FOR BHF USE

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

I. Facility ID Number: 1000020

Facility Name: BETH-ANNE PLACE

Address: 1143 NORTH LAVERGNE (Number) CHICAGO (City) 60651 (Zip Code)

County: COOK

Telephone Number: (773) 287-2711 **Fax #** (773) 287-2017

Federal Employer ID Number:

Date Current Owners were Certified:

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: VALARIE HINES **Telephone Number:** (773) 473-7870 #125
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 07/01/2009 to 06/30/2010 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) Lawrence L. Wilson
(Title) President/CEO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name BETH-ANNE PLACE Report Period Beginning: 07/01/2009 Ending: 06/30/2010

III. STATISTICAL DATA

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

Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	85	Single Unit Apartment	85	31,025	1
2		Double Unit Apartment			2
3		Other			3
4	85	TOTALS	85	31,025	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	25,892	365		26,257	5
6	Double Unit					6
7	Other					7
8	TOTALS	25,892	365		26,257	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.63%

D. Indicate the number of paid bed-hold days the SLF had during this year 61 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 692 **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: Fiscal Year: JUNE 30
* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? NO **If yes, did the facility make all of the required payments of interest and principle?**
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO **If yes, did the facility make all of the required payments of interest and principle?**
If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? **If yes, did the facility make all of the required payments of interest and principle?**
If no, explain. NOT APPLICABLE

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 07/01/2009 Ending: 06/30/2010**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	178,373	197,665		376,038		376,038	1
2	Housekeeping, Laundry and Maintenance	137,003	111,071		248,074		248,074	2
3	Heat and Other Utilities			226,414	226,414		226,414	3
4	Other (specify):	51,550		127,520	179,070		179,070	4
5	**TOTAL General Services**	366,926	308,736	353,934	1,029,596		1,029,596	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	300,308	1,665		301,973		301,973	6
7	Activities and Social Services	94,297		6,933	101,230		101,230	7
8	Other (specify): Wheel Chair Purchase			2,200	2,200		2,200	8
9	**TOTAL Health Care and Programs**	394,605	1,665	9,133	405,403		405,403	9
	C. General Administration							
10	Administrative and Clerical	177,970	36,378	114,310	328,658		328,658	10
11	Marketing Materials, Promotions and Advertising			5,068	5,068		5,068	11
12	Employee Benefits and Payroll Taxes	165,142			165,142		165,142	12
13	Insurance-Property, Liability and Malpractice			78,618	78,618		78,618	13
14	Other (specify): Managers	111,836		34,820	146,656		146,656	14
15	**TOTAL General Administration**	454,948	36,378	232,816	724,142		724,142	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,216,479	346,778	595,883	2,159,141		2,159,141	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			319,054	319,054		319,054	17
18	Interest			6,031	6,031		6,031	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Misc taxes, permits			584	584		584	22
23	**TOTAL Ownership**			325,669	325,669		325,669	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,216,479	346,778	921,553	2,484,810		2,484,810	24

Facility Name: BETH-ANNE PLACE Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 39.17	1
2	Licensed Practical Nurses	2	19.59	2
3	Certified Nurse Assistants	11	10.61	3
4	Activity Director & Assistants	4	12.63	4
5	Social Service Workers	2	21.63	5
6	Head Cook	1	13.00	6
7	Cook Helpers/Assistants	5	12.00	7
8	Dishwashers			8
9	Maintenance Workers	3	12.83	9
10	Housekeepers	6	9.46	10
11	Laundry			11
12	Managers	3	26.72	12
13	Other Administrative	5	21.92	13
14	Clerical			14
15	Marketing	2	21.80	15
16	Other **Dietary Manager**	2	24.98	16
17	**Total (lines 1 thru 16)**	47	$ 246.34	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	HSR	$ 56,467	1
2			2
		Total $ 56,467	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Busines	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [ ] NO [X]

Name of related entity: _____ **If yes, what is the value of those services? $** _____

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES [ ] NO [ ]

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: BETH-ANNE PLACE Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1			2000	2002	$ 100,000	$		$	$	$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Building Improvements			1/31/2003	10,558,484	263,962	40	263,962			6
7	Security System			7/1/2003	8,637	216	20	216			7
8	Outside Lighting			4/22/2004	3,937	197	20	197			8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 10,671,058	$ 264,375		$ 264,375	$	$	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	$ 270,632	$ 27,063	$ 27,063	$		$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 270,632	$ 27,063	$ 27,063	$		$	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: BETH-ANNE PLACE Report Period Beginning: 07/01/2009 Ending: 6/30/2010

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related Long-Term										
1					/ /	$	$	/ /		$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4		X		Line of Credit	10/28/02	194,115	164,458	6/1/2012	4.5000		4
5											5
6											6
7	TOTAL Facility Related					$ 194,115	$ 164,458			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 194,115	$ 164,458			$	10

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: BETH-ANNE PLACE **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2010 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 249,066	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	276,363		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	60,766		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 586,194	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	10,574,252		14
15	Leasehold Improvements, at Historical Cost	240,800		15
16	Equipment, at Historical Cost	271,472		16
17	Accumulated Depreciation (book methods)	(203,801)		17
18	Deferred Charges **Utility Deposits**	25,380		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,032,298)		20
21	Restricted Funds	120,175		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	27,298		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,123,279	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,709,473	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 361,382	$	26
27	Officer's Accounts Payable	16,769		27
28	Accounts Payable-Patient Deposits	18,675		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	548		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Expenses	16,980		35
36	Notes Pay/Recoverable Capital Advan			36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 414,354	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	164,458		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Recoverable Advance	8,092,848		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 8,257,306	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 8,671,660	$	45
46	**TOTAL EQUITY**	$ 1,037,813	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 9,709,473	$	47

***(See instructions.)**

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 07/01/2009 Ending: 06/30/2010**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,117,784	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,117,784	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	49	10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 49	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	446	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 446	14
	D. Other Revenue (specify):		
15		279,918	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 279,918	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,398,196	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,029,596	19
20	Health Care/ Personal Care	405,403	20
21	General Administration	724,142	21
	B. Capital Expense		
22	Ownership	325,669	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)**	$ 2,484,810	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 913,386	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 913,386	31

LINE 4 COLUMN 3

GARBAGE & TRASH REMOVAL	12,962.28
POSTAGE/OFFICE SUPPLIES/FEES	738.30
EXTERMINATING	65.00
SECURITY GUARD SERVICE CONTRACT	113,754.10
TOTAL	**127,519.68**

GNERAL ADMINISTRATION
LINE 14 COLUMN 3

QUALITY ASSURANCE	5,895.98
SOCIAL SERVICE COORDINATOR EXPENSE	1,440.18
CONVENTIONS AND MEETINGS	7,402.69
BOOKKEEPING AND ACCOUNTING SERVICES	18,360.00
MISCELLANEOUS	529.50
STAFF DEVELOPMENT	1,192.00
TOTAL	**34,820.35**