

		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>Supportive Living of Washington</u></p> <p>Address: <u>1150 New Castle Road</u> <u>Washington</u> <u>61571</u> <small>Number City Zip Code</small></p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: (<u>309</u>) <u>444-3641</u> Fax # <u>309 444-8763</u></p> <p>Federal Employer ID Number: <u>20-5109088</u></p> <p>Date Current Owners were Certified: <u>9/24/07</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 Washington

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 11/24/08

	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	54	Single Unit Apartment	52	19,688	1
2	6	Double Unit Apartment	8	2,272	2
3		Other		2,272	3
4	60	TOTALS	60	24,232	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	6,107	9,184		15,291	5
6	Double Unit	599	1,521		2,120	6
7	Other	558	1,521		2,079	7
8	TOTALS	7,264	12,226		19,490	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 80.43%

D. Indicate the number of paid bed-hold days the SLF had during this year 52 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

ACCURAL 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 Washington

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	65,306	117,318	3,665	186,289	(18)	186,271	1
2	Housekeeping, Laundry and Maintenance	31,940	12,886	35,439	80,265		80,265	2
3	Heat and Other Utilities			61,143	61,143	(5,553)	55,590	3
4	Other (specify): Waste Removal			4,434	4,434		4,434	4
5	TOTAL General Services	97,246	130,204	104,681	332,131	(5,571)	326,560	5
B. Health Care and Programs								
6	Health Care/ Personal Care	148,752	1,076	85	149,913		149,913	6
7	Activities and Social Services	63,379	3,836		67,215		67,215	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	212,131	4,912	85	217,128		217,128	9
C. General Administration								
10	Administrative and Clerical	65,719	9,341	127,236	202,296	(3,991)	198,305	10
11	Marketing Materials, Promotions and Advertising			80,677	80,677		80,677	11
12	Employee Benefits and Payroll Taxes			41,659	41,659		41,659	12
13	Insurance-Property, Liability and Malpractice			9,296	9,296		9,296	13
14	Other (specify):							14
15	TOTAL General Administration	65,719	9,341	258,868	333,928	(3,991)	329,937	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	375,096	144,457	363,634	883,187	(9,562)	873,625	16
Capital Expenses								
D. Ownership								
17	Depreciation			267,812	267,812		267,812	17
18	Interest			571,896	571,896		571,896	18
19	Real Estate Taxes			119,990	119,990		119,990	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			828	828		828	21
22	Other (specify):							22
23	TOTAL Ownership			960,526	960,526		960,526	23
24	GRAND TOTAL (Sum of lines 16 and 23)	375,096	144,457	1,324,160	1,843,713	(9,562)	1,834,151	24

Facility Name: Supportive Living of Washington

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	1.10	\$ 18.07	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.50	9.52	3
4	Activity Director & Assistants	0.54	10.62	4
5	Social Service Workers	0.50	9.88	5
6	Head Cook	1.20	11.42	6
7	Cook Helpers/Assistants	2.00	8.85	7
8	Dishwashers			8
9	Maintenance Workers	0.45	11.53	9
10	Housekeepers	1.25	8.13	10
11	Laundry			11
12	Managers	1.00	19.79	12
13	Other Administrative			13
14	Clerical	1.00	11.81	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16.54	\$ 119.62	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	\$ 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 <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 Washington

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

VIII. OWNERSHIP COSTS

A. Purchase price of land 89,000 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	60		2007	2006	\$ 7,389,337	\$ 202,540	30	\$ 202,540	\$	\$ 373,975	1
2					386,145	19,307	30	19,307		19,307	2
3											3
4											4
5											5
Improvement Type											
6		Landscaping		2007	31,548	2,103	15	2,103		3,681	6
7		Staking Fees		2007	11,643	776	15	776		1,358	7
8		Staking Fees		2007	8,018	535	15	535		936	8
9		Paving & Surfacing		2007	47,898	3,193	15	3,193		5,588	9
10		Dump Fees		2007	11,514	768	15	768		1,343	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,886,103	\$ 229,222		\$ 229,222	\$	\$ 406,188	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	\$ 186,522	\$ 37,090	\$ 37,090	\$	Various	\$ 73,880	18
19	Vehicles	6,000	1,500	1,500		3	1,500	19
20	TOTAL (lines 18 and 19)		\$ 192,522	\$ 38,590	\$ 38,590	\$	\$ 75,380	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 Washington

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	12/31/06	\$ 1,842,199	\$ 1,842,199	12/31/30	7.5000	\$ 148,528
2	US Bank		X	Construction	10/31/06	4,900,000	4,885,003	12/1/23	6.7100	328,706
3	See Attachment		X		/ /	1,597,512	240,709	/ /		94,662
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 8,339,711	\$ 6,967,911			\$ 571,896
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,339,711	\$ 6,967,911			\$ 571,896

* 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 Washington

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	\$ 110,727	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	316,426		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,646		6
7	Other Prepaid Expenses	6,660		7
8	Accounts Receivable (owners or related parties)	3,535		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 446,994	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	89,000		13
14	Buildings, at Historical Cost	7,775,482		14
15	Leasehold Improvements, at Historical Cost	110,621		15
16	Equipment, at Historical Cost	192,522		16
17	Accumulated Depreciation (book methods)	(388,534)		17
18	Deferred Charges	240,709		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	940,460		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,960,260	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,407,254	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 18,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,661		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,574		30
31	Accrued Taxes Payable	120,059		31
32	Accrued Interest Payable	286,692		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35	Due to Related Parties	309,244		35
36	See Attached Schedule	973,803		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,756,643	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	1,842,199		38
39	Mortgage Payable	4,885,003		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)	\$ 6,727,202	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,483,845	\$	45
46	TOTAL EQUITY	\$ 923,409	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,407,254	\$	47

*(See instructions.)

Facility Name: Supportive Living of Washington

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	\$ 1,457,103	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,457,103	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	18	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 18	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	35,741	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 35,741	14
D. Other Revenue (specify):			
15	Cable TV Revenue	5,553	15
16	Miscellaneous Revenue	984	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,537	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,499,399	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	332,131	19
20	Health Care/ Personal Care	217,128	20
21	General Administration	333,928	21
B. Capital Expense			
22	Ownership	960,526	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)	\$ 1,843,713	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (344,314)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (344,314)	31

Washington Village Estates
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	1,340,000	0	10/1/2008	7.2500	80,958
	No	Deferred Tax Credit Fees & Org Cost		257,512	240,709			13,704
Total				<u>1,597,512</u>	<u>240,709</u>			<u>94,662</u>

Schedule IV - Column 5
Reclassification and Adjustments

Line 1 Dietary and Food Purchases	(18) offset meal revenue
Line 3 Heat and Utilities	(5,553) offset cable TV revenue
Line 10 Administrative and Clerical	<u>(3,991) nonallowable bank charges</u>
	<u><u>(9,562)</u></u>

Schedule XI
Balance Sheet - Other Current Liabilities

Accrued Management Fees	102,003
Contracts Payable	871,000
Other Accrued Expenses	<u>800</u>
	<u><u>973,803</u></u>