

		FOR BHF USE			

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Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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 Living of Washington</u></p> <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>309 444-8763</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>09/24/2007</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>Susan McGhee</u> Telephone Number: (<u>314</u>) <u>587-7903</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>01/01/2011</u> to <u>12/31/2011</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%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Susan McGhee</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Partner</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314</u>) <u>925-4379</u> Fax <u>(314) 925-4350</u> </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) _____ (Type or Print Name) <u>Susan McGhee</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Allan B. Larson, CPA</u> <u>Partner</u> (Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Avenue, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>314</u>) <u>925-4379</u> Fax <u>(314) 925-4350</u>
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Facility Name Supportive Living of Washington

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

Date of change in certified units 11/24/2008

	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	52	Single Unit Apartment	52	18,980	1
2	8	Double Unit Apartment	8	2,920	2
3		Other		2,920	3
4	60	TOTALS	60	24,820	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	9,918	8,972		18,890	5
6	Double Unit	474	1,252		1,726	6
7	Other	473	1,252		1,725	7
8	TOTALS	10,865	11,476		22,341	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.01%

D. Indicate the number of paid bed-hold days the SLF had during this year 129 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 545 (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? _____
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? _____
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 principle? _____
If no, explain. _____

Facility Name: Supportive Living of Washington

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

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	92,233	129,733	1,821	223,787	(1,410)	222,377	1
2	Housekeeping, Laundry and Maintenance	49,244	18,775	31,245	99,264		99,264	2
3	Heat and Other Utilities			90,413	90,413	(6,457)	83,956	3
4	Other-Trash			5,575	5,575		5,575	4
5	TOTAL General Services	141,477	148,508	129,054	419,039	(7,867)	411,172	5
B. Health Care and Programs								
6	Health Care/ Personal Care	266,697	1,742	290	268,729		268,729	6
7	Activities and Social Services	18,274	2,883	740	21,897		21,897	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	284,971	4,625	1,030	290,626		290,626	9
C. General Administration								
10	Administrative and Clerical	72,064	6,868	84,315	163,247	(2,448)	160,799	10
11	Marketing Materials, Promotions and Advertising			2,414	2,414		2,414	11
12	Employee Benefits and Payroll Taxes			98,572	98,572		98,572	12
13	Insurance-Property, Liability and Malpractice			17,917	17,917	(4,448)	13,469	13
14	Other (specify):							14
15	TOTAL General Administration	72,064	6,868	203,218	282,150	(6,896)	275,254	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	498,512	160,001	333,302	991,815	(14,763)	977,052	16
Capital Expenses								
D. Ownership								
17	Depreciation			306,577	306,577		306,577	17
18	Interest			511,434	511,434		511,434	18
19	Real Estate Taxes			134,054	134,054		134,054	19
20	Rent -- Facility and Grounds			3,364	3,364		3,364	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			955,429	955,429		955,429	23
24	GRAND TOTAL (Sum of lines 16 and 23)	498,512	160,001	1,288,731	1,947,244	(14,763)	1,932,481	24

Facility Name: Supportive Living of Washington

Report Period Beginning 01/01/2011

Ending:

12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.54	\$ 20.26	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	9.27	10.16	3
4	Activity Director & Assistants	0.84	10.40	4
5	Social Service Workers			5
6	Head Cook	0.79	15.60	6
7	Cook Helpers/Assistants	3.57	8.84	7
8	Dishwashers			8
9	Maintenance Workers	0.54	11.81	9
10	Housekeepers	1.98	8.56	10
11	Laundry			11
12	Managers	1.00	19.74	12
13	Other Administrative	0.91	13.40	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	20.44	\$ 118.77	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	N/A			\$	1	
2					2	
3					3	
4					4	
5					5	
				Total	\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$
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 Living of Washington

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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		2007	2006	\$ 7,389,337	\$ 246,413	30	\$ 246,413	\$	\$ 1,046,823	1
2					386,145	12,872	30	12,872		54,704	2
3					1,117	121	5	121		344	
4					992	132	5	132		132	
5					558	37	5	37		37	
6					8,939	248	15	248		248	3
7					41,370	230	15	230		230	4
8					521	9	5	9		9	5
	Improvement Type										
9		Landscaping		2007	31,548	2,103	15	2,103		9,990	6
10		Staking Fees		2007	11,643	776	15	776		3,687	7
11		Staking Fees		2007	8,018	535	15	535		2,539	8
12		Paving & Surfacing		2007	47,898	3,193	15	3,193		15,167	9
13		Dump Fees		2007	11,514	768	15	768		3,647	10
14		Signage		2011	6,208	103	10	103		103	11
15		Patio		2011	5,706	127	15	127		127	12
16		Landscaping		2011	6,968	39	15	39		39	13
17											14
18											15
19											16
20	TOTAL (lines 1 thru 19)				\$ 7,958,482	\$ 267,706		\$ 267,706	\$	\$ 1,137,826	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	\$ 223,685	\$ 38,473	\$ 38,473	\$	Various	\$ 159,369	18
19	Vehicles	6,000	500	500		3	6,000	19
20	TOTAL (lines 18 and 19)		\$ 229,685	\$ 38,973	\$ 38,973	\$	\$ 165,369	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 Living of Washington**Report Period Beginning: **01/01/2011**

Ending:

12/31/2011**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2011**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 353,920	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	336,370		3
4	Supply Inventory (priced at)	10,726		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,102		6
7	Other Prepaid Expenses	11,139		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 724,257	\$	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	7,828,979		14
15	Leasehold Improvements, at Historical Cost	129,503		15
16	Equipment, at Historical Cost	229,685		16
17	Accumulated Depreciation (book methods)	(1,303,196)		17
18	Deferred Charges	200,338		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	657,122		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,831,431	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,555,688	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 439,216	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,005		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,926		30
31	Accrued Taxes Payable	130,104		31
32	Accrued Interest Payable	106,555		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Current Portion of LTD	76,046		35
36	Accrued Liabilities	14,615		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 807,467	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,842,199		38
39	Mortgage Payable	4,614,125		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)	\$ 6,456,324	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,263,791	\$	45
46	TOTAL EQUITY	\$ 1,291,897	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,555,688	\$	47

*(See instructions.)

Facility Name: Supportive Living of Washington

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,944,693	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,944,693	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	1,305	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,305	11
C. Non-Operating Revenue			
12	Contributions	690	12
13	Interest and Other Investment Income	3,009	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,699	14
D. Other Revenue (specify):			
15	Cable TV	12,606	15
16	Rental/Miscellaneous	5,100	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 17,706	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,967,403	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	419,039	19
20	Health Care/ Personal Care	290,626	20
21	General Administration	282,150	21
B. Capital Expense			
22	Ownership	955,429	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)	\$ 1,947,244	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 20,159	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 20,159	31

Line 1	Dietary and Food Purchases	(1,305)	offset meal revenue
Line 1	Dietary and Food Purchases	(105)	Offset Vending Machine Income
Line 3	Heat and Utilities	(6,152)	offset cable TV revenue, to the extent of expense
Line 3	Heat and Utilities	(305)	Offset Space Rental
Line 10	Administrative and Clerical	(242)	offset miscellaneous revenue
Line 10	Administrative and Clerical	(2,151)	nonallowable bank charges
Line 10	Administrative and Clerical	(55)	offset late fees and finance charges
Line 13	Insurance - Property, Liab	(4,448)	Offset insurance Gain
		<u>(14,763)</u>	

<u>Related Party</u>	<u>Nature of Services</u>	<u>Cost on Books</u>	<u>Cost to Related Party</u>
Christian Homes, Inc.	Management Services	52,514	52,514

Line 16	Space Rental	305	Offset to Line 3
	Vending Revenue	105	Offset to Line 1
	Miscellaneous Revenue	242	Offset to Line 10
	Insurance Gain	4,448	Offset to Line 13
		<u>5,100</u>	

