

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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 Chicago 60651

County: Cook

Telephone Number: (773) 287-2711 Fax # (312) 473-7871

Federal Employer ID Number:

Date Current Owners were Certified:

Type of Ownership:

VOLUNTARY, NON-PROFIT

X Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name: Michael Zahtz

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 7/1/2019 to 6/30/2020 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)

(Type or Print Name) Michael Zahtz

(Title) Manager

Paid Preparer

(Signed)

(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

HFS 3745C (N-4-05)

IL478-2471

Report Period Beginning: 7/1/2019 Ending: 6/30/2020

A. Certified units; enter number of units and unit days

/ /

E. Does page 3 include expenses for services or investments not directly related to SLF services?

--	--

X

YES ☐ NO ☒

--	--

X

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

ACCUAL		MODIFIED	
	X	CASH*	
		CASH*	

X

S

6/30/2020

6/30/2020

*** All facilities other than governmental must report on the accrual basis.**

No

If yes, did the facility make all of the

required payments of interest and principal?

If no, explain.

No

If yes, did the facility make all of the

required payments of interest and principal?

If no, explain.

No

If yes, did the facility

make all of the required payments of interest and principal?

If no, explain.

1	2	3	4	5	
Type of Unit	Resident Days by Unit and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
Single Unit	6,096	121		6,217	5
Double Unit	19,396	366		19,762	6
Other					7
TOTALS	25,492	487		25,979	8

83.51%

326

Also, indicate the number of unpaid bed-hold days the SLF

had during this year. **22 (Do not include bed-hold days in Section B.)**

22

(Do not include bed-hold days in Section B.)

STATE OF ILLINOIS

Facility Name: Beth Anne Place

Report Period Beginning:

7/1/2019

Ending:

Page 3
6/30/2020

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	98,625	126,556	2,300	227,481		227,481	1
2	Housekeeping, Laundry and Maintenance	12,919	872	44,119	57,910	323,499	381,409	2
3	Heat and Other Utilities			6,107	6,107	155,888	161,995	3
4	Other (specify): Waste Removal			1,001	1,001	10,156	11,157	4
5	TOTAL General Services	111,544	127,428	53,527	292,499	489,543	782,042	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	226,306	14,582	28,072	268,960		268,960	6
7	Activities and Social Services	3,044	4,033	1,765	8,842	35,662	44,504	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	229,350	18,615	29,837	277,802	35,662	313,464	9
	C. General Administration							
10	Administrative and Clerical	167,419	29,625	467,530	664,574	(5,115)	659,459	10
11	Marketing Materials, Promotions and Advertising		16,181	11,988	28,169		28,169	11
12	Employee Benefits and Payroll Taxes			74,695	74,695	39,857	114,552	12
13	Insurance-Property, Liability and Malpractice					39,851	39,851	13
14	Other (specify):							14
15	TOTAL General Administration	167,419	45,806	554,213	767,438	74,593	842,031	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	508,313	191,849	637,577	1,337,739	599,798	1,937,537	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					309,099	309,099	17
18	Interest					8,046	8,046	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership					317,145	317,145	23
24	GRAND TOTAL (Sum of lines 16 and 23)	508,313	191,849	637,577	1,337,739	916,943	2,254,682	24

Facility Name: Beth Anne Place

Report Period Beginning 7/1/2019 Ending: 6/30/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 32.23	1
2	Licensed Practical Nurses	1	30.70	2
3	Certified Nurse Assistants	7	14.30	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	17.94	6
7	Cook Helpers/Assistants	3	13.94	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers	1	38.01	12
13	Other Administrative	2	19.48	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	16	\$	17

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
Moraine Court	Bridgeview
Asbury of Kankakee	Kankakee
Bethel Supportive Living	Chicago

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	\$	1
2		2
Total		\$ 3

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Asbury Healthcare	Lincolnwood	Consulting

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:

7/1/2019

Ending:

6/30/2020

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					\$	\$		\$	\$	\$	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)				\$	\$		\$	\$	\$	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

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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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	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.

STATE OF ILLINOIS

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Facility Name: Beth Anne Place

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Ending:

6/30/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 339,808	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	759,096		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,302		7
8	Accounts Receivable (owners or related parties)	25,408		8
9	Other(specify): Refunds in transit	28,389		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,155,003	\$	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	10,989,118		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	206,565		16
17	Accumulated Depreciation (book methods)	(4,758,481)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,537,202	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,692,205	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 27,957	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	92,900		29
30	Accrued Salaries Payable	29,340		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	Management Fee Payable	16,461		35
36	Due to Affiliates	12,419		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 179,077	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			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)	\$ 9,988,700	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,167,777	\$	45
46	TOTAL EQUITY	\$ (2,475,572)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,692,205	\$	47

*(See instructions.)

Facility Name: Beth Anne Place

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,675,862	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,675,862	3
	B. Other Operating Revenue		
4	Special Services	732	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		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 732	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,468	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,468	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,678,062	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	782,042	19
20	Health Care/ Personal Care	313,464	20
21	General Administration	842,031	21
	B. Capital Expense		
22	Ownership	317,145	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)	\$ 2,254,682	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 423,380	29
30	Income Taxes	\$ 4,000	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 419,380	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,477,560	32
33	Private Pay - Net Inpatient Revenue	198,302	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,675,862	37

Pg3 Expenses Adjustments:

Maintenance	323,499.00	pg. 3 IV. 2
Utilities	155,888.00	pg. 3 IV. 3
Waste Removal	10,156.00	pg. 3 IV. 4
Social Services	35,662.00	pg. 3 IV. 7
Bad Debt	(180,000.00)	pg. 3 IV. 10
State Taxes	(4,000.00)	pg. 3 IV. 10
Administrative	178,885.00	pg. 3 IV. 10
Employee Benefits	39,857.00	pg. 3 IV. 12
Insurance	39,851.00	pg. 3 IV. 13
Depreciation	309,099.00	pg. 3 IV. 17
Interest	8,046.00	pg. 3 IV. 18
Total Adjustments	<u>916,943</u>	