

		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: 1000012

Facility Name: Saint Clares Villa

Address: 915 East 5th Street Alton 62002

Number City Zip Code

County: Madison

Telephone Number: (618) 463-9000 Fax # (618))

Federal Employer ID Number:

Date Current Owners were Certified: 4/08/02 - 33 units 3/24/02 - 31 units

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☒	Partnership	☐	County
		☐	Corporation	☐	Other
IRS Exemption Code		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	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 1/1/20 to 12/31/20 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)	Lori Vadnal	
	(Title)	Director of Finance	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()

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

Name: Holly Steider Telephone Number: (309) 308-6336

Email Address:

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

III. STATISTICAL DATA

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

Date of change in certified units 10/21/20

	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	38	Single Unit Apartment		11,248	1
2	26	Double Unit Apartment		7,696	2
3		Other			3
4	64	TOTALS	0	18,944	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	3,262			3,262	5
6	Double Unit	3,853	550		4,403	6
7	Other					7
8	TOTALS	7,115	550	0	7,665	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 40.46%

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

56 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 194 (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: 9/30 Fiscal Year: 12/31

* 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? 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 principal? N/A
If no, explain.

STATE OF ILLINOIS

Facility Name: Saint Clares Villa

Report Period Beginning:

1/1/20

Ending:

Page 3

12/31/20

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	60,766	82,039		142,805		142,805	1
2	Housekeeping, Laundry and Maintenance	152,760	7,732	38,232	198,724		198,724	2
3	Heat and Other Utilities			124,085	124,085		124,085	3
4	Other (specify):	42,889	114	2,326	45,329		45,329	4
5	TOTAL General Services	256,415	89,885	164,643	510,943	0	510,943	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	268,476	2,015		270,491		270,491	6
7	Activities and Social Services	44,953	605		45,558		45,558	7
8	Other (specify):				0		0	8
9	TOTAL Health Care and Programs	313,429	2,620	0	316,049	0	316,049	9
	C. General Administration							
10	Administrative and Clerical	108,224	250	120,215	228,689		228,689	10
11	Marketing Materials, Promotions and Advertising				0		0	11
12	Employee Benefits and Payroll Taxes			158,521	158,521		158,521	12
13	Insurance-Property, Liability and Malpractice			73,355	73,355		73,355	13
14	Other (specify):				0		0	14
15	TOTAL General Administration	108,224	250	352,091	460,565	0	460,565	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	678,068	92,755	516,734	1,287,557	0	1,287,557	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			259,049	259,049		259,049	17
18	Interest			5,192	5,192		5,192	18
19	Real Estate Taxes			28,252	28,252		28,252	19
20	Rent -- Facility and Grounds				0		0	20
21	Rent -- Equipment			179	179		179	21
22	Other (specify): Impairment on building at 9/30/2020			2,761,056	2,761,056		2,761,056	22
23	TOTAL Ownership	0	0	3,053,728	3,053,728	0	3,053,728	23
24	GRAND TOTAL (Sum of lines 16 and 23)	678,068	92,755	3,570,462	4,341,285	0	4,341,285	24

Facility Name: Saint Clares Villa

Report Period Beginning 1/1/20 Ending: 12/31/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.04	\$ 31.43	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.37	15.09	3
4	Activity Director & Assistants	1.37	15.74	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1.21	16.84	7
8	Dishwashers			8
9	Maintenance Workers	1.01	24.13	9
10	Housekeepers	3.82	12.85	10
11	Laundry			11
12	Managers	0.83	35.77	12
13	Other Administrative			13
14	Clerical	0.92	24.42	14
15	Marketing			15
16	Other	1.68	17.52	16
17	Total (lines 1 thru 16)	18.25	\$	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
OSF Health Care St. Anthony's	Alton, IL

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
St. Anthony's LLC	Alton, IL	General Partner

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				\$ 0	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1		\$	1
2			2
Total		\$ 0	3

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				2002	\$ 9,566,565	\$ 344,228	27.5	\$ 344,228	\$ 0	\$ 6,427,554	1
2				2020	(2,751,675)	(86,057)	27.5	(86,057)	0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Beauty Shop			2003	3,685	134	27.5	134	0	2,416	6
7	Vinyl Flooring			2006	3,910	142	27.5	142	0	1,961	7
8	Nurse Call System			2014	64,274	0	5.0		0	64,274	8
9	Masonry Fitup to Outside Wall			2018	24,600	895	27.5	895	0	1,715	9
10									0		10
11	Impairment			2020	(9,260)	(293)		(293)	0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)				\$ 6,902,099	\$ 259,049		\$ 259,049	\$ 0	\$ 6,497,920	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	\$ 196,034	\$	\$	\$		\$ 196,034	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 196,034	\$ 0	\$ 0	\$		\$ 196,034	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: Saint Clares Villa

Report Period Beginning: 1/1/20

Ending: 12/31/20

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 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		0		\$ 0			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	IDHA			Building Improvements	7/19/01	750,000	\$ 446,197	/ /	0.0100	\$ 4,174	1
2	Madison County			Building Improvements	/ /	300,000	18,355	/ /	0.0582	1,017	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,050,000	\$ 464,552			\$ 5,191	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,050,000	\$ 464,552			\$ 5,191	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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Ending:

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 123,683	\$	1
2	Cash-Patient Deposits	2		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	594		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 124,279	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost See Attached	6,737,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	360,600		16
17	Accumulated Depreciation (book methods)	(6,693,953)		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): Oper & Repl Reserves	348,417		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 752,595	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 876,874	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,000	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	18,379		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	29,545		31
32	Accrued Interest Payable	1,728		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Amounts due to Affiliates	1,565,238		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,620,890	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	443,613		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)	\$ 443,613	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,064,503	\$ 0	45
46	TOTAL EQUITY	\$ (1,187,629)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 876,874	\$ 0	47

*(See instructions.)

Facility Name: Saint Clares Villa

Report Period Beginning: 1/1/20

Ending:

12/31/20

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	\$ 702,613	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 702,613	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)	\$ 0	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	11,242	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 11,242	14
	D. Other Revenue (specify):		
15	Cares Act Revenue	11,143	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 11,143	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 724,998	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	510,943	19
20	Health Care/ Personal Care	316,049	20
21	General Administration	460,565	21
	B. Capital Expense		
22	Ownership	3,053,728	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)	\$ 4,341,285	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (3,616,287)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (3,616,287)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 607,549	32
33	Private Pay - Net Inpatient Revenue	55,264	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>SNAP</u>	39,800	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 702,613	37

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Date of change of Certified Units 10/21/2020

Please note the St Clare's Villa is no longer in oprtions and all residents were vacated.

The certificate to operate the low income housing was surreneder to the State of Illinois on 10/21/2020.

Villa	- Direct Cost Transfer no markup	
Salaries/Wages		538,067
Supplies		2,238
Other		271

Food Service Cost - Rate is \$17.40 per resident Day (includes 3 meals plus snacks)
\$1.64 of the daily rate is included below in benefits

Salaries/Wages	42,402
Supplies	82,039

Engineering, Security, Utilities, Building Communications and Housekeeping
(all allocation are based on building square footage)

Salaries/Wages	97,555
Supplies	5,733
Other	38,552
Utilities	124,085
Insurance	14,317

Benefits- Allocated based on a % of Salary cost

Benefits	157,226
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Total Cost of service provided	
by OSF Saint Anthony's	
Health Center	<u>\$ 1,102,485</u>

Historical Cost	
Building Improvements	\$ 9,498,467.00
Impairment recorded at 9/30/2020	<u>(2,760,935.71)</u>
New Cost for Building and Improvement	<u><u>6,737,531.29</u></u>

Impairment was recorded at 9/30/20 to adjust the related value to market value based on what building could be sold for.