

		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.

I. Facility ID Number: 1000031

Facility Name: CAMBRIDGE HOUSE OF OFALLON

Address: 844 CAMBRIDGE BLVD OFALLON 62269

Number City Zip Code

County: ST CLAIR

Telephone Number: (618) 624-9900 Fax # 618 624-9904

Federal Employer ID Number:

Date Current Owners were Certified: 04/16/2004

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT ☐ PROPRIETARY ☐ GOVERNMENTAL

☐ 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: Thomas Staszak Telephone Number: (815) 935-1992

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 01/01/2016 to 12/31/2016 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) David J. Mitchell	
	(Title) CFO, Gardant Management Solutions	
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	

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	100	Single Unit Apartment	100	36,600	1
2	3	Double Unit Apartment	3	1,098	2
3		Other			3
4	103	TOTALS	103	37,698	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	27,041	9,546		36,587	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,041	9,546		36,587	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.05%

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

494 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 3 (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

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 2016 Fiscal Year: 2016

* 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 principle? 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 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.

STATE OF ILLINOIS

Page 3

Facility Name: CAMBRIDGE HOUSE OF OFALLON

ID#:

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	269,643	188,957	1,810	460,410		460,410	1
2	Housekeeping, Laundry and Maintenance	104,263	50,049	59,648	213,960		213,960	2
3	Heat and Other Utilities			156,087	156,087	(27,230)	128,857	3
4	Other (specify): See Page 3 Attachment			43,645	43,645		43,645	4
5	TOTAL General Services	373,906	239,006	261,190	874,102	(27,230)	846,872	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	466,429	14,177		480,606		480,606	6
7	Activities and Social Services	33,457	4,759		38,216		38,216	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	499,886	18,936		518,822		518,822	9
	C. General Administration							
10	Administrative and Clerical	173,979	31,127	359,704	564,810	(34,997)	529,813	10
11	Marketing Materials, Promotions and Advertising	50,633	9,546	33,247	93,426		93,426	11
12	Employee Benefits and Payroll Taxes			263,877	263,877		263,877	12
13	Insurance-Property, Liability and Malpractice			91,326	91,326		91,326	13
14	Other (specify): See Page 3 Attachment			17,269	17,269	(1,021)	16,248	14
15	TOTAL General Administration	224,612	40,673	765,423	1,030,708	(36,018)	994,690	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,098,404	298,615	1,026,613	2,423,632	(63,248)	2,360,384	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			377,381	377,381		377,381	17
18	Interest			400,049	400,049	(22,050)	377,999	18
19	Real Estate Taxes			68,115	68,115		68,115	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,099	8,099		8,099	21
22	Other (specify): See Page 3 Attachment			533,588	533,588		533,588	22
23	TOTAL Ownership			1,387,232	1,387,232	(22,050)	1,365,182	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,098,404	298,615	2,413,846	3,810,865	(85,298)	3,725,567	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	\$ Inc line 1	1
2	Licensed Practical Nurses	1	21.13	2
3	Certified Nurse Assistants	16	10.38	3
4	Activity Director & Assistants	Inc line 12	Inc line 1	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10	10.58	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	3	9.48	10
11	Laundry			11
12	Managers	4	21.51	12
13	Other Administrative	5	19.99	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	Total (lines 1 thru 16)	39	\$	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
CAMBRIDGE HOUSE OF MARYVILLE		MARYVILLE	
CAMBRIDGE HOUSE OF SWANSEA		SWANSEA	

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).

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	Gardant Management Solutions	\$ 226,776	1
2			2
Total		\$ 226,776	3

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES					
<u>Name</u>	<u>1</u>	<u>City</u>	<u>2</u>	<u>Name</u>	<u>3</u>	<u>City</u>	<u>4</u>	<u>Type of Business</u>	<u>5</u>
CAMBRIDGE HOUSE OF MARYVILLE		MARYVILLE							
CAMBRIDGE HOUSE OF SWANSEA		SWANSEA							

Facility Name: CAMBRIDGE HOUSE OF OFALLON ID#: Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,028,000 Year land was acquired 2002

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	103			2003	\$ 8,086,895	\$ 294,684	27.5	\$ 294,069	\$ (615)	\$ 3,860,270	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				236,973	15,487	15	15,798	311	201,383	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)				\$ 8,323,868	\$ 310,171		\$ 309,867	\$ (304)	\$ 4,061,653	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	\$ 829,473	\$ 67,211	\$ 165,895	98,684	5	\$ 727,698	18
19	Vehicles				\$		-	19
20	TOTAL (lines 18 and 19)	\$ 829,473	\$ 67,211	\$ 165,895	98,684		\$ 727,698	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

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	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	IHDA		X	FIRST MORTGAGE	12/01/03	\$ 7,470,000	\$ 6,647,405	08/01/44	.0598	\$ 400,049	1
2					/ /	-		/ /	.0000		2
3					/ /	-		/ /	.0000		3
4						-			.0000		
5						-			.0000		
	Working Capital										
6					/ /				.0000		4
7	TOTAL Facility Related					\$ 7,470,000	\$ 6,647,405			\$ 400,049	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 7,470,000	\$ 6,647,405			\$ 400,049	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

Page 7

Facility Name: CAMBRIDGE HOUSE OF OFALLON

ID#:

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,689,696	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (19,180))	839,412		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,478		6
7	Other Prepaid Expenses	15,473		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	6,026		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,620,084	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,028,000		13
14	Buildings, at Historical Cost	8,086,895		14
15	Leasehold Improvements, at Historical Cost	236,973		15
16	Equipment, at Historical Cost	829,473		16
17	Accumulated Depreciation (book methods)	(4,789,351)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	226,775		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(226,775)		20
21	Restricted Funds	1,658,476		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,050,465	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,670,549	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,558	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,155		30
31	Accrued Taxes Payable	68,783		31
32	Accrued Interest Payable	34,511		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	553,286		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 729,294	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,525,002		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)	\$ 6,525,002	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,254,296	\$	45
46	TOTAL EQUITY	\$ 2,416,254	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,670,549	\$	47

*(See instructions.)

Facility Name: CAMBRIDGE HOUSE OF OFALLON

ID#:

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	\$ 3,658,718	1
2	Discounts and Allowances	(22,188)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,636,530	3
	B. Other Operating Revenue		
4	Special Services	145,907	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	14,362	8
9	Non-Resident Meals	8,357	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 168,626	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	22,050	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 22,050	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	2,807	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,807	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,830,013	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	874,102	19
20	Health Care/ Personal Care	518,822	20
21	General Administration	1,030,708	21
	B. Capital Expense		
22	Ownership	1,387,232	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)	\$ 3,810,865	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 19,148	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 19,148	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,373,790	32
33	Private Pay - Net Inpatient Revenue	2,262,740	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,636,530	37

Expenses PG 3 Other

[illegible]

Balance Sheet

Other Current Assets Detail			Amt	Current Liabilities Detail			Amt
1102-9971-0-0	A/R-Employee Advance	-		2111-0040-0-0	Construction Account Payable	-	
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-		2112-0100-0-0	Accrued Asset Management Fee	5,004	
1102-9973-0-0	A/R-Insurance Reimbursemen	-		2112-0101-0-0	Accrued Partnership Mgmt Fee	25,000	
1102-9974-0-0	A/R-Subscription Receivable	-		2112-0102-0-0	Accrued Incentive Mgmt Fee	484,407	
1102-9975-0-0	A/R-CIP	-		2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-	
1102-9976-0-0	A/R-Other	-		2112-0105-0-0	Accrued Liabilities	22,696	
1102-9978-0-0	A/R-TIF/Abatement	-		2112-0110-0-0	Accrued Insurance	-	
1105-0006-0-0	Security Deposit-Equip & Util	6,026		2112-0115-0-0	Accrued Developer Fee	-	
1105-0009-0-0	Transfer Account	-		2112-0130-0-0	Accrued MIP	-	
1105-0012-0-0	Undeposited Funds	-		2112-0140-0-0	Accrued Vacation	-	
				2112-0144-0-0	Payroll Union Dues	-	
				2112-0146-0-0	Payroll Benefits	-	
				2112-0150-0-0	Security Deposits	-	
				2112-0154-0-0	Unclaimed Property	2,609	
				2112-0155-0-0	Reservation Deposit	-	
				2112-0156-0-0	Buy Down Credit	-	
				2112-0157-0-0	Unapplied Last Month Rent	-	
				2112-0158-0-0	Deferred Gain on Sale	-	
				2112-0159-0-0	Unearned Revenue	13,570	
				2112-0159-1-0	Medicaid Prepayments	-	
				2112-0159-2-0	Prepaid Medicaid Clearing	-	
				2112-0159-3-0	Prepaid Rent	-	
			6,026				553,286
Other Long Term Assets Detail							
1201-0020-0-0	CIP	-					
1201-0021-0-0	CIP- Land Option Addition	-					
1201-0022-0-0	CIP- Other Addition	-					
			-				

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,807
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		2,807