

		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: 1000050

Facility Name: Rockford Supportive Lvg Ctr

Address: 2114 Kishwaukee St Rockford 61104

Number City Zip Code

County: Winnebago

Telephone Number: (815) 966-1030 Fax #

Federal Employer ID Number:

Date Current Owners were Certified: 1/1/2016

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: Steven N. Lavenda Telephone Number: (847) 282 - 6300

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 1/1/2017 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	* Subject to the attached Accountants' Consulting Report	
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) _____	Fax (847) 282-6301

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 Rockford Supportive Lvg Ctr Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	123	Single Unit Apartment	123	44,895	1
2	13	Double Unit Apartment	13	4,745	2
3		Other			3
4	136	TOTALS	136	49,640	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	33,599	2,578		36,177	5
6	Double Unit					6
7	Other					7
8	TOTALS	33,599	2,578		36,177	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 72.88%

D. Indicate the number of paid bed-hold days the SLF had during this year None Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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)
None

H. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO
Tax Year: 12/31/17 Fiscal Year: 12/31/17
* 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. _____

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. _____

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. _____

Facility Name: Rockford Supportive Lvg Ctr

Report Period Beginning:

1/1/2017

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	199,695	238,841	3,369	441,905		441,905	1
2	Housekeeping, Laundry and Maintenance	138,776	44,673	97,412	280,861	6,471	287,332	2
3	Heat and Other Utilities			122,732	122,732	736	123,468	3
4	Other (specify):							4
5	TOTAL General Services	338,471	283,514	223,513	845,498	7,207	852,705	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	750,998	9,282		760,280	3,450	763,730	6
7	Activities and Social Services	63,145	2,100	4,290	69,535		69,535	7
8	Other (specify):					637	637	8
9	TOTAL Health Care and Programs	814,143	11,382	4,290	829,815	4,087	833,902	9
	C. General Administration							
10	Administrative and Clerical	197,786	5,932	214,490	418,208	(102,623)	315,585	10
11	Marketing Materials, Promotions and Advertising	63,645		14,548	78,193	282	78,475	11
12	Employee Benefits and Payroll Taxes			245,053	245,053		245,053	12
13	Insurance-Property, Liability and Malpractice			60,112	60,112	1,486	61,598	13
14	Other (specify):					12,230	12,230	14
15	TOTAL General Administration	261,431	5,932	534,203	801,566	(88,625)	712,941	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,414,045	300,828	762,006	2,476,879	(77,331)	2,399,548	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					292,095	292,095	17
18	Interest					383,439	383,439	18
19	Real Estate Taxes			92,148	92,148		92,148	19
20	Rent -- Facility and Grounds			887,184	887,184	(881,124)	6,060	20
21	Rent -- Equipment			4,612	4,612		4,612	21
22	Other (specify):							22
23	TOTAL Ownership			983,944	983,944	(205,590)	778,354	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,414,045	300,828	1,745,950	3,460,823	(282,921)	3,177,902	24

STATE OF ILLINOIS		Page 3A
Rockford Supportive Lvg Ctr		
Report Period Beginning:	1/1/2017	
Ending:	12/31/2017	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Non-Straight Line Depreciation	\$ (443,520)	17 1
2		2
3 Bank Charges	(5,250)	10 3
4 Cable Service	(11,124)	2 4
5 Meals & Entertainment	(160)	10 5
6 Use Tax	(27.0)	10 6
7 Capitalized R&M	(13,960)	02 7
8		8
9 MANAGEMENT OFFICE ALLOCATION		9
10 Housekeeping/Maint/Laundry	510	2 10
11 Utilities	736	3 11
12 Health Care/Personal Care	3,456	6 12
13 Health Care Emp Ben/Payroll Taxes	637	8 13
14 Administrative and General	83,104	10 14
15 Advertising and Marketing	282	11 15
16 Insurance	1,486	13 16
17 Admin Emp Benefits & Payroll Taxes	12,230	14 17
18 Building Rental	6,060	20 18
19 Management Office Allocation	(180,027)	10 19
20		20
21 BUILDING COMPANY		21
22 Rent	(807,184)	20 22
23 Interest Expense	383,435	18 23
24 Depreciation and Amortization	735,623	17 24
25 Asset Management Fee	31,051	02 25
26		26
27		27
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99		99
100		100
101 Total	(282,921)	101

Facility Name: Rockford Supportive Lvg Ctr

Report Period Beginning 1/1/2017 Ending: 12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	4.90	\$ 31.20	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	18.28	11.39	3
4	Activity Director & Assistants	2.12	14.30	4
5	Social Service Workers			5
6	Head Cook	1.02	18.99	6
7	Cook Helpers/Assistants	7.53	10.20	7
8	Dishwashers			8
9	Maintenance Workers	1.18	18.73	9
10	Housekeepers	4.36	10.22	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.10	32.87	13
14	Clerical	3.10	19.08	14
15	Marketing	1.07	28.64	15
16	Other			16
17	Total (lines 1 thru 16)	44.65	\$ 15.23	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
Coles SLF		Chicago, IL	
Jackson Park SLF		Chicago, IL	
Robbins SLF		Robbins, IL	

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	\$	1
2			2
Total		\$	3

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Grand Lifestyles		Skokie, IL		Management Co	
Rockford SLF Realty		Rockford, IL		Building Co	
Grand at Twin Lakes		Palatine, IL		Ind Living	

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: N/A If yes, what is the value of those services? \$ N/A

(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: Rockford Supportive Lvg Ctr Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land 550,000 Year land was acquired 2016

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	136		2016	2005	\$ 4,400,000	\$ 735,623	35	\$ 125,714	\$ (609,909)	\$ 251,428	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				13,966			698	698	698	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)				\$ 4,413,966	\$ 735,623		\$ 126,413	\$ (609,210)	\$ 252,126	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	\$ 1,656,824	\$	\$ 165,682	165,682		\$ 330,682	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 1,656,824	\$	\$ 165,682	165,682		\$ 330,682	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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2	2017	6,502		20	325	325	325	2
3	2017	3,646		20	182	182	182	3
4	2017	3,818		20	191	191	191	4
5								5
6								6
7								7
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10								10
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30								30
31								31
32								32
33								33
34		\$ 13,966	\$		\$ 698	\$ 698	\$ 698	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Rockford Supportive Lvg Ctr

Report Period Beginning: 1/1/2017

Ending: 2/31/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☐ NO
3	Original Building			/ /	\$			3	9. Rental amount for movable equipment \$ 4,612
4	Additions			/ /				4	
5				/ /				5	
6	Allocated from Grand Lifestyles			/ /	6,060			6	
7	TOTAL				\$ 6,060			7	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	MB Financial		X	Mortgage	/ /	\$	8,414,729	/ /		\$ 383,439	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	8,414,729			\$ 383,439	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	8,414,729			\$ 383,439	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: Rockford Supportive Lvg Ctr

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 242,712	\$ 488,421	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	345,069	345,069	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	88,247	108,247	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	46,888	181,047	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 722,916	\$ 1,122,784	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		550,000	13
14	Buildings, at Historical Cost		4,382,624	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,824	1,674,200	16
17	Accumulated Depreciation (book methods)		(1,471,245)	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): See Attached	77,691	4,477,691	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 84,515	\$ 9,613,270	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 807,431	\$ 10,736,054	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 54,552	\$ 181,278	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,644	65,644	30
31	Accrued Taxes Payable	100,451	100,451	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	13,856	58,221	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 234,503	\$ 405,594	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		8,414,729	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43	See Attached	15,049	15,049	43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 15,049	\$ 8,429,778	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 249,552	\$ 8,835,372	45
46	TOTAL EQUITY	\$ 557,879	\$ 1,900,682	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 807,431	\$ 10,736,054	47

*(See instructions.)

Facility Name: Rockford Supportive Lvg Ctr

Report Period Beginning: 1/1/2017

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	\$ 3,603,507	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,603,507	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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,603,507	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	845,498	19
20	Health Care/ Personal Care	829,815	20
21	General Administration	801,566	21
	B. Capital Expense		
22	Ownership	983,944	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)	\$ 3,460,823	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 142,684	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 142,684	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,138,395	32
33	Private Pay - Net Inpatient Revenue	1,465,112	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,603,507	37