

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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: 1000111

Facility Name: Fox Meadows

Address: 605 South Marshall Mcleansboro 62859

County: Hamilton

Telephone Number: (618) 643-2908 Fax # 618 643-2941

Federal Employer ID Number:

Date Current Owners were Certified: 12/22/2008

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT Charitable Corp. ☐ PROPRIETARY Individual ☐ GOVERNMENTAL 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: Johnny Younger Telephone Number:618-643-2908

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 01/01/2020 to 12/31/2020 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) Esther Minton
 (Title) President, JSL 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name Fox Meadows

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	41	Single Unit Apartment	41	15,006	1
2		Double Unit Apartment			2
3		Other			3
4	41	TOTALS	41	15,006	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	4,758	2,928		7,686	5
6	Double Unit					6
7	Other					7
8	TOTALS	4,758	2,928		7,686	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 51.22%

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

 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 ☒

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: 2020 Fiscal Year: 2020

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

J. Does the facility have any Illinois Housing Development Authority Loans
outstanding? Yes If yes, did the facility make all of the
required payments of interest and principal? Yes
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

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Facility Name: Fox Meadows

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	180,345	41,000	5,433	226,778		226,778	1
2	Housekeeping, Laundry and Maintenance	60,099	8,540	7,800	76,439		76,439	2
3	Heat and Other Utilities			1,980	1,980		1,980	3
4	Other (specify): Extermination, Vehicle Expenses)			1,780	1,780		1,780	4
5	TOTAL General Services	240,444	49,540	16,993	306,977		306,977	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	166,593	1,200		167,793		167,793	6
7	Activities and Social Services	29,551	1,276		30,827		30,827	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	196,144	2,476		198,620		198,620	9
	C. General Administration							
10	Administrative and Clerical	87,360			87,360		87,360	10
11	Marketing Materials, Promotions and Advertising	29,551	3,259		32,810		32,810	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			24,145	24,145		24,145	13
14	Other (specify): Legal Fees & Management Fees			62,573	62,573		62,573	14
15	TOTAL General Administration	116,911	3,259	86,718	206,888		206,888	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	553,499	55,275	103,711	712,485		712,485	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			133,400	133,400		133,400	17
18	Interest			139,633	139,633		139,633	18
19	Real Estate Taxes			27,417	27,417		27,417	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			10,422	10,422		10,422	21
22	Other (specify):			11,344	11,344		11,344	22
23	TOTAL Ownership			322,216	322,216		322,216	23
24	GRAND TOTAL (Sum of lines 16 and 23)	553,499	55,275	425,927	1,034,701		1,034,701	24

Facility Name: Fox Meadows

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		\$	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).

Facility Name: Fox Meadows

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 145,000 Year land was acquired 2005

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	41			2008	4,948,747	\$ 115,471	40	\$ 123,719	\$ 8,248	\$ 1,600,097	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				352,520						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)				\$ 5,301,267	\$ 115,471		\$ 123,719	\$ 8,248	\$ 1,600,097	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	\$ 561,111	\$ 15,209	\$ 62,346	47,137	10	\$ 513,359	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 561,111	\$ 15,209	\$ 62,346	47,137		\$ 513,359	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: Fox Meadows

Report Period Beginning: 01/01/2020

Ending: 2/31/2020

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		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	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	Peoples National Bank		X	FIRST MORTGAGE	2/28/08	\$ 2,760,000	\$ 2,276,106	9/1/39	6.0000	\$ 130,757	1
2	IHDA		X	SECOND MORTGAGE	2/28/08	2,000,000	2,000,000	9/1/29	0.1000		2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 4,760,000	\$ 4,276,106			\$ 130,757	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 4,760,000	\$ 4,276,106			\$ 130,757	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.

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Facility Name: Fox Meadows

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 53,843	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	32,903		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,797		6
7	Other Prepaid Expenses	14,621		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 126,164	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	145,000		13
14	Buildings, at Historical Cost	4,948,747		14
15	Leasehold Improvements, at Historical Cost	352,520		15
16	Equipment, at Historical Cost	561,111		16
17	Accumulated Depreciation (book methods)	(2,325,554)		17
18	Deferred Charges	1,220		18
19	Organization & Pre-Operating Costs	12,519		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,519)		20
21	Restricted Funds	686,982		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,370,026	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,496,190	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,121	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,866		30
31	Accrued Taxes Payable	27,417		31
32	Accrued Interest Payable	12,620		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)	\$ 69,024	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,212,802		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)	\$ 4,212,802	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,281,826	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,281,826	\$	47

*(See instructions.)

Facility Name: Fox Meadows

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	\$ 1,199,250	1
2	Discounts and Allowances	(14,753)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,184,497	3
	B. Other Operating Revenue		
4	Special Services	43,058	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)	\$ 43,058	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,529	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,529	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)	\$ 1,229,084	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	306,977	19
20	Health Care/ Personal Care	158,986	20
21	General Administration	322,216	21
	B. Capital Expense		
22	Ownership	348,922	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)	\$ 1,137,101	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 91,983	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 91,983	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 291,227	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 291,227	37