FOR BHF USE

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSU
THAT IS NECESSARY TO ACCOMPLISH TH
PURPOSE AS OUTLINED IN SECTION 146.2
CODE. DISCLOSURE OF THIS INFORMATI
FAILURE TO PROVIDE ANY INFORMATIO
DUE DATE WILL RESULT IN CESSATION O
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	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICI

I have examined the contents of the accompanying report State of Illinois, for the period from 7/1/14 to and certify to the best of my knowledge and belief that the sa are true, accurate and complete statements in accordance w instructions. Declaration of preparer (other than provider) is information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any inforn in this cost report may be punishable by fine and/or imprisor

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Stephen Woods

(Title) ADMINISTRATOR

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax

In the event there are further questions about this report, please contact:
Name: LINDA BARNETT **Telephone Number:** (773) 473-7870 ext. #111
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
IL DEPT OF HEALTHCARE AND FAMILY SE
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

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(Date)

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ne # (217) 782-1630

STATE OF ILLINOIS

Facility Name BETH-ANNE EXTENDED LIVING #REF! Report Period Beginning: 7/1/14 Ending:

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		Single Unit Apartment	85	31,025	1
2		Double Unit Apartment			2
3		Other			3
4		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	20,106	1,958		22,064	5
6	Double Unit					6
7	Other					7
8	TOTALS	20,106	1,958		22,064	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 71.12%

D. Indicate the number of paid bed-hold days the SLF had during this year 406 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 293 (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 [ ]
Tax Year: Fiscal Year: 6/30/15
* All facilities other than governmental must report on the accrual basi

J. Does the facility have any Illinois Housing Development Authority L outstanding? NO If yes, did the facility make all of t required payments of interest and principle? NO
If no, explain. NOT APPLICABLE

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of t required payments of interest and principle? NO
If no, explain. NOT APPLICABLE

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

NO

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NO

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 7/1/14** **Ending:**

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	200,324	234,673	4,879	439,876		439,876	1
2	Housekeeping, Laundry and Maintenance	87,787	78,804		166,591		166,591	2
3	Heat and Other Utilities			193,711	193,711		193,711	3
4	Other (specify):			106,016	106,016		106,016	4
5	**TOTAL General Services**	288,111	313,477	304,606	906,194		906,194	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	280,166	1,470	2,266	283,902		283,902	6
7	Activities and Social Services	72,065	2,784		74,849		74,849	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	352,231	4,254	2,266	358,751		358,751	9
	C. General Administration							
10	Administrative and Clerical	105,572	16,215	29,958	151,745		151,745	10
11	Marketing Materials, Promotions and Advertising		28,205	1,395	29,600		29,600	11
12	Employee Benefits and Payroll Taxes	193,185			193,185		193,185	12
13	Insurance-Property, Liability and Malpractice			59,380	59,380		59,380	13
14	Other (Managers)	166,672		143,445	310,117	(7,279)	302,838	14
15	**TOTAL General Administration**	465,428	44,420	234,178	744,026	(7,279)	736,747	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,105,770	362,151	541,050	2,008,971	(7,279)	2,001,692	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			314,841	314,841		314,841	17
18	Interest			537	537		537	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			50,447	50,447		50,447	22
23	**TOTAL Ownership**			365,825	365,825		365,825	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,105,770	362,151	906,875	2,374,796	(7,279)	2,367,517	24

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE **Report Period Beginning 7/1/14 Ending:**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	25.00	1
2	Licensed Practical Nurses	4	21.00	2
3	Certified Nurse Assistants	16	11.30	3
4	Activity Director & Assistants	1	14.92	4
5	Social Service Workers	2	22.56	5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	7	11.60	7
8	Dishwashers			8
9	Maintenance Workers	1	11.43	9
10	Housekeepers	4	9.79	10
11	Laundry			11
12	Managers	3	27.51	12
13	Other Administrative	5	24.91	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	46	$ 192.02	17

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

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Cor th
1				$
2				
3				
4				
5				
			Total	$

VI. (B) Management fees paid to unrelated parties A

1	EVERGREEN	$
2		
	Total	$

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES				
Name	1	City	2	Name	3	City	4	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? **YES** ☐
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).

6/30/15

)WNERS,

Amount of mpensation for is Reporting Period	
	1
	2
	3
	4
	5
	6

mount of Fee

50,447	1
	2
50,447	3

Type of Business	5

NO ☐

Facility Name: BETH-ANNE PLACE Report Period Beginning: 7/1/14 Ending: 6/30/15

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			1/13/2013	10,547,485	263,687	40	263,687			6
7	Security system			2/1/2003	8,637	216	40	216			7
8	Outside Lighting			4/22/2004	3,937	98	40	98			8
9	Building 'improvement			12/5/2011	267,262	29,696	9	29,696			9
10	Building Improvement			7/6/2012	25,958	2,596	10	2,596			10
11	Building Improvement			7/9/2013	17,141	1,714	10	1,714			11
12	Building Improvement			8/1/2013	23,612	3,373	7	3,373			12
13	Land Imrpovement			8/15/2013	1,476	500	10	500			13
14	Equipment			11/30/2013	6,500	650	10	650			14
15	Capital improvement			11/20/2013	1,418	203	7	203			15
16	Building Improvement			1/24/2014	121,075	12,108	10	12,108			16
17	TOTAL (lines 1 thru 16)				$ 11,124,501	$ 314,841		$ 314,841	$	$	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	$	$	$	$		$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$	$	$	$		$	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: 7/1/14 Ending: 6/30/15

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					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$			$	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.

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE **Report Period Beginning:** 7/1/14 **Ending:**

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/15 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 57,330	$	1
2	Cash-Patient Deposits	16,044		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	235,692		3
4	Supply Inventory (priced at)	2,581		4
5	Short-Term Investments			5
6	Prepaid Insurance	56,236		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,937,366		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,305,249	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	107,600		13
14	Buildings, at Historical Cost	10,891,807		14
15	Leasehold Improvements, at Historical Cost	416,563		15
16	Equipment, at Historical Cost	16,576		16
17	Accumulated Depreciation (book methods)	(3,796,150)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	332,241		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,968,637	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,273,886	$	25

		1 Operating	
	C. Current Liabilities		
26	Accounts Payable	$ 117,104	$
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits	15,765	
29	Short-Term Notes Payable		
30	Accrued Salaries Payable		
31	Accrued Taxes Payable		
32	Accrued Interest Payable		
33	Deferred Compensation		
34	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
35	Accrued Vacation	16,239	
36			
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 149,108	$
	D. Long-Term Liabilities		
38	Long-Term Notes Payable	160,918	
39	Mortgage Payable	9,988,700	
40	Bonds Payable		
41	Deferred Compensation		
	Other Long-Term Liabilities(specify):		
42			
43			
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 10,149,618	$
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 10,298,726	$
46	**TOTAL EQUITY**	$ 1,975,160	$
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 12,273,886	$

***(See instructions.)**

2 After Consolidation*	
	26
	27
	28
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Facility Name: BETH-ANNE PLACE **Report Period Beginning: 7/1/14 Ending: 6/30/15**

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	$ 3,046,985	1
2	Discounts and Allowances	(316,370)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,730,615	3
	B. Other Operating Revenue		
4	Special Services	35,000	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	70,321	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 105,321	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Invest Income-Prompt Pymnt	1,949	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 1,949	14
	D. Other Revenue (specify):		
15	**LINK**	79,305	15
16	**RESIDENT CHARGE**	934	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 80,239	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,918,124	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	906,194	19
20	Health Care/ Personal Care	358,751	20
21	General Administration	736,747	21
	B. Capital Expense		
22	Ownership	365,825	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)**	$ 2,367,517	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 550,607	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 550,607	31

GENERAL SERVICES
LINE 1 COLUMN 3

Dining Consultant	2,540
Telephone	2,339
TOTAL	**4,879**

GENERAL SERVICES
LINE 3 COLUMN 3

Utilities	193,711
TOTAL	**193,711**

GENERAL SERVICES
LINE 4 COLUMN 3

Background Check	538
Drug Test	660
Exterminating	22,609
Elevator	12,792
Garbage & Trash	6,916
Security	60,806
Travel	1,695
TOTAL	**106,016**

HEALTH CARE AND PROGRAMS
LINE 6 COLUMN 3

Nurse Staffing	2,266

TOTAL	**2,266**

GENERAL ADMINISTRATION
LINE 10 COLUMN 3

Telephone	15,544
Conference	13,400
Legal	1,014
TOTAL	**29,958**

GENERAL ADMINISTRATRION
LINE 11 COLUMN 3

Advertising & Marketing	1,395
TOTAL	**1,395**

GENERAL ADMINISTRATION
LINE 13 COLUMN 3

Insurance	52,365
Alarm System Contract	7,015
TOTAL	**59,380**

GENERAL ADMINISTRATRION
LINE 14 COLUMN 3

Repair & Maintenance	68,374
Printing	330
Professional Fees	40,332
Staff Development	1,241
Postage	17
Copier Maintenance	1,328
Membership Dues	954
License & Fees	4,006
Credit Reports	56
Conference	888
Bookeeping	18,360
Recruitment	279
Bad Debt	7,279
TOTAL	**143,444**
Eliminate Bad Debt	(7,279)
TOTAL LESS BAD DEBT	**136,165**