FOR BHF USE

LL2

Supportive Living Facility

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)

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 7/1/10 to 6/30/11 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 # ( )

In the event there are further questions about this report, please contact:
Name: Linda Barnett **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 PLACE Report Period Beginning: 7/1/10 Ending: 6/30/11

A. Certified units; enter number of units and unit days
Date of change in certified units 8/15/2011

	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	27,393	347		27,740	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,393	347		27,740	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.00%

D. Indicate the number of paid bed-hold days the SLF had during this year 412 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 0 **(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: **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?** NO
If no, explain. NOT APPLICABLE

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

STATE OF ILLINOIS

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 7/1/10** **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	160,866	194,424		355,290		355,290	1
2	Housekeeping, Laundry and Maintenance	127,032	126,898		253,930		253,930	2
3	Heat and Other Utilities			233,727	233,727		233,727	3
4	Other (specify): Garbage & Trash Removal -Security Service-Exterminating			137,101	137,101		137,101	4
5	**TOTAL General Services**	287,898	321,322	370,828	980,048		980,048	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	124,667	3,722		128,389		128,389	6
7	Activities and Social Services	89,097		2,084	91,181		91,181	7
8	Other (specify):Supplies		2,868		2,868		2,868	8
9	**TOTAL Health Care and Programs**	213,764	6,590	2,084	222,438		222,438	9
	C. General Administration							
10	Administrative and Clerical	161,099	31,935	17,494	210,528		210,528	10
11	Marketing Materials, Promotions and Advertising		2,799	4,320	7,119		7,119	11
12	Employee Benefits and Payroll Taxes	182,023			182,023		182,023	12
13	Insurance-Property, Liability and Malpractice			72,662	72,662		72,662	13
14	Other (specify): Bad Debt, Conference ,Professional Fees			66,283	66,283	(30,737)	35,546	14
15	**TOTAL General Administration**	343,122	34,734	160,759	538,615	(30,737)	507,878	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	844,783	362,646	533,671	1,741,100	(30,737)	1,710,363	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			312,521	312,521		312,521	17
18	Interest			6,009	6,009		6,009	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Management Fees			59,340	59,340		59,340	22
23	**TOTAL Ownership**			377,870	377,870		377,870	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	844,783	362,646	911,541	2,118,970	(30,737)	2,088,233	24

Facility Name: BETH-ANNE PLACE Report Period Beginning 7/1/10 Ending: 6/30/11

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 35.90	1
2	Licensed Practical Nurses	1	21.54	2
3	Certified Nurse Assistants	8	10.75	3
4	Activity Director & Assistants	1	11.28	4
5	Social Service Workers	3	21.75	5
6	Head Cook	1	22.68	6
7	Cook Helpers/Assistants	8	10.48	7
8	Dishwashers			8
9	Maintenance Workers	3	13.27	9
10	Housekeepers	3	9.29	10
11	Laundry			11
12	Managers	3	21.86	12
13	Other Administrative	1	20.51	13
14	Clerical	3	12.27	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	36	$ 211.58	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 Management Company	$ 59,340	1
2			2
	Total	$ 59,340	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

Name 1	City 2

OTHER RELATED BUSINESS ENTITIES

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 [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 [X]
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: 7/1/10 Ending: 6/30/11

VIII. OWNERSHIP COSTS

A. Purchase price of land 100,000.00 Year land was acquired 1/13/03

B. Building Depreciation -- *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	1/13/2003	$ 10,547,485	$ 263,687	40	$ 263,687	$	$ 2,217,623	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Security System			7/1/2003	8,637	216	40	216		1,620	6
7	Outside Lighting			4/22/2004	3,937	98	40	98		737	7
8	Building Improvements				15,513	388	40	388		2,019	8
9	Building Improvements			8/30/2004	11,000	733	15	733		4,766	9
10	Phone System				41,616	4,162	10	4,162		30,365	10
11					151,358	18,530	7	18,530		71,376	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 10,779,546	$ 287,814		$ 287,814	$	$ 2,328,506	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	$ 252,104	$ 27,281	$ 27,281	(0)		$ 184,370	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 252,104	$ 27,281	$ 27,281	(0)		$ 184,370	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:** 7/1/10 **Ending:** 6/30/11

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/11 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,010,447	$	1
2	Cash-Patient Deposits	19,110		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	39,218		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)	670,805		8
9	Other(specify):	338		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,739,917	$	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			15
16	Equipment, at Historical Cost	326,716		16
17	Accumulated Depreciation (book methods)	# (2,548,066)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	1,262,154		20
21	Restricted Funds	216,499		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Capital Improvement	213,145		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,144,699	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,884,616	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 244,340	$	26
27	Officer's Accounts Payable	45,793		27
28	Accounts Payable-Patient Deposits	15,475		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	447		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Vacation	20,355		35
36	Miscellaneous-Accrued Expense	33,400		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 359,810	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	295,007		38
39	Mortgage Payable	249,718		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Recoverable Capital advance	7,462,697		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 8,007,422	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 8,367,232	$	45
46	**TOTAL EQUITY**	$ 3,517,384	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,884,616	$	47

***(See instructions.)**

Facility Name: BETH-ANNE PLACE Report Period Beginning: 7/1/10 Ending: 6/30/11

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 [X] 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 [X] 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	7/1/09	200,000	134,089	6/20/12	4.000	6,000	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 200,000	$ 134,089			$ 6,000	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 200,000	$ 134,089			$ 6,000	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: 7/1/10** **Ending: 6/30/11**

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	$ 3,114,299	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,114,299	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	696	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 696	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	523	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 523	14
	D. Other Revenue (specify):		
15	**LINK**	54,474	15
16	**Amortization of Recoverable Capital Adv**	279,718	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 334,192	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,449,710	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	980,048	19
20	Health Care/ Personal Care	222,438	20
21	General Administration	507,878	21
	B. Capital Expense		
22	Ownership	377,870	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)**	$ 2,088,234	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 1,361,476	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 1,361,476	31

14,741.00	
122,137.00	
223.00	
137,101.00	
2,868.00	
8,750.00	
2,548.00	
1,762.00	
277.00	
106.00	
3,663.00	
80.00	
18,360.00	
30,737.00	Adjust out

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