

		FOR BHF USE			

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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>Supportive Living of Wabash</u></p> <p>Address: <u>532 Abelson Drive</u> <u>Carmi</u> <u>62821</u> <small>Number City Zip Code</small></p> <p>County: <u>White</u></p> <p>Telephone Number: (<u>618</u>) <u>382-2900</u> Fax # <u>618 382-8067</u></p> <p>Federal Employer ID Number: <u>20-5108743</u></p> <p>Date Current Owners were Certified: <u>6/26/07</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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>Susan McGhee</u> Telephone Number: (<u>217 732-5175</u>)</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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>6/26/2007</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" style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Tim Phillippe</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u> (Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr, Ste 100, St. Louis, MO 63131</u> (Telephone) <u>314 336-3679</u> Fax <u>314-3336-3650</u></td> </tr> </table> <p align="center">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>Tim Phillippe</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u> (Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr, Ste 100, St. Louis, MO 63131</u> (Telephone) <u>314 336-3679</u> Fax <u>314-3336-3650</u>
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Facility Name: Supportive Living of Wabash

Report Period Beginning:

6/26/2007

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	27,579	27,018	242	54,839		54,839	1
2	Housekeeping, Laundry and Maintenance	11,924	7,582	6,597	26,103		26,103	2
3	Heat and Other Utilities			39,277	39,277	(2,594)	36,683	3
4	Other (specify): Waste Removal			409	409		409	4
5	TOTAL General Services	39,503	34,600	46,525	120,628	(2,594)	118,034	5
B. Health Care and Programs								
6	Health Care/ Personal Care	70,331	705	59	71,095		71,095	6
7	Activities and Social Services	7,407	441	7	7,855		7,855	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	77,738	1,146	66	78,950		78,950	9
C. General Administration								
10	Administrative and Clerical	46,111	4,440	103,032	153,583	(349)	153,234	10
11	Marketing Materials, Promotions and Advertising			48,000	48,000		48,000	11
12	Employee Benefits and Payroll Taxes			24,663	24,663		24,663	12
13	Insurance-Property, Liability and Malpractice			8,818	8,818		8,818	13
14	Other (specify):							14
15	TOTAL General Administration	46,111	4,440	184,513	235,064	(349)	234,715	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	163,352	40,186	231,104	434,642	(2,943)	431,699	16
Capital Expenses								
D. Ownership								
17	Depreciation			147,046	147,046		147,046	17
18	Interest			239,323	239,323		239,323	18
19	Real Estate Taxes			20,168	20,168		20,168	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,864	3,864		3,864	21
22	Other (specify): Mgmt Fees							22
23	TOTAL Ownership			410,401	410,401		410,401	23
24	GRAND TOTAL (Sum of lines 16 and 23)	163,352	40,186	641,505	845,043	(2,943)	842,100	24

Facility Name: Supportive Living of Wabash

Report Period Beginning: 6/26/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.40	\$ 20.32	1
2	Licensed Practical Nurses	1.00	15.32	2
3	Certified Nurse Assistants	6.00	8.66	3
4	Activity Director & Assistants	1.00	9.26	4
5	Social Service Workers			5
6	Head Cook	1.00	13.81	6
7	Cook Helpers/Assistants	1.50	8.47	7
8	Dishwashers			8
9	Maintenance Workers	0.50	10.94	9
10	Housekeepers	0.50	8.93	10
11	Laundry			11
12	Managers	1.00	23.78	12
13	Other Administrative	0.12	8.52	13
14	Clerical	1.00	9.80	14
15	Marketing	0.70	8.82	15
16	Other	1.00	8.88	16
17	Total (lines 1 thru 16)	15.72	\$	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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$
2		\$
Total		\$

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>
Christian Homes, Inc.	Lincoln

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: Supportive Living of Wabash

Report Period Beginning:

6/26/2007

Ending:

12/31/2007

VIII. OWNERSHIP COSTSA. Purchase price of land 17,000 Year land was acquired 2006

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	49		2007	2006	\$ 5,979,500	\$ 117,796	25.5	\$ 117,796	\$	\$ 117,796	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Landscaping		2007		22,330	744	15	744		744	6
7	Staking Fees		2007		6,500	217	15	217		217	7
8	Walks/Curbs		2007		21,843	728	15	728		728	8
9	Paving & Surfacing		2007		22,445	748	15	748		748	9
10	Dump Fees		2007		14,140	471	15	471		471	10
11	Misc		2007		1,068	33	15	33		33	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,067,826	\$ 120,737		\$ 120,737	\$	\$ 120,737	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	\$ 263,085	\$ 26,309	\$ 26,309	\$	5	\$ 26,309	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 263,085	\$ 26,309	\$ 26,309		\$ 26,309	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: Supportive Living of Wabash

Report Period Beginning: 6/26/2007

Ending: 2/31/2007

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	
		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				
		YES	NO			Original	Balance				
A. Directly Facility Related											
Long-Term											
1	Christian Homes, Inc	X		Startup Construction	10/31/06	\$ 1,452,900	\$ 1,452,900	12/31/30	7.5000	\$ 54,488	1
2	US Bank		X	Construction	10/31/06	4,000,000	4,000,000	12/1/23	6.7100	134,200	2
3	US Bank		X	Construction	10/31/06	1,094,000	1,094,000	10/1/08	7.2500	39,658	
4			X	Deferred Tax Credit Fees & Org Costs		205,644	194,667			10,977	
5											3
Working Capital											
6					/ /			/ /			4
7					/ /			/ /			6
8	TOTAL Facility Related					\$ 6,752,544	\$ 6,741,567			\$ 239,323	7
B. Non-Facility Related											
9											8
10											9
11	TOTALS (lines 7, 8 and 9)					\$ 6,752,544	\$ 6,741,567			\$ 239,323	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: Supportive Living of Wabash

Report Period Beginning: 6/26/2007

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	\$ 84,829	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	82,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,464		6
7	Other Prepaid Expenses	5,551		7
8	Accounts Receivable (owners or related parties)	14,324		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 191,627	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,000		13
14	Buildings, at Historical Cost	5,979,500		14
15	Leasehold Improvements, at Historical Cost	88,326		15
16	Equipment, at Historical Cost	263,085		16
17	Accumulated Depreciation (book methods)	(147,046)		17
18	Deferred Charges	194,667		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,441,931		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,837,463	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,029,090	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 430,626	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,038		30
31	Accrued Taxes Payable	20,168		31
32	Accrued Interest Payable	108,967		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Liabilities	40,176		35
36	Contracts Payable	696,000		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,315,475	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,452,900		38
39	Mortgage Payable	5,094,000		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)	\$ 6,546,900	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,862,375	\$	45
46	TOTAL EQUITY	\$ 166,715	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,029,090	\$	47

*(See instructions.)

Facility Name: Supportive Living of Wabash

Report Period Beginning: 6/26/2007

Ending:

12/31/2007

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	\$ 287,529	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 287,529	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	134,905	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 134,905	14
D. Other Revenue (specify):			
15	Cable TV Revenue	2,594	15
16	Miscellaneous Revenue	14,366	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 16,960	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 439,394	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	124,002	19
20	Health Care/ Personal Care	78,950	20
21	General Administration	210,291	21
B. Capital Expense			
22	Ownership	431,800	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)	\$ 845,043	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (405,649)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (405,649)	31

Reclassifications and Adjustments
Schedule IV - Column 5

Line 3	Heat and Other Utilities	(2,594) offset cable TV revenue
Line 10	Administrative and Clerical	<u>(349) nonallowable bank charges</u>
		<u><u>(2,943)</u></u>

