

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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.

<p>I. Facility ID Number: <u>1000083</u></p> <p>Facility Name: <u>Supportive Lvg of Washington</u></p> <hr/> <p>Address: <u>1150 New Castle Road</u> <u>Washington</u> <u>61571</u> <small>Number City Zip Code</small></p> <p>County: <u>Tazewell</u></p> <p>Telephone Number: (<u>309</u>) <u>444-3641</u> Fax # (<u>309</u>) <u>444-8763</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>9/24/207</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kenna Hudson</u> Telephone Number: (<u>314</u>) <u>587-7924</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Chuck Schmitz</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) _____</td> <td>Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Chuck Schmitz</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) _____	Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) _____	Fax # () _____																																												

Facility Name Supportive Lvg of Washington

Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	57	Single Unit Apartment	57	20,862	1
2	3	Double Unit Apartment	3	1,098	2
3		Other			3
4	60	TOTALS	60	21,960	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	10,147	8,526		18,673	5
6	Double Unit	368	368		736	6
7	Other					7
8	TOTALS	10,515	8,894		19,409	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.38%

D. Indicate the number of paid bed-hold days the SLF had during this year

476 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 13 (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

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

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*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 12/31

* 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? N/A

If no, explain. N/A

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? N/A

If no, explain. N/A

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? N/A

If no, explain. N/A

Facility Name: Supportive Lvg of Washington

Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	93,785	126,682	2,872	223,338	(817)	222,521	1
2	Housekeeping, Laundry and Maintenance	52,523	9,572	69,654	131,748		131,748	2
3	Heat and Other Utilities			76,698	76,698	(7,796)	68,902	3
4	Other (specify): Trash			4,432	4,432		4,432	4
5	TOTAL General Services	146,307	136,253	153,656	436,216	(8,613)	427,603	5
B. Health Care and Programs								
6	Health Care/ Personal Care	287,294	3,377	66	290,737		290,737	6
7	Activities and Social Services	19,682	2,825	3,501	26,008		26,008	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	306,975	6,202	3,567	316,744		316,744	9
C. General Administration								
10	Administrative and Clerical	90,355	4,237	251,569	346,162	(34,927)	311,234	10
11	Marketing Materials, Promotions and Advertising		10,504	1,718	12,222		12,222	11
12	Employee Benefits and Payroll Taxes			125,844	125,844		125,844	12
13	Insurance-Property, Liability and Malpractice			17,674	17,674		17,674	13
14	Other (specify):							14
15	TOTAL General Administration	90,355	14,741	396,805	501,902	(34,927)	466,974	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	543,638	157,197	554,027	1,254,863	(43,540)	1,211,322	16
Capital Expenses								
D. Ownership								
17	Depreciation			305,041	305,041		305,041	17
18	Interest			214,130	214,130	(720)	213,410	18
19	Real Estate Taxes			61,574	61,574		61,574	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			28,043	28,043		28,043	22
23	TOTAL Ownership			608,787	608,787	(720)	608,068	23
24	GRAND TOTAL (Sum of lines 16 and 23)	543,638	157,197	1,162,815	1,863,650	(44,260)	1,819,390	24

Facility Name: Supportive Lvg of Washington

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	0.40	19.05	2
3	Certified Nurse Assistants	9.54	11.05	3
4	Activity Director & Assistants	0.81	11.71	4
5	Social Service Workers			5
6	Head Cook	1.21	12.61	6
7	Cook Helpers/Assistants	3.25	9.17	7
8	Dishwashers			8
9	Maintenance Workers	0.59	13.02	9
10	Housekeepers	1.92	9.40	10
11	Laundry			11
12	Managers	1.04	27.31	12
13	Other Administrative	0.89	17.02	13
14	Clerical			14
15	Marketing			15
16	Other Wellness Manager	1.00	25.03	16
17	Total (lines 1 thru 16)	20.65	\$ 12.68	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	\$	1
2		2
Total		\$ 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
Christian Homes, Inc.		Lincoln	

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: Supportive Lvg of Washington

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 89,000 Year land was acquired 2006

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	60		2012 & Prior	2006	\$ 7,833,557	\$ 263,748	VARIOUS	\$ 263,748	\$	\$ 2,420,270	1
2			2013		18,509	1,461	5-20	1,461		5,111	2
3			2014		33,473	6,142	5-15	6,142		17,410	3
4			2015		14,153	2,316	5-10	2,316		3,764	4
5			2016		51,022	4,181	5-10	4,181		4,181	5
Improvement Type											
6		Landscaping		2006	31,548	2,103	15	2,103		19,455	6
7		Staking		2006	19,661	1,311	15	1,311		12,124	7
8		Paving and Surfacing		2006	47,898	3,193	15	3,193		29,537	8
9		Dump Fees		2006	11,514	768	15	768		7,100	9
10		Signage		2011	6,208	621	10	621		3,207	10
11		Patio		2011	5,706	380	15	380		2,029	11
12		Landscaping		2011	6,968	465	15	465		2,323	12
13		Mulch		2012	1,660		3			1,660	13
14		Ramp		2012	2,640	176	12	176		821	14
15		Parking		2013	2,280		2			2,280	15
16		Sprinkler System		2016	28,650	637		637		637	16
17		TOTAL (lines 1 thru 16)			\$ 8,115,447	\$ 287,502		\$ 287,502	\$	\$ 2,531,908	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	\$ 306,519	\$ 17,540	\$ 17,540	\$	7	\$ 257,873	18
19	Vehicles	6,000				3	6,000	19
20	TOTAL (lines 18 and 19)	\$ 312,519	\$ 17,540	\$ 17,540	\$		\$ 263,873	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: Supportive Lvg of Washington

Report Period Beginning: 01/01/2016

Ending: 2/31/2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	HUD-Mortgage		X	Refinance - Construction	9/1/13	\$ 5,840,000	\$ 5,559,838	10/1/48	3.7300	\$ 209,207
2			X	Deferred Tax Cred Fees & Org Costs	/ /	93,218	69,488	/ /		3,614
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,933,218	\$ 5,629,326			\$ 212,822
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,933,218	\$ 5,629,326			\$ 212,822

* 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: Supportive Lvg of Washington

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 515,014	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>51,060</u>)	260,262		3
4	Supply Inventory (priced at)	1,716		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,132		6
7	Other Prepaid Expenses	7,118		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 810,241	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	89,000		13
14	Buildings, at Historical Cost	7,979,365		14
15	Leasehold Improvements, at Historical Cost	136,083		15
16	Equipment, at Historical Cost	312,519		16
17	Accumulated Depreciation (book methods)	(2,795,781)		17
18	Deferred Charges	1,308		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	557,583		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,280,076	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,090,317	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,548	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,695		30
31	Accrued Taxes Payable	57,859		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Liabilities	6,360		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 114,461	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,559,839		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred Org Costs	(68,180)		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,491,659	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,606,120	\$	45
46	TOTAL EQUITY	\$ 1,484,197	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,090,317	\$	47

*(See instructions.)

Facility Name: Supportive Lvg of Washington

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

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	\$ 1,909,434	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,909,434	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	817	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 817	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	882	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 882	14
D. Other Revenue (specify):			
15			15
16	Miscellaneous Revenue	42,160	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 42,160	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,953,292	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	436,216	19
20	Health Care/ Personal Care	316,744	20
21	General Administration	501,902	21
B. Capital Expense			
22	Ownership	608,787	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)	\$ 1,863,650	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 89,643	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 89,643	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 980,687	32
33	Private Pay - Net Inpatient Revenue	410,072	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Tax Credit</u>	518,675	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,909,434	37