

		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: 1000081

Facility Name: Supportive Living of Wabash

Address: 532 Abelson Drive Carmi 62821

County: White

Telephone Number: (618) 382-2900 Fax # 618 382-8067

Federal Employer ID Number:

Date Current Owners were Certified: 6/26/07

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

X 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: Kenna Hudson Telephone Number: (314 587-7924

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)

(Type or Print Name) Chuck Schmitz

(Title) Chief Financial Officer

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

III. STATISTICAL DATA

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

Date of change in certified units 6/26/2007

	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	49	Single Unit Apartment	49	17,934	1
2		Double Unit Apartment			2
3		Other			3
4	49	TOTALS	49	17,934	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	8,795	7,899		16,694	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,795	7,899		16,694	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.09%

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

622 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 27 (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

ACCRAUAL ☒ 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 Living of Wabash

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	73,218	111,334	1,524	186,076	(948)	185,128	1
2	Housekeeping, Laundry and Maintenance	50,916	9,933	30,596	91,446		91,446	2
3	Heat and Other Utilities			92,743	92,743	(6,170)	86,573	3
4	Other (specify): Trash			837	837		837	4
5	TOTAL General Services	124,134	121,268	125,700	371,101	(7,118)	363,984	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	186,682	1,480	672	188,834		188,834	6
7	Activities and Social Services	31,253	1,503	1,586	34,342		34,342	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	217,935	2,983	2,258	223,176		223,176	9
	C. General Administration							
10	Administrative and Clerical	84,840	2,029	130,019	216,888	(2,347)	214,541	10
11	Marketing Materials, Promotions and Advertising		13,318	480	13,798		13,798	11
12	Employee Benefits and Payroll Taxes			99,124	99,124		99,124	12
13	Insurance-Property, Liability and Malpractice			33,726	33,726		33,726	13
14	Other (specify):							14
15	TOTAL General Administration	84,840	15,347	263,350	363,537	(2,347)	361,190	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	426,908	139,598	391,308	957,814	(9,465)	948,349	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			231,975	231,975		231,975	17
18	Interest			176,471	176,471	(76)	176,395	18
19	Real Estate Taxes			33,178	33,178		33,178	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			23,049	23,049		23,049	22
23	TOTAL Ownership			464,673	464,673	(76)	464,597	23
24	GRAND TOTAL (Sum of lines 16 and 23)	426,908	139,598	855,980	1,422,487	(9,541)	1,412,946	24

Facility Name: Supportive Living of Wabash

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	0.15	\$ 23.35	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.26	11.86	3
4	Activity Director & Assistants	0.96	15.59	4
5	Social Service Workers			5
6	Head Cook	1.07	13.46	6
7	Cook Helpers/Assistants	2.20	9.47	7
8	Dishwashers			8
9	Maintenance Workers	0.93	16.26	9
10	Housekeepers	0.99	9.41	10
11	Laundry			11
12	Managers	1.00	27.92	12
13	Other Administrative	1.04	12.22	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15.60	\$ 13.14	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
Christian Homes, Inc.		Lincoln	

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

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 Wabash

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land 17,000 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	47		2011 & Prior	2006	\$ 5,985,540	\$ 199,743	10-30	\$ 199,743	\$	\$ 1,895,676	1
2			2012		5,240	623	5-10	623		2,869	2
3			2013		5,812	1,013	5	1,013		3,149	3
4			2014		10,917	2,019	5-10	2,019		5,491	4
5			2015/2016		59,644	4,590	5-10	4,590		5,193	5
	Improvement Type										
6	VARIOUS			2007	88,326	5,888		5,888		55,940	6
7	Striping and Coating			2010	1,253					1,253	7
8	Concrete Walking Path			2013	4,150	277		277		991	8
9	Landscaping			2013	2,959	592		592		1,923	9
10	Landscaping			2014	5,804	1,161		1,161		3,192	10
11	Concrete Slab for Gazebo			2014	1,552	103		103		267	11
12	Asphalt Reseal & Striping			2014	1,689	211		211		510	12
13	Gazebo			2014	4,890	611		611		1,579	13
14	Concrete & Landscaping			2015	1,996	100		100		108	14
15	Bocce Ball Court			2016	8,954	187		187		187	15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,188,726	\$ 217,118		\$ 217,118	\$	\$ 1,978,328	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	\$ 399,352	\$ 14,857	\$ 14,857	\$	VARIOUS	\$ 324,830	18
19	Vehicles	50,639				VARIOUS	50,639	19
20	TOTAL (lines 18 and 19)	\$ 449,991	\$ 14,857	\$ 14,857	\$		\$ 375,468	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 Wabash

Report Period Beginning: 01/01/2016 Ending: 2/31/2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NA

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	\$ 4,800,000	\$ 4,569,730	10/1/48	3.7300	\$ 171,951	1
2	HUD - NOTE PAY	X		Refinance - Startup Construction	9/1/13	750,000	500,000	10/1/48			2
3			X	Deferred Tax Cred Fees & Org Costs	/ /	86,840	64,534	/ /		4,520	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,636,840	\$ 5,134,264			\$ 176,471	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,636,840	\$ 5,134,264			\$ 176,471	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: Supportive Living of Wabash

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	\$ 260,927	\$	1
2	Cash-Patient Deposits	1,998		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	292,925		3
4	Supply Inventory (priced at)	1,416		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,043		6
7	Other Prepaid Expenses	9,733		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 594,043	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,000		13
14	Buildings, at Historical Cost	6,067,153		14
15	Leasehold Improvements, at Historical Cost	121,572		15
16	Equipment, at Historical Cost	449,991		16
17	Accumulated Depreciation (book methods)	(2,353,799)		17
18	Deferred Charges	637		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	439,597		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction in Progress</u>	750		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,742,902	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,336,944	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,039		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	<u>Accrued Real Estate Taxes</u>	25,290		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 74,329	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	500,000		38
39	Mortgage Payable	4,569,730		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Accrued Liabilities/Deferred Org Costs</u>	(52,161)		42
43	<u>Security Deposit Payable</u>	1,998		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,019,567	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,093,896	\$	45
46	TOTAL EQUITY	\$ 243,048	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,336,944	\$	47

*(See instructions.)

Facility Name: Supportive Living of Wabash

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	\$ 1,556,285	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,556,285	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	829	8
9	Non-Resident Meals	948	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,777	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	202	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 202	14
	D. Other Revenue (specify):		
15			15
16	Other Miscellaneous Revenue	548	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 548	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,558,812	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	371,101	19
20	Health Care/ Personal Care	223,176	20
21	General Administration	363,537	21
	B. Capital Expense		
22	Ownership	464,673	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)	\$ 1,422,487	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 136,326	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 136,326	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 836,109	32
33	Private Pay - Net Inpatient Revenue	597,928	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Tax Credit</u>	122,248	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,556,285	37