

		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: 1000022

Facility Name: Quincy Sen & Fam Resource Ct

Address: 639 York Quincy 62301

County: Adams

Telephone Number: (217) 592-3668 Fax # 217 592-3732

Federal Employer ID Number:

Date Current Owners were Certified:

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

☒ 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: Marcia Strother Telephone Number: (217 223-7904 ext 123

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 01/01/2019 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) Michael Drew

(Title) General and managing partner

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

Facility Name Quincy Sen & Fam Resource Ct

Report Period Beginning: 01/01/2019 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	51	Single Unit Apartment	51	18,615	1		
2	6	Double Unit Apartment	6	2,190	2		
3		Other		730	3		
4	57	TOTALS	57	21,535	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	15,218	2,521		17,739	5
6	Double Unit	1,286			1,286	6
7	Other					7
8	TOTALS	16,504	2,521		19,025	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.34%

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

246 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **49 (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

ACCUAL		MODIFIED	
		CASH*	CASH*
	X		

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

Tax Year: Jan - Dec **Fiscal Year:** Jan - Dec

* 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: Quincy Sen & Fam Resource Ct

Report Period Beginning:

01/01/2019

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		139,216		139,216		139,216	1
2	Housekeeping, Laundry and Maintenance	47,538	30,686	34,879	113,103		113,103	2
3	Heat and Other Utilities			62,948	62,948	(11,285)	51,663	3
4	Other (specify): waste removal and pest control			7,817	7,817		7,817	4
5	TOTAL General Services	47,538	169,902	105,644	323,084	(11,285)	311,799	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	459,484	2,222	4,124	465,831		465,831	6
7	Activities and Social Services	27,296	20,914	26,151	74,361		74,361	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	486,780	23,137	30,274	540,192		540,192	9
	C. General Administration							
10	Administrative and Clerical	69,263	28,781	82,251	180,296		180,296	10
11	Marketing Materials, Promotions and Advertising			540	540		540	11
12	Employee Benefits and Payroll Taxes	287,246			287,246		287,246	12
13	Insurance-Property, Liability and Malpractice		31,114		31,114		31,114	13
14	Other (specify): Audit expense and bad debt uncol rent			21,961	21,961		21,961	14
15	TOTAL General Administration	356,509	59,895	104,752	521,157		521,157	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	890,828	252,934	240,670	1,384,432	(11,285)	1,373,147	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			251,650	251,650		251,650	17
18	Interest			224,317	224,317		224,317	18
19	Real Estate Taxes			110,000	110,000		110,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): mortgage insurance amortization			19,393	19,393		19,393	22
23	TOTAL Ownership			605,359	605,359		605,359	23
24	GRAND TOTAL (Sum of lines 16 and 23)	890,828	252,934	846,030	1,989,792	(11,285)	1,978,507	24

Facility Name: Quincy Sen & Fam Resource Ct

Report Period Beginning: 01/01/2019 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	5	12.80	2
3	Certified Nurse Assistants	14	9.96	3
4	Activity Director & Assistants	1	12.92	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	3	9.70	10
11	Laundry			11
12	Managers	1	20.78	12
13	Other Administrative	1	13.42	13
14	Clerical			14
15	Marketing			15
16	Other CGA	6	8.91	16
17	Total (lines 1 thru 16)	30	\$	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
West Central Illinois Area Agency on Aging	Quincy, 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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	West Central Illinois Area Agency on Aging	\$ 75,615	1
2			2
Total		\$ 75,615	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: Quincy Sen & Fam Resource Ct

Report Period Beginning:

01/01/2019

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	57		2002	2002	\$ 7,006,426	\$		\$ 251,650	\$ 251,650	\$ 4,306,201	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				\$ 7,006,426	\$		\$ 251,650	\$ 251,650	\$ 4,306,201	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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

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	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	Merchants Capitol			Mortgage Loan	11/26 2011	\$ 4,195,900	\$ 3,921,212	12/1/53	0.0422	\$ 166,642	1
2	General Partner			Surplus	4/23/03	500,000	1,260,233	/ /	0.0800	57,675	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 4,695,900	\$ 5,181,445			\$ 224,317	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 4,695,900	\$ 5,181,445			\$ 224,317	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: Quincy Sen & Fam Resource Ct

Report Period Beginning: 01/01/2019

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	\$ (6,556)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(5,928)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,601		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	98,861		8
9	Other(specify): <u>Medicaid</u>	371,339		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 477,318	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,920,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	164,345		16
17	Accumulated Depreciation (book methods)	(4,306,201)		17
18	Deferred Charges	736,635		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(630,775)		20
21	Restricted Funds	437,785		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,322,152	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,799,470	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 422,411	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	669,231		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	2,103		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,093,744	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,260,233		38
39	Mortgage Payable	3,921,212		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Development Fee due to AAA</u>	122,629		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,304,074	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,397,818	\$	45
46	TOTAL EQUITY	\$ (2,598,348)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,799,470	\$	47

*(See instructions.)

Facility Name: Quincy Sen & Fam Resource Ct

Report Period Beginning: 01/01/2019

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	\$ 1,537,212	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,537,212	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	1,738	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,738	14
	D. Other Revenue (specify):		
15	Office Rent Revenue	33,150	15
16	Donations fund raising postage income	1,199	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 34,349	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,573,299	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	311,799	19
20	Health Care/ Personal Care	540,192	20
21	General Administration	521,157	21
	B. Capital Expense		
22	Ownership	605,359	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)	\$ 1,978,507	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (405,208)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (405,208)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 759,826	32
33	Private Pay - Net Inpatient Revenue	777,386	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(donations interest income postage)	36,087	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,573,299	37