FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/16 to 6/30/17 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) Christopher Dale

(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:

Name: **Telephone Number:** (773) 473-7870 ext. #111

Email Address: lbarnett@bethelnewlife.org

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 EXTENDED LIVING #REF! Report Period Beginning: 7/1/16 Ending: 6/30/17

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	22,281	1,095		23,376	5
6	Double Unit					6
7	Other					7
8	TOTALS	22,281	1,095		23,376	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 75.35%

D. Indicate the number of paid bed-hold days the SLF had during this year 548 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 395 **(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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 6/30/17 Fiscal Year: 6/30/17
* 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?** 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 the 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 the facility make all of the required payments of interest and principle?** NO
If no, explain. NOT APPLICABLE

Facility Name: BETH-ANNE PLACE **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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	167,442	182,249	1,300	350,991		350,991	1
2	Housekeeping, Laundry and Maintenance	72,487	3,615		76,102		76,102	2
3	Heat and Other Utilities			156,353	156,353		156,353	3
4	Other (specify):			168,711	168,711		168,711	4
5	**TOTAL General Services**	239,929	185,864	326,364	752,157		752,157	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	377,270	546	4,195	382,011		382,011	6
7	Activities and Social Services	74,736		1,164	75,900		75,900	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	452,006	546	5,359	457,911		457,911	9
	C. General Administration							
10	Administrative and Clerical	108,558	3,372	38,292	150,222		150,222	10
11	Marketing Materials, Promotions and Advertising	40,650	6,577	22,189	69,416		69,416	11
12	Employee Benefits and Payroll Taxes	203,388			203,388		203,388	12
13	Insurance-Property, Liability and Malpractice			37,991	37,991		37,991	13
14	Other (specify): telephone	124,944		40,889	165,833	(201)	165,632	14
15	**TOTAL General Administration**	477,540	9,949	139,361	626,850	(201)	626,649	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,169,475	196,359	471,084	1,836,918	(201)	1,836,717	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			309,083	309,083		309,083	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			54,209	54,209		54,209	22
23	**TOTAL Ownership**			363,292	363,292		363,292	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,169,475	196,359	834,376	2,200,210	(201)	2,200,009	24

Facility Name: BETH-ANNE PLACE Report Period Beginning 7/1/16 Ending: 6/30/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	30.25	1
2	Licensed Practical Nurses	1	21.96	2
3	Certified Nurse Assistants	34	11.87	3
4	Activity Director & Assistants	1	12.35	4
5	Social Service Workers	1	22.86	5
6	Head Cook	1	12.07	6
7	Cook Helpers/Assistants	14	11.66	7
8	Dishwashers			8
9	Maintenance Workers	1	11.43	9
10	Housekeepers	5	10.84	10
11	Laundry			11
12	Managers	2	31.28	12
13	Other Administrative	4	14.23	13
14	Clerical	1	10.50	14
15	Marketing	1	20.85	15
16	Other			16
17	**Total (lines 1 thru 16)**	67	$ 222.15	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	EVERGREEN	$ 54,209	1
2			2
		Total $ 54,209	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 Business	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 ☐
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: 7/1/16 Ending: 6/30/17

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	85		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	280,862	31,207	9	31,207			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	211	7	211			13
14	Equipment			11/30/2013	6,500	650	10	650			14
15	Capital improvement			11/20/2013	26,537	881	7	881			15
16	Building Improvement			1/24/2014	121,075	12,108	10	12,108			16
17	TOTAL (lines 1 thru 16)				$ 11,163,220	$ 316,740		$ 316,740	$	$	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: 7/1/16 Ending: 6/30/17

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.

Facility Name: BETH-ANNE PLACE **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/17 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,914	$	1
2	Cash-Patient Deposits	17,883		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	932,956		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,775		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,037,618		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,041,146	$	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	10,958,882		14
15	Leasehold Improvements, at Historical Cost	468,329		15
16	Equipment, at Historical Cost	18,165		16
17	Accumulated Depreciation (book methods)	(4,412,905)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	392,693		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,532,764	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,573,910	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,631	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,284		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,429		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Vacation	19,515		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 56,859	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	206,711		38
39	Mortgage Payable	9,988,700		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 10,195,411	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 10,252,270	$	45
46	**TOTAL EQUITY**	$ 2,321,640	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 12,573,910	$	47

***(See instructions.)**

Facility Name: BETH-ANNE PLACE **Report Period Beginning:** 7/1/16 **Ending:** 6/30/17

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

	I. Re Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,243,411	1
2	Discounts and Allowances	(264,693)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,978,718	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	14,092	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 14,092	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	604	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 604	14
	D. Other Revenue (specify):		
15		131,466	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 131,466	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,124,880	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	752,157	19
20	Health Care/ Personal Care	457,911	20
21	General Administration	626,649	21
	B. Capital Expense		
22	Ownership	363,292	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)**	$ 2,200,009	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 924,871	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 924,871	31
	III. NET RESIDENT CARE REVENUE detailed by PAYER SOURCE		
32	**Medicaid - Net Impatient Revenue**	$ 1,738,619	32
33	**Private Pay-Net Revenue**		33
33	**Medicare - Net Impatient Revenue**		34
33	**Other - (specify)**	1,040,052	35
33	**Other - (Specify)**	200,047	36
33	**TOTAL (This total must agree to Line 3)**	2,978,718	37

GENERAL SERVICES
LINE 1 COLUMN 3

Dining Consultant	925
Repair and Maintenance	375
TOTAL	**1,300**

GENERAL SERVICES
LINE 3 COLUMN 3

Utilities	156,353
TOTAL	**156,353**

GENERAL SERVICES
LINE 4 COLUMN 3

Background Check	834
Drug Test	2,951
Garbage & Trash	8,645
Security	131,260
HVAC	23,060
Snow Removal	1,787
	175
TOTAL	**168,712**

HEALTH CARE AND PROGRAMS
LINE 6 COLUMN 3

Nurse Staffing	4,195

TOTAL	**4,195**

HEALTH CARE AND PROGRAMS
LINE 7 COLUMN 3

Staff Development	1,164
TOTAL	**1,164**

GENERAL ADMINISTRATRION
LINE 10 COLUMN 3

Telephone	17,806
Subsription	395
Fuel	1,366
Professional Fees	4,774
Audit Expense	13,950
TOTAL	**38,291**

GENERAL ADMINISTRATRION
LINE 11 COLUMN 3

Advertising & Marketing	22,189
TOTAL	**22,189**

GENERAL ADMINISTRATRION
LINE 13 COLUMN 3

Insurance	37,991
	-

TOTAL	**37,991**

GENERAL ADMINISTRATRION
LINE 14 COLUMN 3

Repair & Maintenance	12,839
Printing	660
Staff Development	525
Food for Meeting	230
Postage	23
Copier Maintenance	4,823
Membership Dues	910
License & Fees	360
Conference	275
Bookeeping	18,360
Rebnting Expense	1,683
Late Charges	54
Bad Debt	147
TOTAL	**40,889**
Eliminate Finance Charge	(54)
Eliminate Bad Debt	(147)
TOTAL LESS BAD DEBT	**40,835**