

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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

County: Champaign

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

Federal Employer ID Number:

Date Current Owners were Certified: 2/21/17

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2019 to 12/31/2019 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) Ari Haas

(Title)

Paid Preparer

(Signed)

(Print Name and Title) Jacob Karmel

(Firm Name & Address) Apex Global Solutions

(Telephone) (845) 490-6060 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

In the event there are further questions about this report, please contact:

Name: Shlomo Brisk

Telephone Number: (845) 579-6565

Email Address:

HFS 3745C (N-4-05)

IL478-2471

Facility Name Eagles View Memory Care

Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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	<u>100</u>	Single Unit Apartment	<u>100</u>	<u>36,500</u>	1
2	<u>16</u>	Double Unit Apartment	<u>16</u>	<u>5,840</u>	2
3		Other		<u>1,825</u>	3
4	<u>116</u>	TOTALS	<u>116</u>	<u>44,165</u>	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	<u>15,949</u>	<u>4,500</u>		<u>20,449</u>	5
6	Double Unit	<u>365</u>			<u>365</u>	6
7	Other	<u>365</u>			<u>365</u>	7
8	TOTALS	<u>16,679</u>	<u>4,500</u>		<u>21,179</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 47.95%

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

422 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 45 (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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2019 Fiscal Year: 2019

* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

STATE OF ILLINOIS

Page 3

Facility Name: Eagles View Memory Care

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	131,083	128,741	20,514	280,338		280,338	1
2	Housekeeping, Laundry and Maintenance	91,247	47,209	18,596	157,052		157,052	2
3	Heat and Other Utilities			210,303	210,303		210,303	3
4	Other (specify):			12,937	12,937		12,937	4
5	TOTAL General Services	222,330	175,950	262,350	660,630		660,630	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	482,305	18,292	3,256	503,853		503,853	6
7	Activities and Social Services	37,910	8,956	4,701	51,567		51,567	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	520,215	27,248	7,957	555,419		555,419	9
	C. General Administration							
10	Administrative and Clerical	156,573	10,742	194,839	362,154	(3,686)	358,469	10
11	Marketing Materials, Promotions and Advertising	52,018	6,942	2,663	61,624		61,624	11
12	Employee Benefits and Payroll Taxes	68,839		113,825	182,663		182,663	12
13	Insurance-Property, Liability and Malpractice			48,068	48,068		48,068	13
14	Other (specify):			35,020	35,020	(35,020)		14
15	TOTAL General Administration	277,430	17,685	394,416	689,530	(38,706)	650,824	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,019,974	220,882	664,723	1,905,579	(38,706)	1,866,874	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			2,733	2,733		2,733	17
18	Interest			6,011	6,011		6,011	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			720,000	720,000		720,000	20
21	Rent -- Equipment			8,658	8,658		8,658	21
22	Other (specify):							22
23	TOTAL Ownership			737,402	737,402		737,402	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,019,974	220,882	1,402,125	2,642,981	(38,706)	2,604,276	24

Landlord is a

Expenses PG 3 Other

General Services Other	
8250-040-00 Maintenance Exp>Sanitation & Incineration	9,104
8250-041-00 Maintenance Exp>Extermination	3,833
	12,937

Reclassifications & Adjustments	
8010-076-00 Admin Exp>Bank Fees	3,686
8410-000-00 Bad Debt Exp	35,020
	38,706

General Administration Other	
8410-000-00 Bad Debt Exp	35,020
	35,020

Facility Name: Eagles View Memory Care

Report Period Beginning 1/1/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	2	25.16	2
3	Certified Nurse Assistants	12	12.06	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	18.51	5
6	Head Cook			6
7	Cook Helpers/Assistants	4	11.31	7
8	Dishwashers			8
9	Maintenance Workers	1	13.04	9
10	Housekeepers	1	10.01	10
11	Laundry			11
12	Managers	4	30.01	12
13	Other Administrative	1	19.68	13
14	Clerical	1	13.46	14
15	Marketing	1	26.44	15
16	Other			16
17	Total (lines 1 thru 16)	28	\$	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

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).

PG 4 Related Parties

Related Party Realty	
9376-000-00 Rent Exp	720,000
	720,000

Facility Name: Eagles View Memory Care

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

VIII. OWNERSHIP COSTS**A. Purchase price of land** _____ **Year land was acquired** _____**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	116				\$	\$	28	\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements						15				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)				\$	\$		\$	\$	\$	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	\$ 21,405	\$ 1,677	\$ 1,677	\$	10	\$ 17,954	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 21,405	\$ 1,677	\$ 1,677	\$		\$ 17,954	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: Eagles View Memory Care

Report Period Beginning: 1/1/2019

Ending: 2/31/2019

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

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					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Line of Credit				/ /		182,275	/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 182,275			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 182,275			\$	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: 1/1/2019

Ending: 12/31/2019

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 51,424	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (98,135))	477,278		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,089		6
7	Other Prepaid Expenses	4,928		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 553,719	\$	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	54,671		15
16	Equipment, at Historical Cost	21,405		16
17	Accumulated Depreciation (book methods)	(19,314)		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)	\$ 56,763	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 610,482	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,293	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,512		28
29	Short-Term Notes Payable	242,667		29
30	Accrued Salaries Payable	186,654		30
31	Accrued Taxes Payable	193,459		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	99,544		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 981,129	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,504,313		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)	\$ 2,504,313	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,485,442	\$	45
46	TOTAL EQUITY	\$ (2,874,960)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 610,482	\$	47

*(See instructions.)

Balance Sheet PG 7 Other

Current Liabilities	
2011-209-00 AR Related Payables>Other Payor	30,922
2025-000-00 Other Accrued	47,786
2025-064-00 Other Accrued>Accounting Fees	1,000
2025-208-00 Other Accrued>Insurance	9,216
2040-000-00 Due To/(From)	620
2040-000-90 Due To/(From)>Realty	(25,000)
2040-940-00 Due To/(From)>Related Parties	35,000
	99,544

Facility Name: Eagles View Memory Care

Report Period Beginning: 1/1/2019

Ending:

12/31/2019

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	\$ 2,321,774	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,321,774	3
	B. Other Operating Revenue		
4	Special Services	59,815	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	416	8
9	Non-Resident Meals	45	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 60,276	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	8	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8	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)	\$ 2,382,058	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	660,630	19
20	Health Care/ Personal Care	555,419	20
21	General Administration	689,530	21
	B. Capital Expense		
22	Ownership	737,402	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)	\$ 2,642,981	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (260,923)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (260,923)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,708,474	32
33	Private Pay - Net Inpatient Revenue	613,300	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,321,774	37