

		FOR BHF USE			

LL2

Supportive Living Facility
2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)

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>QUINCY SENIOR AND FAMILY RESOURCE CENTER SL</u></p> <p>Address: <u>639 YORK STREET</u> <u>QUINCY</u> <u>62301</u> Number City Zip Code</p> <p>County: <u>ADAMS</u></p> <p>Telephone Number: (<u>217</u>) <u>592-3668</u> Fax # (<u>217</u>) <u>592-3732</u></p> <p>Federal Employer ID Number: <u>37-1409741</u></p> <p>Date Current Owners were Certified: <u>04/04/2003</u></p> <p>Type of Ownership:</p> <table border="0"> <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 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 checked="" 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>TODD SHACKELFORD</u> Telephone Number: (<u>217</u>) <u>223-7904</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" 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>01/01/2007</u> to <u>12/31/2007</u> 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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>LYNN NIEWOHNER</u></td> <td></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>GENERAL AND MANAGING PARTNER</u></td> </tr> <tr> <td rowspan="4">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>LYNN NIEWOHNER</u>			(Title) <u>GENERAL AND MANAGING PARTNER</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: QUINCY SENIOR AND FAMILY RESOURCE CENTER SI

Report Period Beginning:

01/01/2007

Ending: 12/31/2007

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			
A. General Services								
1	Dietary and Food Purchase		200,485		200,485		200,485	1
2	Housekeeping, Laundry and Maintenance	31,829	45,070	15,000	91,899		91,899	2
3	Heat and Other Utilities			72,587	72,587	(10,069)	62,518	3
4	Other (specify):							4
5	TOTAL General Services	31,829	245,555	87,587	364,971	(10,069)	354,902	5
B. Health Care and Programs								
6	Health Care/ Personal Care	353,765	1,626		355,391		355,391	6
7	Activities and Social Services		5,455	19,612	25,067		25,067	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	353,765	7,081	19,612	380,458		380,458	9
C. General Administration								
10	Administrative and Clerical	56,859	2,478	18,680	78,017		78,017	10
11	Marketing Materials, Promotions and Advertising			8,055	8,055		8,055	11
12	Employee Benefits and Payroll Taxes	152,734			152,734		152,734	12
13	Insurance-Property, Liability and Malpractice	21,358			21,358		21,358	13
14	Other (specify):							14
15	TOTAL General Administration	230,951	2,478	26,735	260,164		260,164	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	616,545	255,114	133,934	1,005,593	(10,069)	995,524	16
Capital Expenses								
D. Ownership								
17	Depreciation			269,054	269,054		269,054	17
18	Interest			312,665	312,665		312,665	18
19	Real Estate Taxes			45	45		45	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): MORTGAGE PREMIUM INSURNACE			20,576	20,576		20,576	22
23	TOTAL Ownership			602,340	602,340		602,340	23
24	GRAND TOTAL (Sum of lines 16 and 23)	616,545	255,114	736,274	1,607,933	(10,069)	1,597,864	24

Facility Name: QUINCY SENIOR AND FAMILY RESOURCE CENTER SL

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.00	1
2	Licensed Practical Nurses	2	15.00	2
3	Certified Nurse Assistants	10	9.00	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.50	10
11	Laundry	1	7.50	11
12	Managers	1	16.20	12
13	Other Administrative			13
14	Clerical	1	10.00	14
15	Marketing			15
16	Other	5	7.50	16
17	Total (lines 1 thru 16)	22	\$ 11.84	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

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>
NDC EQUITY FUNDS IV	NEW YORK, NY
West Central Illinois Area Agency on Aging	Quincy, IL

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1 West Central Illinois Area Agency on Aging	\$ 41,613	1
2		2
Total		\$ 41,613 3

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: QUINCY SENIOR AND FAMILY RESOURCE CENTER SI.

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	57		2002	2002	\$ 7,006,426	\$	24	\$ 269,054	\$ 269,054	\$ 1,242,897	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,006,426	\$		\$ 269,054	\$ 269,054	\$ 1,242,897	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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: **QUINCY SENIOR AND FAMILY RESOURCE CENTER SL**

Report Period Beginning: **01/01/2007**

Ending: **2/31/2007**

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	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					/ /	\$		/ /		\$
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$				\$
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$				\$

* 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: **QUINCY SENIOR AND FAMILY RESOURCE CENTER SL**Report Period Beginning: **01/01/2007**

Ending:

12/31/2007**12/31/2007****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2007**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 154,912	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,147		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,349		7
8	Accounts Receivable (owners or related parties)	258,535		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 428,943	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,920,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	164,345		16
17	Accumulated Depreciation (book methods)	(1,242,897)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	227,480		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Unamortized Mortgage Loan</u>	535,021		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,604,312	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,033,255	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,262	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,442		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	25,990		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Current Maturities on Mortgage Loan</u>	24,017		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 108,711	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	780,233		38
39	Mortgage Payable	4,079,658		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Development Fee</u>	122,629		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,982,520	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,091,231	\$	45
46	TOTAL EQUITY	\$ 1,942,024	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,033,255	\$	47

*(See instructions.)

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	\$ 683,760	1
2	Discounts and Allowances	27,417	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 711,177	3
B. Other Operating Revenue			
4	Special Services	746,616	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)	\$ 746,616	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
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,457,793	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	78,321	19
20	Health Care/ Personal Care	859,401	20
21	General Administration	121,057	21
B. Capital Expense			
22	Ownership	394,644	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):	3,672	25
26	Depreciation	269,054	26
27	Amortization	20,393	27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,746,542	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (288,749)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (288,749)	31

ATTACHMENT

IV. COST CENTER EXPENSES

A. Row 3, Column 5

Cable Television Expenses	10,069
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D. Row 22, Column 3

Mortgage Premium Insurance	20,576
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