FOR BHF USE

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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: 1000012

Facility Name: Saint Clares Villa

Address: 915 East 5th Street (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: (618) 463-9000 **Fax #** (618) 463-0995

Federal Employer ID Number:

Date Current Owners were Certified: 04/08/02 - 33 units 07/24/02 -31 units

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[X] 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 1/1/2018 to 12/31/2018 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) 4/24/2019 (Date)

(Type or Print Name) Lori A. Vadnal

(Title) Director of Finance

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: Holly Steider **Telephone Number:** (309) 308-6336
Email Address: holly.j.steider@osfhealthcare.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 Saint Clares Villa Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	38	Single Unit Apartment	38	13,870	1
2	26	Double Unit Apartment	26	9,490	2
3		Other			3
4	64	TOTALS	64	23,360	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	Studio Unit	7,004	223		7,227	5
6	One Bedroom	6,942	1,132		8,074	6
7	Other					7
8	TOTALS	13,946	1,355	0	15,301	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 65.50%

D. Indicate the number of paid bed-hold days the SLF had during this year 290 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 4 (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? [ ] YES [X] NO
Tax Year: 09/30 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? Yes If yes, did the facility make all of the required payments of interest and principal? Yes
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 principal? N/A
If no, explain.

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 principal? N/A
If no, explain.

Facility Name: Saint Clares Villa **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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	106,649	163,869		270,518		270,518	1
2	Housekeeping, Laundry and Maintenance	133,330	13,817	28,644	175,790		175,790	2
3	Heat and Other Utilities			153,565	153,565		153,565	3
4	Other (specify):	43,838	458	1,462	45,758		45,758	4
5	**TOTAL General Services**	283,816	178,144	183,672	645,632	0	645,632	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	324,431	2,818	0	327,250		327,250	6
7	Activities and Social Services	31,747	2,799		34,546		34,546	7
8	Other (specify):				0		0	8
9	**TOTAL Health Care and Programs**	356,178	5,618	0	361,796	0	361,796	9
	C. General Administration							
10	Administrative and Clerical	132,323	302	151,237	283,862		283,862	10
11	Marketing Materials, Promotions and Advertising				0		0	11
12	Employee Benefits and Payroll Taxes			193,534	193,534		193,534	12
13	Insurance-Property, Liability and Malpractice			51,552	51,552		51,552	13
14	Other (specify):				0		0	14
15	**TOTAL General Administration**	132,323	302	396,323	528,948	0	528,948	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	772,318	184,064	579,995	1,536,376	0	1,536,376	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			352,045	352,045		352,045	17
18	Interest			6,216	6,216		6,216	18
19	Real Estate Taxes			27,992	27,992		27,992	19
20	Rent -- Facility and Grounds				0		0	20
21	Rent -- Equipment			151	151		151	21
22	Other (specify):			120	120		120	22
23	**TOTAL Ownership**	0	0	386,524	386,524	0	386,524	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	772,318	184,064	966,519	1,922,901	0	1,922,901	24

Facility Name: Saint Clares Villa Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.10	$ 34.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.84	15.19	3
4	Activity Director & Assistants	1.01	15.10	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.41	16.84	7
8	Dishwashers			8
9	Maintenance Workers	1.16	23.79	9
10	Housekeepers	3.01	12.13	10
11	Laundry			11
12	Managers	1.00	32.20	12
13	Other Administrative			13
14	Clerical	1.31	24.51	14
15	Marketing			15
16	Other	2.14	14.59	16
17	Total (lines 1 thru 16)	20.98	$	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	$ 0	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
OSF Health Care Saint Anthony's	Alton, Il	Saint Anthony's LLC	Alton, IL	General Ptnr

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: OSF Health Care Saint Anthony's 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 [X] 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). See CR Attachment

Facility Name: Saint Clares Villa Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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				2002	$ 9,566,565	$ 344,228	27.5	$ 344,228	$ 0	$ 5,825,155	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Beauty Shop Addition			2003	3,685	134	27.5	134	0	2,182	6
7	Vinyl Flooring			2006	3,910	142	27.5	142	0	1,712	7
8	Nurse Call System			2014	64,274	7,392	5.0	7,392	0	60,546	8
9	Masonry fitup to outside wall			2018	24,600	149	27.5	149	0	149	9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)				$ 9,663,034	$ 352,045		$ 352,045	$ 0	$ 5,889,744	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	$ 196,034	$	$	$		$ 196,034	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 196,034	$ 0	$ 0	$		$ 196,034	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: Saint Clares Villa Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 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		0		$ 0			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	IDHA		X	Building & Improvements	7 /19 /01	$ 750,000	$ 482,409	/ /	0.0100	$ 4,906	1
2	Madison County		X	Building & Improvements	/ /	300,000	18,355	/ /	0.0582	1,310	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 1,050,000	$ 500,764			$ 6,216	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 1,050,000	$ 500,764			$ 6,216	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: Saint Clares Villa **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 78,211	$	1
2	Cash-Patient Deposits	2		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	484,433		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	131		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	16,132		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 578,909	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	9,498,467		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	360,600		16
17	Accumulated Depreciation (book methods)	(6,085,778)		17
18	Deferred Charges	2,800		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): Oper & Repl Reserves	333,975		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,110,064	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,688,973	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,473	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	28,369		31
32	Accrued Interest Payable	5,871		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	DUE TO AFFILIATES	1,051,812		35
36	PREPAID RENT	8,137		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,095,662	$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	500,763		38
39	Mortgage Payable			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)**	$ 500,763	$ 0	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,596,425	$ 0	45
46	**TOTAL EQUITY**	$ 3,092,548	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 4,688,973	$ 0	47

***(See instructions.)**

Facility Name: Saint Clares Villa Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,492,695	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,492,695	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	69	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 69	11
	C. Non-Operating Revenue		
12	Contributions	2,950	12
13	Interest and Other Investment Income	22,623	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 25,573	14
	D. Other Revenue (specify):		
15	**Application Fees**	100	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 100	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,518,437	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	645,632	19
20	Health Care/ Personal Care	361,796	20
21	General Administration	528,948	21
	B. Capital Expense		
22	Ownership	386,524	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)**	$ 1,922,900	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (404,463)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (404,463)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,328,449	32
33	Private Pay - Net Inpatient Revenue	107,341	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) SNAP	56,905	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,492,695	37

CR Attachment
Page 4 VII Line C

Villa - Direct Cost Transfer no markup

Salaries/Wages	568,050
Supplies	4,746
Other	1,969

Food Service Cost - Rate is $17.40 per resident Day (includes 3 meals plus snacks)
$1.64 of the daily rate is included below in benefits

Salaries/Wages	84,561
Supplies	163,869

Engineering, Security, Utilities, Building Communications and Housekeeping
(all allocation are based on building square footage)

Salaries/Wages	119,707
Supplies	11,022
Other	37,232
Utilities	153,565
Insurance	17,672

Benefits- Allocated based on a % of Salary cost

Benefits	193,276

Total Cost of Service provided by OSF Saint Anthony's Health Center	$ 1,355,670