FOR BHF USE

LL2

Supportive Living Facility

2009

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 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: 36-301-3241

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: Valarie Hines **Telephone Number:** (773 473-7870 ext. #125
Email Address: vhines@bethelnewlife.org

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/08 to 06/30/09 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: 07/01/08 Ending: 06/30/09

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	83	Single Unit Apartment	84	30,660	1
2	2	Double Unit Apartment	1	365	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	26,457	729		27,186	5
6	Double Unit	571			571	6
7	Other					7
8	TOTALS	27,028	729		27,757	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.47%

D. Indicate the number of paid bed-hold days the SLF had during this year 563 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 213 **(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. 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?**
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?**
If no, explain. NOT APPLICABLE

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 07/01/08 Ending: 06/30/09**

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	169,177	220,225		389,402		389,402	1
2	Housekeeping, Laundry and Maintenance	148,955	96,635		245,590		245,590	2
3	Heat and Other Utilities			308,998	308,998	(297)	308,702	3
4	Other (specify):	14,583		126,576	141,159	(842)	140,317	4
5	**TOTAL General Services**	332,715	316,860	435,575	1,085,150	(1,139)	1,084,011	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	268,968	1,539		270,507		270,507	6
7	Activities and Social Services	100,982		3,145	104,127		104,127	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	369,950	1,539	3,145	374,633		374,633	9
	C. General Administration							
10	Administrative and Clerical	89,689	32,837	193,476	316,002	(5)	315,997	10
11	Marketing Materials, Promotions and Advertising			8,045	8,045		8,045	11
12	Employee Benefits and Payroll Taxes	141,841			141,841		141,841	12
13	Insurance-Property, Liability and Malpractice			193,138	193,138		193,138	13
14	Other (specify): Managers	85,185		27,770	112,954	(421)	112,534	14
15	**TOTAL General Administration**	316,714	32,837	422,428	771,979	(426)	771,554	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,019,379	351,236	861,147	2,231,762	(1,564)	2,230,198	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			281,682	281,682		281,682	17
18	Interest			10,542	10,542		10,542	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			48,000	48,000		48,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			340,225	340,225		340,225	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,019,379	351,236	1,201,372	2,571,987	(1,564)	2,570,423	24

Facility Name: BETH-ANNE PLACE Report Period Beginning: 07/01/08 Ending: 06/30/09

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 41.03	1
2	Licensed Practical Nurses	1	10.51	2
3	Certified Nurse Assistants	12	9.78	3
4	Activity Director & Assistants	1	12.63	4
5	Social Service Workers	2	21.63	5
6	Head Cook/Dietary Aides	9	10.18	6
7	Cook Helpers/Assistants	6	10.80	7
8	Dishwashers			8
9	Maintenance Workers	3	12.83	9
10	Housekeepers	5	9.46	10
11	Laundry	1	8.76	11
12	Managers	5	32.31	12
13	Other Administrative	3	13.93	13
14	Clerical	2	11.44	14
15	Marketing	1	21.13	15
16	Other **Dietary Director**	1	26.41	16
17	**Total (lines 1 thru 16)**	53	$	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	HSR	$ 56,816	1
2			2
		Total $ 56,816	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 [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: 07/01/08 Ending: 06/30/09

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 Improvements			1/31/2003	10,558,484	263,962	40	263,962			6
7	Security System			7/1/2003	8,637	216	20	216			7
8	Outside Lighting			4/22/2004	3,937	197	20	197			8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 10,671,058	$ 264,375		$ 264,375	$	$	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	$ 270,632	$ 27,063	$ 27,063	$	10	$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 270,632	$ 27,063	$ 27,063	$		$	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: 07/01/08 Ending: 06/30/09

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			X	Line of Credit	10/28/02	200,000	194,115	6/1/12	4.5000		4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 200,000	$ 194,115			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 200,000	$ 194,115			$	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:** 07/01/08 **Ending:** 06/30/09

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/09 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,711	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	843,687		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,661		6
7	Other Prepaid Expenses	25,625		7
8	Accounts Receivable (owners or related parties)	829,701		8
9	Other(specify):	100,582		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,942,968	$	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	201,445		15
16	Equipment, at Historical Cost	271,472		16
17	Accumulated Depreciation (book methods)	(149,004)		17
18	Deferred Charges -Utility Deposit	4,230		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,737,584)		20
21	Restricted Funds	68,556		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	21,980		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,355,346	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,298,315	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 566,721	$	26
27	Officer's Accounts Payable	16,889		27
28	Accounts Payable-Patient Deposits	17,080		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,701		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	1,340		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Expenses	9,859		35
36	Notes Pay/Recoverable Capital Advan	567,502		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,186,091	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	194,161		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Recoverable Advance	8,402,769		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 8,596,930	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 9,783,021	$	45
46	**TOTAL EQUITY**	$ 1,515,294	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,298,315	$	47

***(See instructions.)**

Facility Name: BETH-ANNE PLACE **Report Period Beginning: 07/01/08 Ending: 06/30/09**

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	$ 3,210,667	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,210,667	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		9
10	Laundry	1,916	10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 1,916	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,058	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 1,058	14
	D. Other Revenue (specify):		
15		1,064	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 1,064	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,214,705	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,084,703	19
20	Health Care/ Personal Care	374,080	20
21	General Administration	772,980	21
	B. Capital Expense		
22	Ownership	340,225	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)**	$ 2,571,988	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 642,717	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 642,717	31

LINE 4 COLUMN 3

GARBAGE & TRASH REMOVAL	7,812.32	
BACKGROUND CHECKS	842.00	
EXTERMINATING	4,802.37	
SECURITY GUARD SERVICE CONTRACT	112,254.69	
SEC OF STATE	10.00	adj out
FINANCE CHARGES	631.95	adj out
CROSS CONNECTION INSPECTION/CERTIFICATION	200.00	adj out
DIRECT TRAVEL PARKING FEE REIMBURSEMENT	23.00	
TOTAL	**126,576.33**	

GNERAL ADMINISTRATION
LINE 14 COLUMN 3

QUALITY ASSURANCE	3,805.00	
CONVENTIONS AND MEETINGS	4,741.15	
BOOKKEEPING AND ACCOUNTING SERVICES	17,595.00	
		adj out per R. Hulskotter
MOVE IN DISCOUNT	420.56	
TENANT BACKGROUND CHECKS	544.50	
STAFF DEVELOPMENT	663.55	
TOTAL	**27,769.76**	