			8
9	Maintenance Workers	2	8.37	9
10	Housekeepers	2	9.40	10
11	Laundry	1	8.50	11
12	Managers	3	25.00	12
13	Other Administrative	1	21.15	13
14	Clerical	1	12.00	14
15	Marketing	1	17.95	15
16	Other Dietary Director	1	26.04	16
17	Total (lines 1 thru 16)	51	\$ 231.77	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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	NEW LIFE MANAGEMENT	\$ 41,116 1
2		
Total		\$ 41,116 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

Name	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: _____ If yes, what is the value of those services? \$ _____

(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: BETHE-ANNE EXTENDING LVING

Report Period Beginning:

7/1/2004

Ending: Junew 30, 2005

VIII. OWNERSHIP COSTS

A. Purchase price of land 100,000 Year land was acquired 2000

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	85		2000	2002	\$ 100,000	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6											6
7		Building Improvements		1/31/2003	10,558,485	263,962	40	263,962			7
8		Security System		7/1/2003	8,637	216	20	216			8
9		Outside Lightinh		4/22/2004	3,937	197	20	197			9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,671,059	\$ 264,375		\$ 264,375	\$	\$	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	\$ 270,632	\$ 27,063	\$ 27,063	(0)	10	\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 270,632	\$ 27,063	\$ 27,063	(0)		\$	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: **BETHE-ANNE EXTENDING LVING**

Report Period Beginning: **7/1/2004**

Ending: **6/30/05**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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	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	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	HUD		x	Mortgage-Fees	10/20/01	\$ 1,387,816	\$ 1,387,816	/ /		\$
2	Private Bank		X	Construction	10/28/02	457,000	457,000	6/1/05	4.7500	
3	Avaya Financial		x	Phone System	2/3/03	36,640	19,134	12/31/06	16.0000	
	Working Capital									
4	Private Bank		x	Line of Credit	10/28/02	200,000	200,000	2/2/06	1.0000	
5	Private Bank		X	Commercial Laon	10/28/02	500,000	431,274	12/1/08	6.5000	
6					/ /			/ /		
7	TOTAL Facility Related					\$ 2,581,456	\$ 2,495,224			\$
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 2,581,456	\$ 2,495,224			\$

* 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.

STATE OF ILLINOIS

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Facility Name: **BETHE-ANNE EXTENDING LVING**Report Period Beginning: **7/1/2004**

Ending:

6/30/05**XI. BALANCE SHEET - Unrestricted Operating Fund.**

As of _____

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 42,549	\$	1
2	Cash-Patient Deposits	14,192		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,607		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	488,464		8
9	Other(specify):	22,997		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 611,809	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	10,571,059		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	270,632		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(704,454)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	51,312		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,288,549	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,900,358	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 550,099	\$	26
27	Officer's Accounts Payable	13,734		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35	Accrued Expense:	3,490		35
36	Notes Payables/Recovery. Capital Adv	887,093		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,454,416	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	167,860		38
39	Mortgage Payable	1,387,816		39
40	Bonds Payable			40
41	Deferred Compensation			41
Other Long-Term Liabilities(specify):				
42	Recoverable Advance	7,594,449		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,150,125	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,604,541	\$	45
46	TOTAL EQUITY	\$ 295,817	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,900,358	\$	47

*(See instructions.)

Facility Name: BETHE-ANNE EXTENDING LIVING

Report Period Beginning: 7/1/2004

Ending:

6/30/05

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	\$ 2,331,005	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,331,005	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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15		24,089	15
16		234,887	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 258,976	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,589,981	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	689,179	19
20	Health Care/ Personal Care	319,011	20
21	General Administration	458,465	21
B. Capital Expense			
22	Ownership	449,873	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)	\$ 1,916,528	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 673,453	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 673,453	31