FOR BHF USE

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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) 473-7871

Federal Employer ID Number: 36-4372019

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: Linda Barnett **Telephone Number:** (773) 473-7870
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 7/1/2017 to 6/30/2018 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)
(Title)

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: 7/1/2017 Ending: 6/30/2018

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	21,389	1,580		22,969	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,389	1,580		22,969	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 74.03%

D. Indicate the number of paid bed-hold days the SLF had during this year 624 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 154 (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? [ ] YES [ ] NO
Tax Year: 6/30/2018 Fiscal Year: 6/30/2018
* 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 principal? 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 principal? 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 principal? NO
If no, explain. NOT APPLICABLE

Facility Name: BETH ANNE PLACE **Report Period Beginning: 7/1/2017 Ending: 6/30/2018**

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	193,686	178,874	2,861	375,421		375,421	1
2	Housekeeping, Laundry and Maintenance	75,644	3,153		78,797		78,797	2
3	Heat and Other Utilities			223,326	223,326		223,326	3
4	Other (specify):			172,013	172,013		172,013	4
5	**TOTAL General Services**	269,329	182,027	398,200	849,556		849,556	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	448,502	1,123		449,625		449,625	6
7	Activities and Social Services	73,767	205	5,153	79,125		79,125	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	522,269	1,328	5,153	528,750		528,750	9
	C. General Administration							
10	Administrative and Clerical	73,117	1,953	43,904	118,974		118,974	10
11	Marketing Materials, Promotions and Advertising	10,256	2,170		12,426		12,426	11
12	Employee Benefits and Payroll Taxes	194,769			194,769		194,769	12
13	Insurance-Property, Liability and Malpractice			37,184	37,184		37,184	13
14	Other (specify): Maqnagers	179,139		214,714	393,853	(17,927)	375,926	14
15	**TOTAL General Administration**	457,281	4,123	295,802	757,206	(17,927)	739,279	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,248,880	187,478	699,155	2,135,513	(17,927)	2,117,586	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			313,416	313,416		313,416	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			50,480	50,480		50,480	22
23	**TOTAL Ownership**			363,896	363,896		363,896	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,248,880	187,478	1,063,051	2,499,409	(17,927)	2,481,482	24

Facility Name: BETH ANNE PLACE Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	$ 30.86	1
2	Licensed Practical Nurses	1	22.68	2
3	Certified Nurse Assistants	39	12.28	3
4	Activity Director & Assistants	1	12.04	4
5	Social Service Workers	1	24.25	5
6	Head Cook	1	13.60	6
7	Cook Helpers/Assistants	11	11.85	7
8	Dishwashers			8
9	Maintenance Workers	1	12.07	9
10	Housekeepers	4	11.05	10
11	Laundry			11
12	Managers	3	30.62	12
13	Other Administrative	1	16.01	13
14	Clerical	2	11.48	14
15	Marketing	1	25.26	15
16	Other			16
17	Total (lines 1 thru 16)	68	$ 234.05	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	$ 50,480	1
2			2
		Total $ 50,480	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: 7/1/2017 Ending: 6/30/2018

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											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 100,000	$		$	$	$	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: 7/1/2017 Ending: 6/30/2018

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:** 7/1/2017 **Ending:** 6/30/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2018 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,907	$	1
2	Cash-Patient Deposits	20,158		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	916,961		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,230		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,286,508		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,257,764	$	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	16,576		14
15	Leasehold Improvements, at Historical Cost	11,274,577		15
16	Equipment, at Historical Cost	184,509		16
17	Accumulated Depreciation (book methods)	(4,723,139)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	486,217		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,346,340	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,604,104	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,998	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,411		28
29	Short-Term Notes Payable	45,793		29
30	Accrued Salaries Payable	8,040		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 Vaction	13,481		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 169,723	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	# 276,400		38
39	Mortgage Payable	9,988,700		39
40	Bonds Payable			40
41	Deferred Compensation	6,213		41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 10,271,313	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 10,441,036	$	45
46	**TOTAL EQUITY**	$ 2,163,068	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 12,604,104	$	47

***(See instructions.)**

Facility Name: BETH ANNE PLACE Report Period Beginning: 7/1/2017 Ending: 6/30/2018

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 2,981,713	1
2	Discounts and Allowances	(308,218)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,673,495	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	24,276	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 24,276	11
	C. Non-Operating Revenue		
12	Contributions	25	12
13	Interest and Other Investment Income	2,393	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 2,418	14
	D. Other Revenue (specify):		
15	**Link-Salary Reimbursement**	42,540	15
16	**Resident Charge**	1,440	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 43,980	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,744,169	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	849,556	19
20	Health Care/ Personal Care	528,750	20
21	General Administration	740,188	21
	B. Capital Expense		
22	Ownership	363,896	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)**	$ 2,482,390	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 261,779	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 261,779	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,542,449	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)	908,322	35
36	Other-(specify)	222,714	36
37	TOTAL (This total must agree to Line 3)	$ 2,673,485	37

GENERAL SERVICES
LINE 1 COLUMN 3

Dining Consultant	2,861
Repair and Maintenance	-
TOTAL	**2,861**

GENERAL SERVICES
LINE 3 COLUMN 3

Utilities	223,326
TOTAL	**223,326**

GENERAL SERVICES
LINE 4 COLUMN 3

Background Check	122
Drug Test	2,388
Garbage & Trash	13,582
Security	128,553
HVAC	24,865
Snow Removal	1,733
Fuel	770
TOTAL	**172,013**

TOTAL	-

HEALTH CARE AND PROGRAMS
LINE 7 COLUMN 3

Staff Development	5,153
TOTAL	**5,153**

GENERAL ADMINISTRATRION
LINE 10 COLUMN 3

Telephone	18,073
Subsription	598
Professional Fees	4,340
Audit Expense	14,640
Conference	1,527
Payroll Charges	1,372
Special Events	312
Legal	3,042
TOTAL	**43,904**

GENERAL ADMINISTRATRION
LINE 13 COLUMN 3

Insurance	37,184
	-
TOTAL	**37,184**

GENERAL ADMINISTRATRION
LINE 14 COLUMN 3

Repair & Maintenance	5,674
Printing	-
Staff Development	636
Recruitment	87
Postage	24
Copier Maintenance	3,800
Membership Dues	1,342
License & Fees	3,019
Conference	-
Bookeeping	18,360
Professional Fees	163,629
Building Inspection	215
Late Charges	916
Bad Debt	17,011
TOTAL	**214,713**
Eliminate Finance Charge	(916)
Eliminate Bad Debt	(17,011)
TOTAL LESS BAD DEBT	**213,797**