

		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.

I.

Facility Name: Bishop Edwin Conway Residence

Address: 1900 N. Karlov Chicago 60639
Number City Zip Code

County: Cook

Telephone Number: (773) 252 9941 Fax # 773) 252 9946

Federal Employer ID Number: 36-4482230

Date Current Owners were Certified: 12/15/2003

Type of Ownership:

<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 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 checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Jan 1, 2008 to Dec 31, 2008 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Wendy Seifert

(Title) Division Manager

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () _____ Fax # () _____

In the event there are further questions about this report, please contact:

Name: Joy Manuel Telephone Number: (312 655 7414)
Email Address: jmanuel@Catholiccharities.net

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

Facility Name Bishop Edwin Conway Residence

Report Period Beginning: Jan 1, 2008 Ending: Dec 31, 2008

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	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	7	Single Unit Apartment	7	2,562	1
2	15	Double Unit Apartment	15	10,980	2
3		Other			3
4	22	TOTALS	22	13,542	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	1,003			1,003	5
6	Double Unit	6,496 #	291		6,205	6
7	Other					7
8	TOTALS	7,499	291		7,208	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 53.23%

D. Indicate the number of paid bed-hold days the SLF had during this year

 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(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: 2008 Fiscal Year: 2008

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes

If no, explain. Only Interest

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?

If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

Facility Name: Bishop Edwin Conway Residence

Report Period Beginning:

Jan 1, 2008

Ending: Dec 31, 2008

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	37,720	52,283	2,142	92,145		92,145	1
2	Housekeeping, Laundry and Maintenance	130,569	31,116	158,566	320,251		320,251	2
3	Heat and Other Utilities			58,505	58,505		58,505	3
4	Other (specify):			446	446		446	4
5	TOTAL General Services	168,289	83,399	219,659	471,347		471,347	5
B. Health Care and Programs								
6	Health Care/ Personal Care		610	172,577	173,187		173,187	6
7	Activities and Social Services	29,015		477	29,492		29,492	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	29,015	610	173,054	202,679		202,679	9
C. General Administration								
10	Administrative and Clerical	92,850	3,012	37,087	132,949	(12,003)	120,946	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			109,169	109,169		109,169	12
13	Insurance-Property, Liability and Malpractice			14,250	14,250		14,250	13
14	Other (sp License & Permit)			1,835	1,835		1,835	14
15	TOTAL General Administration	92,850	3,012	162,341	258,203	(12,003)	246,200	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	290,154	87,021	555,054	932,229	(12,003)	920,226	16
Capital Expenses								
D. Ownership								
17	Depreciation			172,888			172,888	17
18	Interest			59,598	59,598		59,598	18
19	Real Estate Taxes			16,098	16,098		16,098	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,018	6,018		6,018	21
22	Other (Amortization of deffered debt):			4,965	4,965		4,965	22
23	TOTAL Ownership			259,567	86,679		259,567	23
24	GRAND TOTAL (Sum of lines 16 and 23)	290,154	87,021	814,621	1,018,908	(12,003)	1,179,793	24

Facility Name: Bishop Edwin Conway Residence

Report Period Beginning Jan 1, 2008 Ending: Dec 31, 2008

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	By Contract	\$	1
2	Licensed Practical Nurses	By Contract		2
3	Certified Nurse Assistants	By Contract		3
4	Activity Director & Assistants	1	12.84	4
5	Social Service Workers			5
6	Head Cook	1	12.91	6
7	Cook Helpers/Assistants	2	9.72	7
8	Dishwashers	1	8.30	8
9	Maintenance Workers			9
10	Janitor	1	15.15	10
11	Housekeeper	2	8.30	11
12	Managers	1	21.60	12
13	Other Administrative	1	18.94	13
14	Clerical			14
15	Marketing			15
16	Other - Security guard	1	9.64	16
17	Total (lines 1 thru 16)	11	\$	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	none			\$	1	
2					2	
3						3
4						4
5						5
Total				\$	6	

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$
		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	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: Bishop Edwin Conway Residence

Report Period Beginning:

Jan 1, 2008

Ending:

Dec 31, 2008

VIII. OWNERSHIP COSTS

A. Purchase price of land 236,734 Year land was acquired 2002

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	22		2003	2003	\$ 5,404,283	\$ 135,094	40	\$ 135,094	\$	\$ 731,777	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvement		2003	79,597	3,980	20	3,980		21,487	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)				\$ 5,483,880	\$ 139,074		\$ 139,074	\$	\$ 753,264	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	\$ 200,945	\$ 20,531	\$ 20,532	1	10	\$ 117,134	18
19	Vehicles	58,436	11,687	11,687		5	37,984	19
20	TOTAL (lines 18 and 19)	\$ 259,381	\$ 32,218	\$ 32,219	1		\$ 155,118	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	Copier	\$ 6,050	\$ 169	\$ 4,220	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 6,050	\$ 169	\$ 4,220	24

Facility Name: Bishop Edwin Conway Residence

Report Period Beginning: Jan 1, 2008

Ending: ec 31, 2008

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	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	CCHD	X		Subordinate Mortgage	8/30/02	184,630	184,630	8/30/42	6.57%	12,130	1
2	CCHD	X		Subordinate Mortgage	4/30/02	121,752	121,752	8/30/42	6.57%	7,999	2
3	CCHD	X		Subordinate Mortgage	4/30/02	559,776	559,776	8/30/42	1.57%	8,788	3
4	CCHD	X		Subordinate Mortgage	3/12/02	423,000	423,000	3/12/33	5.48%	23,180	4
5	IHDA		x	Mortgage	12/31/04	\$ 750,000	\$ 750,000	8/31/33	1%	\$ 7,500	5
6					/ /			/ /			6
	Working Capital										
7					/ /			/ /			7
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTAL Facility Related					\$ 2,039,158	\$ 2,039,158			\$ 59,597	
	B. Non-Facility Related										
11					/ /			/ /			11
12					/ /			/ /			12
13	TOTALS (lines 7, 8 and 9)					\$ 2,039,158	\$ 2,039,158			\$ 59,597	13

* 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: **Bishop Edwin Conway Residence**Report Period Beginning: **Jan 1, 2008**Ending: **Dec 31, 2008****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **Dec 31, 2008** (last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 24,388	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (Resident)	109,524		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 133,912	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	236,734		13
14	Buildings, at Historical Cost	261,978		14
15	Leasehold Improvements, at Historical Cost	5,221,902		15
16	Equipment, at Historical Cost	265,431		16
17	Accumulated Depreciation (book methods)	(904,162)		17
18	Deferred Charges	50,077		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(Escrows & Reserves): See Attachment 2	342,099		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,474,059	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,607,972	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 42,255	\$	26
27	Officer's Accounts Payable			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	257,181		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	CatholicCharites -SeeAttachment# 2	557,377		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 856,813	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,039,158		38
39	Mortgage Payable			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)	\$ 2,039,158	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,895,971	\$	45
46	TOTAL EQUITY	\$ 2,712,001	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,607,972	\$	47

*(See instructions.)

Facility Name: Bishop Edwin Conway Residence

Report Period Beginning: Jan 1, 2008 Ending: Dec 31, 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	\$ 643,278	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 643,278	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	3,497	12
13	Interest and Other Investment Income	12,279	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 15,776	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)	\$ 659,054	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	471,347	19
20	Health Care/ Personal Care	202,679	20
21	General Administration	246,200	21
B. Capital Expense			
22	Ownership	259,567	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)	\$ 1,179,793	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (520,739)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (520,739)	31