		FOR BHF USE					

LL1

2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0038729

Facility Name: Beacon Street Place

Address: 4838 Beacon Drive (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-422-8231 **Fax #** ( )

HFS ID Number: 37-1273581

Date of Initial License for Current Owners: 05/24/93

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA **Telephone Number:** 217-875-2655
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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) David M. Jacobus
(Title) Owner

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
(Telephone) 217-875-2655 Fax # 217-875-1660

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

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I. IDPH License ID Number: 0036764

Facility Name: Autumn Leaves, Inc. d/b/a Hickory Street Place

Address: 3905 East Hickory (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-422-8231 **Fax #** ( )

HFS ID Number: 37-1273581

Date of Initial License for Current Owners: 05/24/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA **Telephone Number:** 217-875-2655
Email Address: mwood@mckcpa.com

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Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David M. Jacobus
(Title) Owner

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
(Telephone) 217-875-2655 Fax # 217-875-1660

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I. IDPH License ID Number: 0038729

Facility Name: Autumn Leaves, Inc. d/b/a Beacon Street Place

Address: 4838 Beacon Drive (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-422-1761 **Fax #** ( )

HFS ID Number: 37-1273581

Date of Initial License for Current Owners: 05/24/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA **Telephone Number:** 217-875-2655
Email Address: 0

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Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David M. Jacobus
(Title) Owner

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
(Telephone) 217-875-2655 Fax # 217-875-1660

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I. IDPH License ID Number: 0038737

Facility Name: Autumn Leaves, Inc. d/b/a Forty-fourth Street Place

Address: 1479 South 44th Street (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: 217-422-2773 **Fax #** ( )

HFS ID Number: 37-1273581

Date of Initial License for Current Owners: 05/24/93

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA **Telephone Number:** 217-875-2655
Email Address: 0

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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.

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Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David M. Jacobus
(Title) Owner

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Mark S. Wood, CPA
(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5/24/93

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,783			5,783	13
14	TOTALS	5,783			5,783	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.02%

D. How many bed-hold days during this year were paid by the Department? 73 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/24/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/24/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/08 Fiscal Year: _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	12,960	2,085	3,564	18,609		18,609		18,609			1
2	Food Purchase		37,575		37,575	(3,945)	33,630		33,630			2
3	Housekeeping	85,664	4,554		90,218		90,218		90,218			3
4	Laundry		1,083		1,083		1,083		1,083			4
5	Heat and Other Utilities			21,230	21,230		21,230	5,332	26,562			5
6	Maintenance	13,624	1,448	16,834	31,906		31,906	147	32,053			6
7	Other (specify):*			12,292	12,292		12,292		12,292			7
8	**TOTAL General Services**	112,248	46,745	53,920	212,913	(3,945)	208,968	5,479	214,447			8
	B. Health Care and Programs											
9	Medical Director			9,925	9,925		9,925		9,925			9
10	Nursing and Medical Records	217,000	5,482	6,250	228,732		228,732	2,826	231,558			10
10a	Therapy											10a
11	Activities	41,738	8,944		50,682		50,682		50,682			11
12	Social Services	54,802		720	55,522		55,522		55,522			12
13	CNA Training	2,463			2,463		2,463		2,463			13
14	Program Transportation			9,926	9,926		9,926		9,926			14
15	Other (specify):*			179,873	179,873		179,873	(176,964)	2,909			15
16	**TOTAL Health Care and Programs**	316,003	14,426	206,694	537,123		537,123	(174,138)	362,985			16
	C. General Administration											
17	Administrative	53,289			53,289		53,289		53,289			17
18	Directors Fees											18
19	Professional Services			16,232	16,232		16,232	523	16,755			19
20	Dues, Fees, Subscriptions & Promotions			5,856	5,856		5,856		5,856			20
21	Clerical & General Office Expenses	11,004	6,310	18,291	35,605		35,605	(6,927)	28,678			21
22	Employee Benefits & Payroll Taxes			44,216	44,216	3,945	48,161		48,161			22
23	Inservice Training & Education											23
24	Travel and Seminar			312	312		312		312			24
25	Other Admin. Staff Transportation			2,578	2,578		2,578		2,578			25
26	Insurance-Prop.Liab.Malpractice			25,667	25,667		25,667		25,667			26
27	Other (specify):*											27
28	**TOTAL General Administration**	64,293	6,310	113,152	183,755	3,945	187,700	(6,404)	181,296			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	492,544	67,481	373,766	933,791		933,791	(175,063)	758,728			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beacon Street Place #0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,460	22,460		22,460	23,506	45,966			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,761	13,761		13,761		13,761			32
33	Real Estate Taxes			8,545	8,545		8,545		8,545			33
34	Rent-Facility & Grounds			73,200	73,200		73,200	(73,200)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			117,966	117,966		117,966	(49,694)	68,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,839	53,839		53,839		53,839			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			53,839	53,839		53,839		53,839			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	492,544	67,481	545,571	1,105,596		1,105,596	(224,757)	880,839			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(176,964)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,650	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (167,314)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(57,443)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (57,443)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,757)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy		X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David M. Jacobus	100	Drew Corp d/b/a Moultrie County Comm Center	Decatur, IL	David Jacobus Central Office	Decatur, IL	Central Office For homes

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	General Office	$ 7,500	David M. Jacobus, Central Office	100.00%	$ 573	$ (6,927)	1
2	V	5	Utilities				5,332	5,332	2
3	V	6	Maintenance				147	147	3
4	V	10	Medical Supplies				2,826	2,826	4
5	V	19	Professional Fees				523	523	5
6	V	30	Depreciation				953	953	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 7,500			$ 10,354	$ * 2,854	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Building Rent - Hickory Street	$ 27,600	David M. Jacobus	100.00%	$	$ (27,600)	15
16	V	30	Depreciation - Hickory Street		David M. Jacobus	100.00%	5,081	5,081	16
17	V								17
18	V								18
19	V	34	Building Rent - Beacon Street	22,800	David M. Jacobus	100.00%		(22,800)	19
20	V	30	Depreciation - Beacon Street		David M. Jacobus	100.00%	2,745	2,745	20
21	V								21
22	V								22
23	V	34	Buildingi Rent - 44th Street	22,800	David M. Jacobus	100.00%		(22,800)	23
24	V	30	Depreciation - 44th Street		David M. Jacobus	100.00%	5,077	5,077	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,200			$ 12,903	$ * (60,297)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David M. Jacobus	Owner	Various	100.00	28,085	6.5	16.25	Dietary	$ 6,860	1-1	1
2						13	32.50	Maintenance	13,720	6-1	2
3						10.5	26.25	General Off	11,020	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,600		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: David Jacobus, Central Office
Street Address: 2576 Greenway
City / State / Zip Code: Cerro Gordo, IL 61818
Phone Number: (217-763-2191
Fax Number: (217-763-2101

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	General Office	Occupied Bed Days	10,775	2	$ 1,068	$ 0	5,783	$ 573	1
2	5	Utilities	Occupied Bed Days	10,775	2	9,934	0	5,783	5,332	2
3	6	Maintenance	Occupied Bed Days	10,775	2	273	0	5,783	147	3
4	10	Medical Supplies	Occupied Bed Days	10,775	2	5,265	0	5,783	2,826	4
5	19	Professional Fees	Occupied Bed Days	10,775	2	975	0	5,783	523	5
6	30	Depreciation	Occupied Bed Days	10,775	2	1,775	0	5,783	953	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 19,290	$		$ 10,354	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Nissan Motor Acceptance		X	2008 Nissan Pathfinder	$1,088.78	09/07/07	$ 36,882	$ 16,051	09/20/10	3.9000	$ 1,134	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National City Bank		X	Operating Cash	N/A	6/30/08	300,000	293,000	6/30/09	4.0000	12,627	6
7												7
8												8
9	TOTAL Facility Related				$1,088.78		$ 336,882	$ 309,051			$ 13,761	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 336,882	$ 309,051			$ 13,761	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 8,709	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 8,586	2
3. Under or (over) accrual (line 2 minus line 1).		$ (123)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 8,668	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,545	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2003	7,664	8
	2004	7,891	9
	2005	8,153	10
	2006	8,633	11
	2007	8,295	12

2008 accrual based on 2007 taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beacon Street Place COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0038729

CONTACT PERSON REGARDING THIS REPORT David M. Jacobus

TELEPHONE 217-763-2191 FAX #: 217-763-2101

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-13-08-152-009	Hickory Street Place	$ 3,446.50	$ 3,446.50
2.	09-13-20-327-006	44th Street Place	$ 2,804.88	$ 2,804.88
3.	09-13-20-282-008	Beacon Street Place	$ 2,336.06	$ 2,336.06
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,587.44	$ 8,587.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,400 B. General Construction Type: Exterior Vinyl Frame Wood w/sprinklers Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	2,400	1998	$ 27,000	1
2	From Pages 11A & 11B			32,000	2
3	TOTALS	2,400		$ 59,000	3

Facility Name & ID Numb Autumn Leaves, Inc. # 0036764 Report Period Beginning: 01/01/07 Ending: 12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 1,320 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	1,320	1993	$ 5,000	1
2					2
3	TOTALS	1,320		$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Numb Autumn Leaves, Inc. # 0036764 Report Period Beginning: 01/01/07 Ending: 12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	2,176	1998	$ 27,000	1
2					2
3	TOTALS	1,320		$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	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	
4	6		1998	1991	$ 198,175	$ 5,081	25	$ 7,927	$ 2,846	$ 85,215	4
5	4		1993	1960	55,000	1,410	25	2,200	790	34,467	5
6	6		1998	1963	198,000	5,077	25	7,920	2,843	82,500	6
7											7
8											8
	Improvement Type**										
9	Landscaping			1991	549		10			549	9
10	Landscaping			1992	3,496		15			3,496	10
11	Flooring			1994	2,931		6			2,931	11
12	Carpet			1994	1,890		6			1,890	12
13	Carpet			1994	1,179		6			1,179	13
14	Landscaping			1995	519	31	15	35	4	460	14
15	Blinds & Curtains			1996	1,795		5			1,795	15
16	Landscaping			1996	2,418	143	10		(143)	2,418	16
17	Office Remodel			2001	2,000	51	15	133	82	989	17
18	Office Remodel			2001	2,000	51	15	133	82	989	18
19	Office Remodel			2001	1,000		10	100	100	733	19
20	HVAC			2006	4,623	119	15	308	189	745	20
21	Roof			2007	6,421	165	20	321	156	562	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioner	1995	$ 1,051	$ 27	8	$	$ (27)	$ 1,051	37
38	Landscaping	1996	2,418	143	10		(143)	2,418	38
39	Furnace	1996	1,030	26	15	69	43	835	39
40	Landscaping	1996	2,101	124	10		(124)	2,101	40
41	Carpet/Blinds	1997	3,074		5			3,074	41
42	Security System	1993	2,259		15	61	61	2,259	42
43	Carpet	1993	1,826		6			1,826	43
44	Flooring	1993	3,547		6			3,547	44
45	Cabinets	1993	2,456		15	67	67	2,456	45
46	Office Remodel	1993	44,254	1,135	15	1,230	95	44,254	46
47	Sprinkler System	1993	7,800	200	15	217	17	7,800	47
48	Plumbing	1999	2,053	53	6		(53)	2,053	48
49	Office Remodel	2001	2,000	51	15	133	82	989	49
50	Office Remodel	2001	1,000		10	100	100	733	50
51	Roof	2006	10,275	263	10	1,028	765	2,398	51
52	Fire Panel	2008	2,675	2,675	10	134	(2,541)	134	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 571,815	$ 16,824		$ 22,116	$ 5,292	$ 298,846	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 571,815	$ 16,824		$ 22,116	$ 5,292	$ 298,846	1
2	Asphalt Drive	1993	5,431	160	16	339	179	5,203	2
3	Carpet	1995	2,094		10			2,094	3
4	Landscaping	1996	2,418	143	10		(143)	2,418	4
5	Furnace	1999	1,285	33	15	86	53	807	5
6	Carpet	2000	1,550		5			1,550	6
7	Office Remodel - Walls	2001	2,000	51	15	133	82	989	7
8	Office Remodel - Flooring	2001	2,000		10	200	200	1,467	8
9	Roof	2006	12,611	323	10	1,261	938	2,943	9
10	Fire Panel	2008	2,675	2,675	10	134	(2,541)	134	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 603,879	$ 20,209		$ 24,269	$ 4,060	$ 316,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 72,903	$	$ 2,843	$ 2,843	3-20 yrs	$ 75,215	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 72,903	$	$ 2,843	$ 2,843		$ 75,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Tras (HSP)	2004 Chevy Express G150	2004	$ 24,490	$	$ 3,571	$ 3,571	4	$ 24,490	76
77	Transportation	Nissan/Admin Vehicles	2008	55,586	13,477	9,221	(4,256)	4	30,998	77
78	Program Tras (BSP)	2003 Town & Country	2004	16,305	1,675	2,038	363	4	16,305	78
79	Program Tras (44th)	2004 Chevy Express	2004	21,046		3,069	3,069	4	21,045	79
80	TOTALS			$ 117,427	$ 15,152	$ 17,899	$ 2,747		$ 92,838	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 853,209	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,361	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,011	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,650	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 484,504	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2009	$
13.	/2010	$
14.	/2011	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	8

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER CNA	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,463		2,463
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,463	$	$ 2,463
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,463			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 193,780	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	259,175		3
4	Supply Inventory (priced at cost)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	14,182		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)**	$ 470,137	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	90,563		15
16	Equipment, at Historical Cost	237,336		16
17	Accumulated Depreciation (book methods)	(237,698)		17
18	Deferred Charges			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(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 90,202	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 560,339	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,339	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	293,001		29
30	Accrued Salaries Payable	13,879		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,156		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,668		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,050		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 354,093	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,051		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,051	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 370,144	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 190,195	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 560,339	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 128,608	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 128,608	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,587	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 61,587	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 190,195	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 990,947	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 990,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	176,973	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 176,973	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,167,920	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	212,913	31
32	Health Care	537,123	32
33	General Administration	183,755	33
	B. Capital Expense		
34	Ownership	117,966	34
	C. Ancillary Expense		
35	Special Cost Centers	53,839	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,105,596	40
41	**Income before Income Taxes (line 30 minus line 40)****	62,324	41
42	**Income Taxes**	(737)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 61,587	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	21,050	21,859	217,000	9.93	5
6	CNA Trainees	223	223	2,463	11.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,800	3,959	41,738	10.54	9
10	Activity Assistants					10
11	Social Service Workers	3,761	3,809	54,802	14.39	11
12	Dietician	911	911	12,960	14.23	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	790	790	13,624	17.25	17
18	Housekeepers	8,417	8,568	85,664	10.00	18
19	Laundry					19
20	Administrator	2,997	3,239	53,289	16.45	20
21	Assistant Administrator	120	120		0.00	21
22	Other Administrative					22
23	Office Manager	395	395	11,004	27.86	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	42,464	43,873	$ 492,544 *	$ 11.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 3,564		35
36	Medical Director	Fee	9,925		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	2,650		43
44	Activity Consultant				44
45	Social Service Consultant	Fee	720		45
46	Other(specify) Psychologist	Fee	3,600		46
47					47
48					48
49	TOTAL (lines 35 - 48)	161	$ 20,459		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Valerie Poling	Administrator	0	$ 18,284
Angela Shelton	Administrator	0	13,249
Tracy Jones	Administrator	0	6,600
Maria Neal	Administrator	0	894
Alissa Reynolds	Administrator	0	4,320
Jane Williams	Administrator	0	9,942
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 53,289

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King, P.C.	Accounting/Bookkeeping	$ 16,232
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 16,232

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 1,755
Unemployment Compensation Insurance	4,601
FICA Taxes	37,860
Employee Health Insurance	
Employee Meals	3,945
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 48,161

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,383
Health Care Worker Background Check	
(Indicate # of checks performed)	
License & Fees	880
Dues & Subscriptions	593
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,856

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	312
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 312

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Beacon Street Place # 0038729 Report Period Beginning: 01/01/08 Ending: 12/31/08

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **No**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,839**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,945** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Autumn Leaves, Inc.
d/b/a Hickory Street Place, Beacon Stree Place, 44th Street Place
December 31, 2008

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,531
Pest Control	1,811
Security	8,950
	12,292

Documentation - Section V, Line 15, Column 3:

Workshop	176,964
Emergency Dental Care	800
Drugs & Medicine	2,109
	179,873

Documentation - Section V, Line 30, Column 7:

Depreciation - Related Party	12,903
Straight-line adjustment	9,650
Central Office	953
	23,506

Reclassifications - Section V, Column 5:

	From Line #	To Line #	Amount
Employee Benefits (Staff Meals)	2	22	3,945

Page 7, Schedule VII, C, Related Parties
Column 5, Compensation Received from Other Homes

David Jacobus	
Drew Corporation d/b/a Moultrie County Community Center Decatur, Illinois	28,085

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.