

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2007**  
**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><b>I. Facility ID Number:</b> 1000020</p> <p><b>Facility Name:</b> <u>BETH-ANNE PLACE</u></p> <p><b>Address:</b> <u>1143 N. LAVERGNE</u> <u>CHICAGO</u> <u>60651</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> ( <u>773</u> ) <u>287-2711</u> Fax # <u>773 287-2017</u></p> <p><b>Federal Employer ID Number:</b> <u>36-3013241</u></p> <p><b>Date Current Owners were Certified:</b> _____</p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>LINDA BARNETT</u> <b>Telephone Number:</b> ( <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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/06</u> to <u>06/30/07</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 rowspan="2" style="width:15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td rowspan="4" style="width:15%;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) _____ ) <b>Fax</b> _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>IL DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 <span style="float:right">Phone # (217) 782-1630</span></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) _____ ) <b>Fax</b> _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) _____ ) <b>Fax</b> _____																																						



Facility Name: BETH-ANNE PLACE

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	185,113	178,776		363,889		363,889	1
2	Housekeeping, Laundry and Maintenance	105,552	116,858		222,410		222,410	2
3	Heat and Other Utilities			207,146	207,146		207,146	3
4	Other (specify): Security Serv, Garbage, Exterminating			123,259	123,259		123,259	4
5	<b>TOTAL General Services</b>	290,665	295,634	330,405	916,704		916,704	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	280,410			280,410		280,410	6
7	Activities and Social Services	145,052	3,590		148,642		148,642	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	425,462	3,590		429,052		429,052	9
<b>C. General Administration</b>								
10	Administrative and Clerical	22,011	14,003	52,822	88,836	(23,865)	64,971	10
11	Marketing Materials, Promotions and Advertising	6,473	2,510	1,229	10,212		10,212	11
12	Employee Benefits and Payroll Taxes	110,490			110,490		110,490	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify): Managers	118,751		5,100	123,851		123,851	14
15	<b>TOTAL General Administration</b>	257,725	16,513	59,151	333,389	(23,865)	309,524	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	973,852	315,737	389,556	1,679,145	(23,865)	1,655,280	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			319,700	319,700		319,700	17
18	Interest			27,467	27,467		27,467	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	<b>TOTAL Ownership</b>			491,167	491,167		491,167	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	973,852	315,737	880,724	2,170,312	(23,865)	2,146,447	24

Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2006 Ending: 6/30/2007

**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	10.32	3
4	Activity Director & Assistants	1	12.57	4
5	Social Service Workers	4	17.63	5
6	Head Cook/Dietary Supervisor	6	12.43	6
7	Cook Helpers/Assistants	15	8.53	7
8	Dishwashers			8
9	Maintenance Workers	2	11.50	9
10	Housekeepers	4	9.74	10
11	Laundry	1	8.76	11
12	Managers	4	21.85	12
13	Other Administrative			13
14	Clerical	2	10.68	14
15	Marketing	1	13.73	15
16	Other-Dietary Director	1	26.41	16
17	<b>Total (lines 1 thru 16)</b>	<b>54</b>	<b>\$ 216.51</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	HSR	\$ 55,677	1
2			2
<b>Total</b>		<b>\$ 55,677</b>	<b>3</b>

**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: 7/1/2006

Ending: 06/30/06 6/30/2007

**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	<b>TOTAL</b>				\$			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		3	4	6		7	8	9
			Related**				Purpose of Loan	Date of Note			
			YES	NO			Original	Balance			
		<b>A. Directly Facility Related Long-Term</b>									
1							\$	\$			\$
2				X	Phone Sys Ttem		36,640	0	12/31/06		
3											
		<b>Working Capital</b>									
4				X	Line of Credit	10/28/02	200,000	84,161	4/30/07	9.2500	
5				X	Commercial Loan	10/28/02	500,000	197,185	12/31/08	6.5000	
6						/ /			/ /		
7		<b>TOTAL Facility Related</b>					\$ 736,640	\$ 281,346			\$
		<b>B. Non-Facility Related</b>									
8						/ /			/ /		
9						/ /			/ /		
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 736,640	\$ 281,346			\$

\* 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: BETH-ANNE PLACE

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

## 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
<b>Improvement Type</b>											
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	(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

## STATE OF ILLINOIS

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Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2006

Ending:

6/30/2007

06/30/07

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 216,591	\$	1
2	Cash-Patient Deposits			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			6
7	Other Prepaid Expenses	14,615		7
8	Accounts Receivable (owners or related parties)	766,267		8
9	Other(specify):	13,571		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,011,044	\$	10
	<b>B. Long-Term Assets</b>			
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	10,572,059		15
16	Equipment, at Historical Cost	271,472		16
17	Accumulated Depreciation (book methods)	(121,605)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,194,952)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	96,579		22
23	Other(specify):	13,032		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 9,736,585	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,747,629	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 227,645	\$	26
27	Officer's Accounts Payable	36,386		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
	<b>Other Current Liabilities(specify):</b>			
35	Accrued Expense	1,717		35
36	Notes Payable /Recovery Capital Advance	385,890		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 651,638	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	197,185		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Recoverabvle Advance	8,491,199		42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 8,688,384	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 9,340,022	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,407,607	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 10,747,629	\$	47

\*(See instructions.)

Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2006

Ending:

7/31/2007

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,957,060	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 2,957,060	3
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	6	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 6	14
<b>D. Other Revenue (specify):</b>			
15		5,618	15
16		249,718	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 255,336	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 3,212,403	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	916,705	19
20	Health Care/ Personal Care	429,052	20
21	General Administration	333,389	21
<b>B. Capital Expense</b>			
22	Ownership	491,167	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 2,170,313	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 1,042,090	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 1,042,090	31

**LINE 4 COLUMN 3**

GARBAGE & TRASH REMOVAL	9,742.20
EXTERMINATING	367.00
SECURITY GUARD SERVICE CONTRACT	113,150.00

**TOTAL 123,259.20**

**GENERAL ADMINISTRATION  
LINE 10 COLUMN 5**

TELEPHONE PAYMENTS FROM RESIDENTS	23,865.00
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**TOTAL 23,865.00**

**GENERAL ADMINISTRATION  
LINE 14 COLUMN 3**

BOOKKEEPING AND ACCOUNTING SERVICE	5,100.00
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**TOTAL 5,100.00**