

		FOR BHF USE			

LL2

Supportive Living Facility
2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)

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. LAVERGNE</u> <u>CHICAGO</u> <u>60651</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: (<u>773</u>) <u>287-2711</u> Fax # (<u>773</u>) <u>473-7871</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 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 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: _____ Telephone Number: (_____) _____ Email Address: _____</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"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>10/31/2008</td> </tr> <tr> <td>(Type or Print Name) <u>Lawrence Wilson</u></td> <td>(Date)</td> </tr> <tr> <td></td> <td>(Title) _____</td> <td>Chief Financial Officer</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) (_____) _____</td> <td>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) _____	10/31/2008	(Type or Print Name) <u>Lawrence Wilson</u>	(Date)		(Title) _____	Chief Financial Officer	Paid Preparer	(Signed) _____	(Date)	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (_____) _____	Fax # (_____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) (_____) _____	Fax # (_____) _____																																								

Facility Name BETH-ANNE PLACE

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

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	83	Single Unit Apartment	83 x 366	30,378	1
2	2	Double Unit Apartment	2 x 366	732	2
3		Other			3
4	85	TOTALS		31,110	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	25,841	366		26,207	5
6	Double Unit	732			732	6
7	Other					7
8	TOTALS	26,573	366		26,939	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.59%

D. Indicate the number of paid bed-hold days the SLF had during this year 754 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 407 (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

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE

Report Period Beginning:

7/1/2007

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	180,876	210,743		391,619		391,619
2	Housekeeping, Laundry and Maintenance	65,932	113,996		179,928		179,928
3	Heat and Other Utilities			245,019	245,019		245,019
4	Other (specify):			130,068	130,068		130,068
5	TOTAL General Services	246,808	324,739	375,087	946,633		946,633
B. Health Care and Programs							
6	Health Care/ Personal Care	313,501			313,501		313,501
7	Activities and Social Services	117,705			117,705		117,705
8	Other (specify):						
9	TOTAL Health Care and Programs	431,206			431,206		431,206
C. General Administration							
10	Administrative and Clerical	24,496	13,897	72,086	110,479		110,479
11	Marketing Materials, Promotions and Advertising		10,501	2,874	13,375		13,375
12	Employee Benefits and Payroll Taxes	139,352			139,352		139,352
13	Insurance-Property, Liability and Malpractice						
14	Other (specify): Managers	178,187		9,265	187,452		187,452
15	TOTAL General Administration	342,035	24,398	84,225	450,658		450,658
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,020,049	349,137	459,312	1,828,497		1,828,497
Capital Expenses							
D. Ownership							
17	Depreciation						
18	Interest			23,167	23,167		23,167
19	Real Estate Taxes						
20	Rent -- Facility and Grounds			144,000	144,000	(6,000)	138,000
21	Rent -- Equipment						
22	Other (specify):		68,586		68,586		68,586
23	TOTAL Ownership		68,586	167,167	235,753	(6,000)	229,753
24	GRAND TOTAL (Sum of lines 16 and 23)	1,020,049	417,723	626,479	2,064,251	(6,000)	2,058,251

Facility Name: BETH-ANNE PLACE

Report Period Beginning 7/1/2007 Ending: 6/30/2008

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 43.93	1
2	Licensed Practical Nurses	1	11.67	2
3	Certified Nurse Assistants	8	10.32	3
4	Activity Director & Assistants	1	12.95	4
5	Social Service Workers	3	17.88	5
6	Head Cook	1	16.64	6
7	Cook Helpers/Assistants	6	12.43	7
8	Dishwashers			8
9	Maintenance Workers	3	11.86	9
10	Housekeepers	4	10.23	10
11	Laundry	1	8.76	11
12	Managers	4	23.76	12
13	Other Administrative			13
14	Clerical	2	11.30	14
15	Marketing			15
16	Other	1	26.41	16
17	Total (lines 1 thru 16)	36	\$ 218	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	\$ 53,689	1
2		2
Total		\$ 53,689 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:

7/1/2007

Ending:

6/30/2008

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: 7/1/2007

Ending: 6/30/2008

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				
		YES	NO			Original	Balance				
A. Directly Facility Related Long-Term											
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
Working Capital											
4			X	Line of Credit	/ /		194,161	7/1/08	6.0000		4
5			X	Commercial Loan	/ /		68,105	12/31/08	6.5000		5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 262,266			\$	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 262,266			\$	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: BETH-ANNE PLACE

Report Period Beginning: 7/1/2007

Ending:

6/30/2008

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	\$ 201,569	\$	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	8,546		7
8	Accounts Receivable (owners or related parties)	1,446,915		8
9	Other(specify):	13,571		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,670,600	\$	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	10,699,397		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	(1,417,501)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	120,640		22
23	Other(specify):	671		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,653,073	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,323,673	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 515,331	\$	26
27	Officer's Accounts Payable	31,823		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	29,704		35
36	Notes Payable/ Recovery Capital Ad	536,750		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,113,607	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	68,105		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Recoverable Advance	8,402,769		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 8,470,874	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,584,482	\$	45
46	TOTAL EQUITY	\$ 1,739,191	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,323,673	\$	47

*(See instructions.)

Facility Name: BETH-ANNE PLACE

Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	\$ 3,219,197	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,219,197	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15		1,695	15
16	Amort of Capital Advance	249,718	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 251,413	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,470,610	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	946,633	19
20	Health Care/ Personal Care	431,206	20
21	General Administration	450,658	21
B. Capital Expense			
22	Ownership	229,753	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,058,250	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 1,412,360	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 1,412,360	31

LINE 4 COLUMN 3

GARBAGE & TRASH REMOVAL	18,500.68
ALARM SYSTEM	
EXTERMINATING	
FIRE EXTINGUISHER & SECURITY	
SECURITY GUARD SERVICE CONTRACT	111,536.99
PLUMBING SERVICE	
LICENSE FEE	
	<hr/>
TOTAL	130,037.67

**GENERAL ADMINISTRATION
LINE 10 COLUMN 5**

TELEPHONE PAYMENTS FROM RESIDENTS	
BANK CHARGES	
TOTAL	

**GENERAL ADMINISTRATION
LINE 14 COLUMN 3**

STAFF DEVELOPMENT	
EMPLOYEE DRUG TESTING	
BOOKEEPING AND ACCOUNTING SERVICE	9,265.00
CREDIT CHECK	
	<hr/>
TOTAL	9,265.00