FOR BHF USE

LL2

Supportive Living Facility

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)

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 7/1/2013 to 6/30/2014 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) LINDA JOHNSON

(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: 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: 7/1/2013 Ending: 6/30/2014

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	23,049	2,751		25,800	5
6	Double Unit					6
7	Other					7
8	TOTALS	23,049	2,751		25,800	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.16%

D. Indicate the number of paid bed-hold days the SLF had during this year 574 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 160 **(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 30TH

* 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

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 7/1/2013 Ending: 6/30/2014**

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	213,243	233,770	12,603	459,616		459,616	1
2	Housekeeping, Laundry and Maintenance	87,586	104,570	39,952	232,108		232,108	2
3	Heat and Other Utilities			194,699	194,699		194,699	3
4	Other (specify):			129,993	129,993		129,993	4
5	**TOTAL General Services**	300,828	338,340	377,247	1,016,415		1,016,415	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	263,648	895	13,171	277,714		277,714	6
7	Activities and Social Services	72,759	3,818		76,577		76,577	7
8	Other (specify): Postage			78	78		78	8
9	**TOTAL Health Care and Programs**	336,408	4,713	13,249	354,370		354,370	9
	C. General Administration							
10	Administrative and Clerical	263,112	5,898	37,656	306,666	(66)	306,600	10
11	Marketing Materials, Promotions and Advertising			22,519	22,519		22,519	11
12	Employee Benefits and Payroll Taxes	215,506			215,506		215,506	12
13	Insurance-Property, Liability and Malpractice			92,471	92,471		92,471	13
14	Other (specify):			135,385	135,385	(11,560)	123,825	14
15	**TOTAL General Administration**	478,618	5,898	288,031	772,547	(11,626)	760,921	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,115,854	348,951	678,527	2,143,332	(11,626)	2,131,706	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			300,411	300,411		300,411	17
18	Interest			2,138	2,138		2,138	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			375	375		375	20
21	Rent -- Equipment							21
22	Other (specify): Management Fees			59,207	59,207		59,207	22
23	**TOTAL Ownership**			362,131	362,131		362,131	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,115,854	348,951	1,040,658	2,505,463	(11,626)	2,493,837	24

Facility Name: BETH-ANNE PLACE **Report Period Beginning 7/1/2013 Ending: 6/30/2014**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	$ 29.50	1
2	Licensed Practical Nurses	6	22.32	2
3	Certified Nurse Assistants	23	11.67	3
4	Activity Director & Assistants	1	14.63	4
5	Social Service Workers	1	21.73	5
6	Head Cook	1	12.34	6
7	Cook Helpers/Assistants	10	11.56	7
8	Dishwashers			8
9	Maintenance Workers	1	11.43	9
10	Housekeepers	6	9.75	10
11	Laundry			11
12	Managers	3	28.10	12
13	Other Administrative	2	14.52	13
14	Clerical	2	10.04	14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	59	$ 197.59	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	$ 59,207	1
2			2
		Total $ 59,207	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 ☐

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: 7/1/2013 Ending: 6/30/2014

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	229,890	28,361	9	28,361			9
10	Building Improvement			7/6/2012	25,958	2,596	10	2,596			10
11	Building Improvement			7/9/2013	17,141	1,600	10	1,600			11
12	Building Improvement			8/1/2013	23,612	2,748	7	2,748			12
13	Land Imrpovement			8/15/2013	1,476	500	10	500			13
14	Equipment			11/30/2013	6,500	487	10	487			14
15	Capital improvement			11/20/2013	1,418	118	7	118			15
16											16
17	TOTAL (lines 1 thru 16)				$ 10,966,054	$ 300,411		$ 300,411	$	$	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: 7/1/2013 Ending: 6/30/2014

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			X	Line of Credit	7/1/09	200,000	36,480	6/1/15	4.000	2,138	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 200,000	$ 36,480			$ 2,138	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 200,000	$ 36,480			$ 2,138	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:** 7/1/2013 **Ending:** 6/30/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2014 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 381,675	$	1
2	Cash-Patient Deposits	17,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	132,646		3
4	Supply Inventory (priced at)	5,172		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,206		6
7	Other Prepaid Expenses	23,162		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,538,446		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,131,306	$	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	10,847,972		14
15	Leasehold Improvements, at Historical Cost	327,649		15
16	Equipment, at Historical Cost	16,576		16
17	Accumulated Depreciation (book methods)	(3,494,868)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	283,768		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,081,097	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,212,403	$	25

		1 Operating	2 After Consolidation*
	C. Current Liabilities		
26	Accounts Payable	$ 124,941	$
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits	16,317	
29	Short-Term Notes Payable	36,480	
30	Accrued Salaries Payable		
31	Accrued Taxes Payable		
32	Accrued Interest Payable	122	
33	Deferred Compensation		
34	Federal and State Income Taxes		
	Other Current Liabilities(specify):		
35	Accrued Vacation	9,340	
36	Prepaid Revenue		
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 187,199	$
	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)**	$ 10,336,817	$
46	**TOTAL EQUITY**	$ 1,875,585	$
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 12,212,403	$

***(See instructions.)**

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Facility Name: BETH-ANNE PLACE **Report Period Beginning: 7/1/2013 Ending: 6/30/2014**

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	$ 2,901,600	1
2	Discounts and Allowances	(185,020)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,716,580	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	74,097	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 74,097	11
	C. Non-Operating Revenue		
12	Contributions	100	12
13	Interest and Other Investment Income (Prompt Pymt0	20,587	13
14	**(sum of lines 12 and 13)**	$ 20,687	14
	D. Other Revenue (specify):		
15	**Link**	108,174	15
16	**Resident Charge**	1,726	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 109,900	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,921,264	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,016,415	19
20	Health Care/ Personal Care	354,370	20
21	General Administration	760,921	21
	B. Capital Expense		
22	Ownership	362,131	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)**	$ 2,493,837	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 427,427	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 427,427	31

12,603.00

12,603.00

13,764.00
11,751.00
8,161.93
6,275.00

39,951.93

194,699.00

194,699.00

17,597.00
91,054.00
2,434.00
1,245.00
17,572.22
92.00

129,994.22

13,171.00

13,171.00