

		FOR BHF USE			

LL2

Supportive Living Facility

2017

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2017)

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: 1000141

Facility Name: EAGLES VIEW MEMORY CARE

Address: 200 W INTERNATIONAL RANTOUL 61866

Number City Zip Code

County: CHAMPAIGN

Telephone Number: (217) 892-2800 Fax # 217 892-2833

Federal Employer ID Number:

Date Current Owners were Certified: 2/21/2017

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 01/01/2017 to 12/31/2017 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) Greg Echols	
	(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	116	Single Unit Apartment	116	42,340	1
2		Double Unit Apartment			2
3		Other			3
4	116	TOTALS	116	42,340	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	5,004	8,964		13,968	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,004	8,964		13,968	8

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

32.99%

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

12

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

(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?

X

YES

NO

Tax Year:

2017

Fiscal Year:

2017

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding?

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: EAGLES VIEW MEMORY CARE

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	136,487	113,117	2,395	251,999		251,999	1
2	Housekeeping, Laundry and Maintenance	78,962	32,530	29,431	140,923		140,923	2
3	Heat and Other Utilities			222,665	222,665		222,665	3
4	Other (specify): See Page 3 Attachment			16,760	16,760		16,760	4
5	TOTAL General Services	215,449	145,647	271,251	632,347		632,347	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	459,506	5,939		465,445		465,445	6
7	Activities and Social Services	20,928	4,935		25,863		25,863	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	480,434	10,874		491,308		491,308	9
	C. General Administration							
10	Administrative and Clerical	111,739	19,687	457,556	588,982	(1,529)	587,453	10
11	Marketing Materials, Promotions and Advertising	42,205	9,442	17,005	68,652		68,652	11
12	Employee Benefits and Payroll Taxes			190,649	190,649		190,649	12
13	Insurance-Property, Liability and Malpractice			46,643	46,643		46,643	13
14	Other (specify): See Page 3 Attachment			15,219	15,219	(7,088)	8,131	14
15	TOTAL General Administration	153,944	29,129	727,072	910,145	(8,617)	901,528	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	849,827	185,650	998,323	2,033,800	(8,617)	2,025,183	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			5,956	5,956		5,956	17
18	Interest			2,123	2,123	(44)	2,079	18
19	Real Estate Taxes			49,323	49,323		49,323	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,159	7,159		7,159	21
22	Other (specify):							22
23	TOTAL Ownership			64,561	64,561	(44)	64,517	23
24	GRAND TOTAL (Sum of lines 16 and 23)	849,827	185,650	1,062,884	2,098,361	(8,661)	2,089,700	24

Facility Name: EAGLES VIEW MEMORY CARE

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 12	1
2	Licensed Practical Nurses	1	22.04	2
3	Certified Nurse Assistants	13	11.90	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	5	10.69	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	1	9.86	10
11	Laundry			11
12	Managers	4	22.19	12
13	Other Administrative	2	18.21	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	Total (lines 1 thru 16)	26	\$	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

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).

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	\$ 81,019	1
2			2
Total		\$ 81,019	3

Ending: 12/31/2017

	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: EAGLES VIEW MEMORY CARE

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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 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				\$			7

8. Is movable equipment rental included in building rental? ☐ YES ☐ NO☐ 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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related Long-Term										
1					\$		\$				1
2											2
3											3
	Working Capital										
4	Line of Credit				/ /		172,000	/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 172,000			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 172,000			\$	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: EAGLES VIEW MEMORY CARE

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 83,342	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (38,694))	403,668		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,954		6
7	Other Prepaid Expenses	7,402		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 516,365	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,675		16
17	Accumulated Depreciation (book methods)	(12,696)		17
18	Deferred Charges			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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,978	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 519,343	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,023	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	172,000		29
30	Accrued Salaries Payable	31,493		30
31	Accrued Taxes Payable	185,959		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	794,401		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,207,876	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,125,813		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)	\$ 1,125,813	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,333,689	\$	45
46	TOTAL EQUITY	\$ (1,814,346)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 519,343	\$	47

*(See instructions.)

Facility Name: EAGLES VIEW MEMORY CARE

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	\$ 1,538,222	1
2	Discounts and Allowances	(29,800)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,508,422	3
	B. Other Operating Revenue		
4	Special Services	19,410	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,529	8
9	Non-Resident Meals	8,472	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 29,411	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	44	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 44	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	6,287	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,287	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,544,164	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	632,347	19
20	Health Care/ Personal Care	491,308	20
21	General Administration	910,145	21
	B. Capital Expense		
22	Ownership	64,561	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)	\$ 2,098,361	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (554,197)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (554,197)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 450,967	32
33	Private Pay - Net Inpatient Revenue	1,057,455	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,508,422	37

Expenses PG 3 Other

	General Services Other		Health Care & Programs		General Administration Other		Amt	Ownership Other		Amt
5200-5000-0-0	Operating Allocation	-		5160-5060-0-0	Consulting	-		9100-9101-0-0	Interest & Dividend Income	-
5200-5124-0-0	Exterminating	4,650		5160-5063-0-0	Legal	3,917		9100-9102-0-0	Assessment Income	-
5200-5127-0-0	Rubbish Removal	6,157		5160-5064-0-0	Accounting	155		9100-9103-0-0	Assessment Expense	-
5200-5130-0-0	Vehicle Expense	1,578		5160-5066-0-0	Audit	-		9200-9201-1-0	Amortization - Loan Fees	-
5200-5131-0-0	Transportation Service	-		5160-5067-0-0	Contract Labor-Serv Prov	-		9200-9202-0-0	Financing Fees	-
5300-5140-0-0	Security & Monitoring	4,375		5160-5068-0-0	Contract Labor	4,059		9200-9203-1-0	Mortgage Interest Premium	-
				5180-5079-0-0	Bad Debt - Resident	789		9200-9204-0-0	Mortgage Service Fee	-
				5180-5079-1-0	Bad Debt - Resident - Recovery	-		9200-9205-0-0	Mortgage Insurance Prem	-
				5180-5080-0-0	Bad Debt - Resident Prior Period	-		9200-9206-0-0	Participation Fee	-
				5180-5081-0-0	Bad Debt - Medicaid Pending Denial	6,300		9200-9207-0-0	Letter of Credit Fee	-
				5180-5081-1-0	Bad Debt - Medicaid Pending - Recovery	-		9200-9208-0-0	Bond & Draw Fee	-
				5180-5082-0-0	Bad Debt - Medicaid Denial Prior Period	-		9200-9209-0-0	Remarketing and Trustee Fee	-
				5180-5083-0-0	Bad Debt - Medicaid MCO	-		9200-9210-0-0	Interest Expense-Note	-
				5190-5000-0-0	Other Admin Allocation	-		9200-9211-0-0	Interest Expense-LP	-
								9200-9212-0-0	Debt Write-Off	-
								9300-9301-0-0	Partnership Management Fee	-
								9300-9302-0-0	Asset Management Fee	-
								9300-9303-0-0	Incentive Management	-
								9300-9303-1-0	Incentive Asset Mgmt Fee	-
								9300-9304-0-0	Tax Credit Fees & Incentive Fee	-
								9300-9305-0-0	Organizational Expense	-
								9300-9306-0-0	Developer Fees	-
								9300-9307-0-0	Closing Costs	-
								9700-9702-0-0	Amortization Expense	-
								9900-9901-0-0	Prior Period Adjustments	-
								9900-9902-0-0	Dissolution of Business	-
								9900-9903-0-0	Loss (Gain) on Sale of Assets	-
								9900-9904-0-0	Business Interruption	-
								9900-9905-0-0	Settlement	-
								9900-9906-0-0	Property Damage Loss	-
								9900-9907-0-0	Abandonment Loss	-
								9900-9908-0-0	Grant Income	-
								9900-9909-0-0	Misc: Title, Recording, Transfe	-
		16,760	-				15,219			

Balance Sheet PG 7 Other
Balance Sheet PG 7 Other, See Attachment

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	-	
1102-9973-0-0	A/R-Insurance Reimbursemen	-		2112-0101-0-0	Accrued Partnership Mgmt Fee	-	
1102-9974-0-0	A/R-Subscription Receivable	-		2112-0102-0-0	Accrued Incentive Mgmt Fee	-	
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	743,941	
1102-9978-0-0	A/R-TIF/Abatement	-		2112-0110-0-0	Accrued Insurance	-	
1105-0006-0-0	Security Deposit-Equip & Util	-		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	18,837	
				2112-0154-0-0	Unclaimed Property	-	
				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	31,624	
				2112-0159-1-0	Medicaid Prepayments	-	
				2112-0159-2-0	Prepaid Medicaid Clearing	-	
				2112-0159-3-0	Prepaid Rent	-	
			-				794,401
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 PG 8 Other

Income Statement PG 8 Other, See Attachment

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	2,244
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	4,043
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,287