

		FOR BHF USE			

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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>Supportive Living of Wabash</u></p> <p>Address: <u>532 Abelson Drive</u> <u>Carmi</u> <u>62821</u> Number City Zip Code</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 border="0"> <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> Email Address: <u>smcghee.co@christianhomes.org</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>1/1/2008</u> to <u>12/31/2008</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">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Tim Phillippe</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Principal</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>LarsonAllen LLP</u> <u>12801 Flushing Meadows Dr. Suite 100, St. Louis, MO 63131</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>314</u>) <u>336-3679</u> Fax <u>314-336-3650</u></td> <td></td> </tr> </table> <p>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>Tim Phillippe</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(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. Suite 100, St. Louis, MO 63131</u>		(Telephone) <u>314</u>) <u>336-3679</u> Fax <u>314-336-3650</u>	
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Facility Name Supportive Living of Wabash

Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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		Single Unit Apartment			1
2	49	Double Unit Apartment	49	17,934	2
3		Other		732	3
4	49	TOTALS	49	18,666	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					5
6	Double Unit	8,586	5,601		14,187	6
7	Other	31	402		433	7
8	TOTALS	8,617	6,003		14,620	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 78.32%

D. Indicate the number of paid bed-hold days the SLF had during this year
50 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)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 12/31

* 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. _____

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: Supportive Living of Wabash

Report Period Beginning:

1/1/2008

Ending: 12/31/2008

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	66,727	68,463	916	136,106		136,106	1
2	Housekeeping, Laundry and Maintenance	25,808	9,888	24,251	59,947		59,947	2
3	Heat and Other Utilities			78,130	78,130	(8,474)	69,656	3
4	Other (specify): Waste Removal			737	737		737	4
5	TOTAL General Services	92,535	78,351	104,034	274,920	(8,474)	266,446	5
B. Health Care and Programs								
6	Health Care/ Personal Care	139,131	1,315	54	140,500		140,500	6
7	Activities and Social Services	19,172	1,368	114	20,654		20,654	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	158,303	2,683	168	161,154		161,154	9
C. General Administration								
10	Administrative and Clerical	72,044	3,984	109,637	185,665	(3,880)	181,785	10
11	Marketing Materials, Promotions and Advertising			80,523	80,523		80,523	11
12	Employee Benefits and Payroll Taxes			38,125	38,125		38,125	12
13	Insurance-Property, Liability and Malpractice			23,161	23,161		23,161	13
14	Other (specify):							14
15	TOTAL General Administration	72,044	3,984	251,446	327,474	(3,880)	323,594	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	322,882	85,018	355,648	763,548	(12,354)	751,194	16
Capital Expenses								
D. Ownership								
17	Depreciation			239,934	239,934		239,934	17
18	Interest			465,152	465,152		465,152	18
19	Real Estate Taxes			19,601	19,601		19,601	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,806	2,806		2,806	21
22	Other (specify):							22
23	TOTAL Ownership			727,493	727,493		727,493	23
24	GRAND TOTAL (Sum of lines 16 and 23)	322,882	85,018	1,083,141	1,491,041	(12,354)	1,478,687	24

Facility Name: Supportive Living of Wabash

Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.70	\$ 17.01	1
2	Licensed Practical Nurses	0.68	15.86	2
3	Certified Nurse Assistants	5.10	8.70	3
4	Activity Director & Assistants	1.01	9.13	4
5	Social Service Workers			5
6	Head Cook	1.05	13.75	6
7	Cook Helpers/Assistants	2.20	8.02	7
8	Dishwashers			8
9	Maintenance Workers	0.60	9.14	9
10	Housekeepers	0.90	7.69	10
11	Laundry			11
12	Managers	1.00	24.36	12
13	Other Administrative			13
14	Clerical	1.00	10.27	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14.24	\$	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:

1/1/2008

Ending:

12/31/2008

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	\$ 181,179	30	\$ 181,179	\$	\$ 298,975	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Landscaping		2007	2007	22,330	1,489	15	1,489		2,233	6
7	Staking Fees		2007	2007	6,500	433	15	433		650	7
8	Walks/ Curbs		2007	2007	21,843	1,456	15	1,456		2,184	8
9	Paving & Surfacing		2007	2007	22,445	1,496	15	1,496		2,244	9
10	Dump Fees		2007	2007	14,140	943	15	943		1,414	10
11	Mis		2007	2007	1,068	71	15	71		104	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,067,826	\$ 187,067		\$ 187,067	\$	\$ 307,804	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	\$ 266,835	\$ 52,867	\$ 52,867	\$	5	\$ 79,176	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 266,835	\$ 52,867	\$ 52,867		\$ 79,176	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: 1/1/2008

Ending: 2/31/2008

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	Christian Homes	X		Startup Construction	10/31/06	\$ 1,452,900	\$ 1,452,900	12/31/30	7.5000	\$ 117,140
2	US Bank		X	Construction	10/31/06	4,000,000	3,987,757	12/1/23	6.7100	268,332
3	See Attachment					1,299,644	181,083	/ /		79,680
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 6,752,544	\$ 5,621,740			\$ 465,152
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 6,752,544	\$ 5,621,740			\$ 465,152

* 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: 1/1/2008

Ending: 12/31/2008

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,324	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	147,583		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,247		6
7	Other Prepaid Expenses	5,542		7
8	Accounts Receivable (owners or related parties)	3,598		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 236,294	\$	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	266,835		16
17	Accumulated Depreciation (book methods)	(386,980)		17
18	Deferred Charges	182,874		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,017,162		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,164,717	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,401,011	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,865	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,454		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,321		30
31	Accrued Taxes Payable	20,062		31
32	Accrued Interest Payable	226,108		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to Related Parties	375,313		35
36	See Attachment	798,339		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,479,462	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,452,900		38
39	Mortgage Payable	3,987,757		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)	\$ 5,440,657	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,920,119	\$	45
46	TOTAL EQUITY	\$ 480,892	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,401,011	\$	47

*(See instructions.)

Facility Name: Supportive Living of Wabash

Report Period Beginning: 1/1/2008

Ending:

12/31/2008

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	\$ 1,086,378	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,086,378	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	29,122	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 29,122	14
D. Other Revenue (specify):			
15	Cable TV Revenue	8,474	15
16	Miscellaneous Revenue	6,198	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 14,672	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,130,172	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	274,920	19
20	Health Care/ Personal Care	161,154	20
21	General Administration	327,474	21
B. Capital Expense			
22	Ownership	727,493	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)	\$ 1,491,041	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (360,869)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (360,869)	31

**Supportive Living of Wabash
12/31/2008**

**Schedule X
Interest Expense**

Name of Lender	Related	Purpose of Loan	Date of Note	Amount of Note		Maturity	Interst Rate	Interest Expense
				Original	Balance			
US Bank	No	Construction	10/31/2006	1,094,000	0	10/1/2008	7.2500	66,096
	No	Deferred Tax Credit Fees & Org Cost		205,644	181,083			13,584
Total				<u>1,299,644</u>	<u>181,083</u>			<u>79,680</u>

**Schedule IV - Column 5
Reclassification and Adjustments**

Line 3 Heat and Utilities	(8,474)	offset cable TV Revenue
Line 10 Administrative and Clerical	(3,880)	Nonallowable Bank Charges
	<u>(12,354)</u>	

**Schedule XI
Balance Sheet - Other Current Liabilities**

Contracts Payable	696,000
Accrued Management Fees	95,905
Other Accrued Expenses	6,434
	<u>798,339</u>