

		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: 1000081

Facility Name: Supportive Living of Wabash

Address: 532 Abelson Drive Carmi 62821

County: White

Telephone Number: (618) 382-2900 Fax # 618 382-8067

Federal Employer ID Number:

Date Current Owners were Certified: 6/26/07

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

X 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: Kenna Hudson

Telephone Number: (314 587-7924

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 1/1/2020 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)

(Type or Print Name) Chuck Schmitz

(Title) Chief Financial Officer

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

III. STATISTICAL DATA

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

Date of change in certified units 6/26/2007

	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	49	Single Unit Apartment	49	17,934	1
2		Double Unit Apartment			2
3		Other			3
4	49	TOTALS	49	17,934	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	9,437	5,764		15,201	5
6	Double Unit					6
7	Other					7
8	TOTALS	9,437	5,764		15,201	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.76%

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

118 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 1 (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 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? NO If yes, did the facility make all of the required payments of interest and principal? N/A
If no, explain. N/A

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. N/A

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. N/A

STATE OF ILLINOIS

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Facility Name: Supportive Living of Wabash

Report Period Beginning:

1/1/2020

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	78,895	125,601	2,988	207,484	(3,906)	203,578	1
2	Housekeeping, Laundry and Maintenance	56,827	6,496	43,260	106,582		106,582	2
3	Heat and Other Utilities			112,457	112,457	(7,473)	104,984	3
4	Other (specify): Trash			4,042	4,042		4,042	4
5	TOTAL General Services	135,722	132,096	162,746	430,565	(11,379)	419,186	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	239,992	5,917	1,348	247,257		247,257	6
7	Activities and Social Services	52,297	2,443		54,740		54,740	7
8	Other (specify): Barber and Beauty		96		96	(96)		8
9	TOTAL Health Care and Programs	292,288	8,456	1,348	302,093	(96)	301,996	9
	C. General Administration							
10	Administrative and Clerical	149,910	1,917	216,845	368,672	(15,794)	352,878	10
11	Marketing Materials, Promotions and Advertising		675	2,783	3,458		3,458	11
12	Employee Benefits and Payroll Taxes			106,701	106,701		106,701	12
13	Insurance-Property, Liability and Malpractice			48,257	48,257		48,257	13
14	Other (specify):							14
15	TOTAL General Administration	149,910	2,592	374,585	527,087	(15,794)	511,293	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	577,921	143,144	538,680	1,259,745	(27,269)	1,232,475	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			246,370	246,370		246,370	17
18	Interest			149,715	149,715		149,715	18
19	Real Estate Taxes			25,816	25,816		25,816	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			21,452	21,452		21,452	22
23	TOTAL Ownership			443,353	443,353		443,353	23
24	GRAND TOTAL (Sum of lines 16 and 23)	577,921	143,144	982,033	1,703,098	(27,269)	1,675,829	24

Facility Name: Supportive Living of Wabash

Report Period Beginning 1/1/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.62	\$ 25.79	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.37	12.68	3
4	Activity Director & Assistants	1.61	12.01	4
5	Social Service Workers			5
6	Head Cook	1.05	17.35	6
7	Cook Helpers/Assistants	1.80	10.37	7
8	Dishwashers			8
9	Maintenance Workers	0.95	17.53	9
10	Housekeepers	1.00	10.90	10
11	Laundry			11
12	Managers	1.04	28.68	12
13	Other Administrative	1.04	12.80	13
14	Clerical			14
15	Marketing			15
16	Other AL Coordinator	1.03	24.97	16
17	Total (lines 1 thru 16)	18	\$	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
Midwest Christian Villages, Inc		St. Louis, MO	

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: Supportive Living of Wabash

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 17,000 Year land was acquired 2006

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	49		2011 & Prior	2006	\$ 5,979,500	\$ 199,317	10-30	\$ 199,317	\$	2,690,775	1
2			2012		10,290	851	5-10	851		7,486	2
3			2013		1,493	149	5	149		1,082	3
4			2014		3,771	164	5-10	164		3,169	4
5			2015/2016/2017/2018/2019/2020		127,074	16,274	5-10	16,274		74,566	5
	Improvement Type										
6	VARIOUS			2007 & 2010	89,579	5,888		5,888		80,746	6
7	Concrete Walking Path			2013	4,150	277		277		2,098	7
8	Landscaping			2014	5,804					5,804	8
9	Concrete Slab for Gazebo			2014	1,552	103		103		681	9
10	Gazebo			2014	4,890	611		611		4,024	10
11	Concrete & Landscaping			2015	1,996	100		100		507	11
12	Bocce Ball Court			2016	8,954	448		448		1,977	12
13	Asphalt Surface Parking Lot			2017	1,500	75		75		256	13
14	New Logo Dryvit Monument			2017	7,996	400		400		1,366	14
15	Concrete Sidewalk Expansion			2019	1,500	75		75		94	15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,250,048	\$ 224,732		\$ 224,732	\$	2,874,633	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	\$ 459,049	\$ 21,638	\$ 21,638		Various	\$ 367,861	18
19	Vehicles	50,639				4	50,639	19
20	TOTAL (lines 18 and 19)	\$ 509,687	\$ 21,638	\$ 21,638	\$		\$ 418,500	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: Supportive Living of Wabash

Report Period Beginning: 1/1/2020

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 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	HUD - MORTGAGE		X	Refinance - Construction	9/1/13	\$ 4,800,000	\$ 4,240,456	10/1/48	3.7300	\$ 146,198	1
2			X	Deferred Tax and Cred Fees & Org Cos	/ /	-86,840	-61,596	/ /		3,516	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 4,713,160	\$ 4,178,860			\$ 149,715	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 4,713,160	\$ 4,178,860			\$ 149,715	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: Supportive Living of Wabash

Report Period Beginning: 1/1/2020

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	\$ 556,775	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (7,701))	66,584		3
4	Supply Inventory (priced at)	551		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,460		6
7	Other Prepaid Expenses	11,067		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 654,436	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	17,000		13
14	Buildings, at Historical Cost	6,122,128		14
15	Leasehold Improvements, at Historical Cost	127,921		15
16	Equipment, at Historical Cost	509,687		16
17	Accumulated Depreciation (book methods)	(3,293,133)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	626,690		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,110,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,764,729	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,145	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,587		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Real Estate Taxes	51,633		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 107,365	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,240,456		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Liabilities	2,030		42
43	Deferred Org Cost	(61,596)		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,180,889	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,288,254	\$	45
46	TOTAL EQUITY	\$ 476,475	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,764,729	\$	47

*(See instructions.)

Facility Name: Supportive Living of Wabash

Report Period Beginning: 1/1/2020

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	\$ 1,765,386	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,765,386	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	5,462	8
9	Non-Resident Meals	3,906	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 9,368	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	5,361	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 5,361	14
	D. Other Revenue (specify):		
15	Miscellaneous Revenue	46,325	15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 46,325	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 1,826,441	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	430,565	19
20	Health Care/ Personal Care	302,093	20
21	General Administration	527,087	21
	B. Capital Expense		
22	Ownership	443,353	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,703,098	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 123,343	29
30	Income Taxes	\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 123,343	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,114,138	32
33	Private Pay - Net Inpatient Revenue	617,434	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Tax Credit</u>	33,814	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,765,386	37