

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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>BETH-ANNE PLACE</u></p> <p>Address: <u>1143 n N. LAVERGNE</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>36-3013241</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>773 473-7870</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 <u>07/01/05</u> to <u>06/30/06</u> and certify to the best of my knowledge : 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 style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Wanda Lewis</u> (Title) <u>Administrator</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____) Fax _____</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) _____ (Type or Print Name) <u>Wanda Lewis</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____) Fax _____
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Facility Name: BETH-ANNE PLACE

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	165,741	159,002	2,504	327,247		327,247	1
2	Housekeeping, Laundry and Maintenance	92,939	69,103		162,042		162,042	2
3	Heat and Other Utilities			175,056	175,056		175,056	3
4	Other (specify): Security Serv, Garbage, Exterminating			132,976	132,976		132,976	4
5	TOTAL General Services	258,680	228,105	310,536	797,321		797,321	5
B. Health Care and Programs								
6	Health Care/ Personal Care	259,434	3,825	28,134	291,393		291,393	6
7	Activities and Social Services	87,910	9,746	1,846	99,502		99,502	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	347,344	13,571	29,980	390,895		390,895	9
C. General Administration								
10	Administrative and Clerical	118,044	16,645	63,805	198,494	(12,225)	186,269	10
11	Marketing Materials, Promotions and Advertising	26,000	1,463	338	27,800		27,800	11
12	Employee Benefits and Payroll Taxes	94,949			94,949		94,949	12
13	Insurance-Property, Liability and Malpractice			71,331	71,331		71,331	13
14	Other (specify):			2,341	2,341		2,341	14
15	TOTAL General Administration	238,993	18,108	137,814	394,915	(12,225)	382,690	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	845,017	259,783	478,330	1,583,131	(12,225)	1,570,906	16
Capital Expenses								
D. Ownership								
17	Depreciation			292,298	292,298		292,298	17
18	Interest			45,804	45,804		45,804	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			144,000	144,000		144,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			482,102	482,102		482,102	23
24	GRAND TOTAL (Sum of lines 16 and 23)	845,017	259,783	960,432	2,065,233	(12,225)	2,053,008	24

Facility Name: BETH-ANNE PLACE

Report Period Beginning 7/1/2005 Ending: 6/30/2006

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 41.03	1
2	Licensed Practical Nurses	1	11.33	2
3	Certified Nurse Assistants	11	10.35	3
4	Activity Director & Assistants	2	14.98	4
5	Social Service Workers	1	21.13	5
6	Head Cook	3	14.50	6
7	Cook Helpers/Assistants	14	8.97	7
8	Dishwashers			8
9	Maintenance Workers	3	13.95	9
10	Housekeepers	3	9.15	10
11	Laundry	1	8.76	11
12	Managers	2	25.46	12
13	Other Administrative	3	10.93	13
14	Clerical			14
15	Marketing	1	13.73	15
16	Other-Dietary Director	1	26.41	16
17	Total (lines 1 thru 16)	47	\$ 231	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	\$ 51,938 1
2		
Total		\$ 51,938 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 <u>1</u>	City <u>2</u>
_____	_____
_____	_____
_____	_____

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ 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: BETH-ANNE PLACE

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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			2000	2002	\$ 100,000	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Building Improvements		1/31/2003	10,558,484	263,962	40	263,962			6
7		Security System		7/1/2003	8,637	216	20	216			7
8		Outside Lighting		4/22/2004	3,937	197	20	197			8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,671,058	\$ 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	\$	10	\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 270,632	\$ 27,063	\$ 27,063	\$		\$	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: BETH-ANNE PLACE

Report Period Beginning: 7/1/2005

Ending: 06/30/ 6/30/2006

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	
		Related**	NO			Original	Balance				
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
A. Directly Facility Related Long-Term											
1						\$	\$			\$	1
2											2
3			X	Phone System	02/03/03	36,640	6,943	12/31/06	16.0000		3
Working Capital											
4			X	Line of Credit	10/28/02	200,000	200,000	4/30/07	Prime + 1%		4
5			X	Commercial Loan	10/28/02	500,000	318,067	12/31/08	6.5000		5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 736,640	\$ 525,010			\$	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 736,640	\$ 525,010			\$	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.

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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06/30/06

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 12,947	\$	1
2	Cash-Patient Deposits	12,635		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	14,615		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	804,931		8
9	Other(specify):	22,997		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 868,125	\$	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			14
15	Leasehold Improvements, at Historical Cost	10,574,252		15
16	Equipment, at Historical Cost	271,472		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(996,752)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	96,963		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,045,935	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,914,060	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 321,998	\$	26
27	Officer's Accounts Payable	14,462		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 Payable /Recovery Capital Advance	577,548		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 917,498	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	358,098		38
39	Mortgage Payable	318,067		39
40	Bonds Payable			40
41	Deferred Compensation			41
Other Long-Term Liabilities(specify):				
42	Recoverabvle Advance	8,423,220		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,099,385	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,016,883	\$	45
46	TOTAL EQUITY	\$ 897,177	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,914,060	\$	47

*(See instructions.)

Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

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	\$ 2,590,667	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,590,667	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		15,130	15
16		234,887	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 250,017	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,840,684	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	797,321	19
20	Health Care/ Personal Care	390,895	20
21	General Administration	382,690	21
B. Capital Expense			
22	Ownership	482,102	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)	\$ 2,053,008	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 787,676	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 787,676	31

LINE 4 COLUMN 3

GARBAGE & TRASH REMOVAL	8,650.04
ALARM SYSTEM	
EXTERMINATING	1,796.32
FIRE EXTINGUISHER & SECURITY	15,804.97
SECURITY GUARD SERVICE CONTRACT	106,725.07
PLIMBING EXPENSES	
LICENSE FEE	

TOTAL 132,976.40

**GNERAL ADMINISTRATION
LINE 10 COLUMN 5**

TELEPHONE PAYMENTS FROM RESIDENTS	12,184.00
BANK CHARGES	40.72

TOTAL 12,224.72

**GNERAL ADMINISTRATION
LINE 14 COLUMN 3**

STAFF DEVELOPMENT	588.30
EMPLOYEE DRUG TESTING	495.00
BOOKKEEPING AND ACCOUNTING SERVIC	850.00
CREDIT CHECK	378.00

TOTAL 2,311.30

LINE 10 COLUIMN 5

TELEPHONE PAYMENTS FROM RESIDENTS	(3,373.00)
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