

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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: 1000159

Facility Name: Cedarhurst of Quincy

Address: 319 South 48th St Quincy 62305

County: Adams

Telephone Number: (217) 557-2019 Fax # (217) 214-7944

Federal Employer ID Number:

Date Current Owners were Certified: 3/13/2020

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X 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 1/1/2021 to 12/31/2021 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)

(Title)

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone)

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

Name: Kevin Wellen

Telephone Number: (314) 925-4300

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

HFS 3745C (N-4-05)

IL478-2471

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	56	Single Unit Apartment	56	20,440	1
2		Double Unit Apartment			2
3		Other			3
4	56	TOTALS	56	20,440	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	5,152	6,817		11,969	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,152	6,817		11,969	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 58.56%

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 X

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO X

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

MODIFIED ACCRUAL X CASH* CASH*

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

Tax Year: 12/31/2021 Fiscal Year: 12/31/2021

* 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

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Facility Name: Cedarhurst of Quincy

Report Period Beginning:

1/1/2021

Ending: 12/31/2021

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	73,339	64,758	4,946	143,043		143,043	1
2	Housekeeping, Laundry and Maintenance	70,103	41,416	20,448	131,967		131,967	2
3	Heat and Other Utilities			74,031	74,031		74,031	3
4	Other (specify):							4
5	TOTAL General Services	143,442	106,174	99,425	349,041		349,041	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	492,515	2,961	3,389	498,865		498,865	6
7	Activities and Social Services	103,110	3,720	612	107,442		107,442	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	595,625	6,681	4,001	606,307		606,307	9
	C. General Administration							
10	Administrative and Clerical	222,592	5,759	344,181	572,532	(35,855)	536,677	10
11	Marketing Materials, Promotions and Advertising	79,173	2,506	123,336	205,015		205,015	11
12	Employee Benefits and Payroll Taxes			169,400	169,400		169,400	12
13	Insurance-Property, Liability and Malpractice			74,811	74,811		74,811	13
14	Other (specify):							14
15	TOTAL General Administration	301,765	8,265	711,728	1,021,758	(35,855)	985,903	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,040,832	121,120	815,154	1,977,106	(35,855)	1,941,251	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			19,446	19,446	214,309	233,755	17
18	Interest			35,156	35,156	499,163	534,319	18
19	Real Estate Taxes			35,417	35,417		35,417	19
20	Rent -- Facility and Grounds			644,484	644,484	(644,484)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			734,503	734,503	68,988	803,491	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,040,832	121,120	1,549,657	2,711,609	33,133	2,744,742	24

Facility Name: Cedarhurst of Quincy

Report Period Beginning 1/1/2021 Ending: 12/31/2021

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	2.20	22.45	2
3	Certified Nurse Assistants	9.75	14.76	3
4	Activity Director & Assistants	0.69	17.58	4
5	Social Service Workers			5
6	Head Cook	0.79	18.10	6
7	Cook Helpers/Assistants	0.91	15.29	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.15	13.14	10
11	Laundry			11
12	Managers	4.29	27.16	12
13	Other Administrative	1.80	15.52	13
14	Clerical			14
15	Marketing	0.85	30.34	15
16	Other			16
17	Total (lines 1 thru 16)	21.43	\$ 21.71	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Cedarhurst of Quincy Real Estate, LLC		Quincy, IL		Real Estate - Landlo	
Cedarhurst of Quincy Holdings, LLC		Clayon, MO		Holding Company	
Cedarhurst of Quincy Operator, LLC		Quincy, IL		Operating Company	

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				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1		\$	1
2			2
Total		\$	3

Facility Name: Cedarhurst of Quincy

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

VIII. OWNERSHIP COSTSA. Purchase price of land 658,172 Year land was acquired 2018

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	56			2019	\$ 6,605,031	\$ 165,126		\$ 165,126	\$	454,096	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Wiring for Washer/Dryer Units			2019	800	40	20	40		93	6
7	SLF Repairs/Renovations			2020	105,366	5,268	20	5,268		9,220	7
8	Fire Door from Lobby to B & C Unit (50%)			2020	1,576	79	20	79		92	8
9	Repair water run-off drainage			2019	4,496	642	20	642		1,392	9
10	Fire Door from Lobby to B & C Unit (50%)			2021	1,576	59	20	59		59	10
11	HVAC duct insulation and hood over dishwasher			2021	3,536	15	20	15		15	11
12	Attic insulation (50%)			2021	13,477		20				12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,735,858	\$ 171,229		\$ 171,229	\$	464,966	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	\$ 425,109	\$ 43,080	\$ 43,080	\$	Various	\$ 116,072	18
19	Vehicles	97,230	19,446	19,446		5	53,477	19
20	TOTAL (lines 18 and 19)	\$ 522,339	\$ 62,526	\$ 62,526	\$		\$ 169,549	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: Cedarhurst of Quincy Report Period Beginning: 1/1/2021 Ending: 2/31/2021

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*		8. Is movable equipment rental included in building rental? YES NO
3	Original Building			/ /	\$			3	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.
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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	Town & Country Bank		X	Note Payable - Mortgage	3/13/19	\$ 8,850,000	\$ 8,763,305	3/13/24	5.1500	\$ 499,163	1
2	Steven W. Lanter	X		Note Payable	10/1/21	250,000	250,000	9/30/26	8.0000	35,156	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 9,100,000	\$ 9,013,305			\$ 534,319	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 9,100,000	\$ 9,013,305			\$ 534,319	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: Cedarhurst of Quincy

Report Period Beginning: 1/1/2021

Ending: 12/31/2021

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 224,512	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	67,270		3
4	Supply Inventory (priced at)	1,375		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,721		6
7	Other Prepaid Expenses	3,309		7
8	Accounts Receivable (owners or related parties)	49		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 321,236	\$	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			15
16	Equipment, at Historical Cost	97,980		16
17	Accumulated Depreciation (book methods)	(53,477)		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)	\$ 44,503	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 365,739	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,284	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,038		30
31	Accrued Taxes Payable	3,559		31
32	Accrued Interest Payable	5,111		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Prepaid Rent (deferred income)	17,440		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 118,432	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	250,000		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to Related Party	1,164,162		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,414,162	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,532,594	\$	45
46	TOTAL EQUITY	\$ (1,166,855)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 365,739	\$	47

*(See instructions.)

Facility Name: Cedarhurst of Quincy

Report Period Beginning: 1/1/2021

Ending:

12/31/2021

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	\$ 2,222,813	1
2	Discounts and Allowances	(140,256)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,082,557	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	29,397	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)	\$ 29,397	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	Other Revenue - Rental Income	3,000	15
16	Other Revenue - See Schedule	2,504	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 5,504	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,117,458	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	349,041	19
20	Health Care/ Personal Care	606,307	20
21	General Administration	1,021,758	21
	B. Capital Expense		
22	Ownership	734,503	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)	\$ 2,711,609	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (594,151)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (594,151)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 718,874	32
33	Private Pay - Net Inpatient Revenue	1,363,683	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,082,557	37