

		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: 1000096

Facility Name: HERITAGE WOODS OF MOLINE

Address: 5500 46TH AVENUE DR MOLINE 61265

Number City Zip Code

County: ROCK ISLAND

Telephone Number: (309) 736-5655 Fax # 309 736-5651

Federal Employer ID Number:

Date Current Owners were Certified: 11/17/2008

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	
Paid Preparer	(Title)	CFO, Gardant Management Solutions	
	(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

Facility Name **HERITAGE WOODS OF MOLINE**

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

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	99	Single Unit Apartment	99	36,135	1		
2		Double Unit Apartment			2		
3		Other			3		
4	99	TOTALS	99	36,135	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	25,335	8,589		33,924	5
6	Double Unit					6
7	Other					7
8	TOTALS	25,335	8,589		33,924	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.88%

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

328 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **9** (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	☒	MODIFIED		
CASH*	☐	CASH*	☐	

I. Is your fiscal year identical to your tax year? ☒ 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? 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: HERITAGE WOODS OF MOLINE

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	240,985	188,284	2,425	431,694		431,694	1
2	Housekeeping, Laundry and Maintenance	97,348	26,832	25,309	149,489		149,489	2
3	Heat and Other Utilities			115,118	115,118	(22,817)	92,301	3
4	Other (specify):			48,268	48,268		48,268	4
5	TOTAL General Services	338,333	215,116	191,120	744,569	(22,817)	721,752	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	441,400	11,040		452,440		452,440	6
7	Activities and Social Services	30,308	4,490		34,798		34,798	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	471,708	15,530		487,238		487,238	9
	C. General Administration							
10	Administrative and Clerical	186,731	23,201	300,636	510,568	(32,691)	477,877	10
11	Marketing Materials, Promotions and Advertising	52,826	8,258	41,031	102,115		102,115	11
12	Employee Benefits and Payroll Taxes			262,540	262,540		262,540	12
13	Insurance-Property, Liability and Malpractice			42,446	42,446		42,446	13
14	Other (specify):			328,929	328,929	(60,405)	268,524	14
15	TOTAL General Administration	239,557	31,459	975,582	1,246,598	(93,096)	1,153,502	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,049,598	262,105	1,166,701	2,478,404	(115,913)	2,362,491	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			435,966	435,966		435,966	17
18	Interest			366,124	366,124	(583)	365,541	18
19	Real Estate Taxes			92,527	92,527		92,527	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,864	7,864		7,864	21
22	Other (specify):			1,252,620	1,252,620		1,252,620	22
23	TOTAL Ownership			2,155,101	2,155,101	(583)	2,154,518	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,049,598	262,105	3,321,802	4,633,505	(116,496)	4,517,009	24

Facility Name: HERITAGE WOODS OF MOLINE

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	21.87	2
3	Certified Nurse Assistants	15	10.55	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	9	10.16	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	9.76	10
11	Laundry			11
12	Managers	5	21.14	12
13	Other Administrative	4	22.99	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)	37	\$	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

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	\$ 176,143	1
2			2
Total		\$ 176,143	3

OTHER RELATED BUSINESS ENTITIES				
Name	3	City	4	Type of Business 5

Facility Name: HERITAGE WOODS OF MOLINE Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ 158,031 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	99			2008	\$ 11,250,598	\$ 408,879	28	\$ 401,807	\$ (7,072)	\$ 3,992,402	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				265,361	15,656	15	17,691	2,034	178,536	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)				\$ 11,515,959	\$ 424,536		\$ 419,498	\$ (5,038)	\$ 4,170,938	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	\$ 676,434	\$ 11,431	\$ 135,287	123,856	5	\$ 640,155	18
19	Vehicles				\$		-	19
20	TOTAL (lines 18 and 19)	\$ 676,434	\$ 11,431	\$ 135,287	123,856		\$ 640,155	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: HERITAGE WOODS OF MOLINE

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		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	AMALGAMATED BANK		X	FIRST MORTGAGE / BOND	12/14/2006	\$ 10,870,000	\$	12/1/2041	0.0600	\$ 69,055	1	
2	LANCASTER POLLARD		X	FIRST MORTGAGE / BOND	1/1/2017	10,479,500		10,348,226	1/1/2052	0.0342	297,069	2
3											3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 21,349,500	\$ 10,348,226			\$ 366,124	7	
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 21,349,500	\$ 10,348,226			\$ 366,124	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: HERITAGE WOODS OF MOLINE

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	\$ 706,378	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (122,028))	622,871		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,004		6
7	Other Prepaid Expenses	6,250		7
8	Accounts Receivable (owners or related parties)	767		8
9	Other(specify):	1,957		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,365,226	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	158,031		13
14	Buildings, at Historical Cost	11,250,598		14
15	Leasehold Improvements, at Historical Cost	265,361		15
16	Equipment, at Historical Cost	676,434		16
17	Accumulated Depreciation (book methods)	(4,811,093)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	22,451		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(21,881)		20
21	Restricted Funds	893,844		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,433,745	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,798,971	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,561	\$	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	93,120		31
32	Accrued Interest Payable	29,492		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	655,944		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 812,118	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,074,062		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)	\$ 10,074,062	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,886,180	\$	45
46	TOTAL EQUITY	\$ (1,087,209)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,798,971	\$	47

*(See instructions.)

Facility Name: HERITAGE WOODS OF MOLINE

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	\$ 3,537,806	1
2	Discounts and Allowances	(17,441)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,520,365	3
	B. Other Operating Revenue		
4	Special Services	102,542	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	12,393	8
9	Non-Resident Meals	1,719	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 116,654	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	583	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 583	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	4,729	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 4,729	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,642,331	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	744,569	19
20	Health Care/ Personal Care	487,238	20
21	General Administration	1,246,598	21
	B. Capital Expense		
22	Ownership	2,155,101	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)	\$ 4,633,505	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (991,174)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (991,174)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,417,211	32
33	Private Pay - Net Inpatient Revenue	2,103,154	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,520,365	37

Expenses PG 3 Other

[illegible]

Balance Sheet PG 7 Other

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	50,000	
1102-9974-0-0	A/R-Subscription Receivable	-		2112-0102-0-0	Accrued Incentive Mgmt Fee	509,335	
1102-9975-0-0	A/R-CIP	-		2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-	
1102-9976-0-0	A/R-Other	92		2112-0105-0-0	Accrued Liabilities	21,093	
1102-9978-0-0	A/R-TIF/Abatement	-		2112-0110-0-0	Accrued Insurance	-	
1105-0006-0-0	Security Deposit-Equip & Util	1,864		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	371	
				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	75,145	
				2112-0159-1-0	Medicaid Prepayments	-	
				2112-0159-2-0	Prepaid Medicaid Clearing	-	
				2112-0159-3-0	Prepaid Rent	-	
			1,957				655,944
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		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	504
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	4,225
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		4,729