

		FOR BHF USE			

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: 1000111 Facility Name: <u>Fox Meadows</u> Address: <u>605 South Marshall</u> <u>Mcleansboro</u> <u>62859</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>Hamilton</u> Telephone Number: (<u>618</u>) <u>643-2908</u> Fax # <u>618 643-2941</u> Federal Employer ID Number: _____ Date Current Owners were Certified: <u>12/22/2008</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name: Barbara Logsdon **Telephone Number:** 217-242-5276
Email Address: _____

Facility Name Fox MeadowsReport Period Beginning: 01/01/2021 Ending: 12/31/21

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	<u>41</u>	Single Unit Apartment	<u>41</u>	<u>14,965</u>	1
2		Double Unit Apartment			2
3		Other			3
4	<u>41</u>	TOTALS	<u>41</u>	<u>14,965</u>	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	<u>8,935</u>	<u>1,390</u>		<u>10,325</u>	5
6	Double Unit					6
7	Other					7
8	TOTALS	<u>8,935</u>	<u>1,390</u>		<u>10,325</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 68.99%D. Indicate the number of paid bed-hold days the SLF had during this year 305 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 132 (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

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: 2021 Fiscal Year: 2021

* 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:

01/01/2021

Ending:

12/31/21

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	187,217	37,441	37,441	262,099		262,099	1
2	Housekeeping, Laundry and Maintenance	84,550			84,550		84,550	2
3	Heat and Other Utilities			51,674	51,674		51,674	3
4	Other (specify): Extermination, Vehicle Expenses)			55,240	55,240		55,240	4
5	TOTAL General Services	271,767	37,441	144,355	453,563		453,563	5
B. Health Care and Programs								
6	Health Care/ Personal Care	181,178	356		181,534		181,534	6
7	Activities and Social Services	30,197			30,197		30,197	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	211,375	356		211,731		211,731	9
C. General Administration								
10	Administrative and Clerical	90,590	46,441		137,031		137,031	10
11	Marketing Materials, Promotions and Advertising	30,195	3,337		33,532		33,532	11
12	Employee Benefits and Payroll Taxes			5,287	5,287		5,287	12
13	Insurance-Property, Liability and Malpractice			41,016	41,016		41,016	13
14	Other (specify): Legal Fees & Management Fees			38,093	38,093		38,093	14
15	TOTAL General Administration	120,785	49,778	84,396	254,959		254,959	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	603,927	87,575	228,751	920,253		920,253	16
Capital Expenses								
D. Ownership								
17	Depreciation				131,073		131,073	17
18	Interest				152,385		152,385	18
19	Real Estate Taxes				24,126		24,126	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):				7,519		7,519	22
23	TOTAL Ownership				315,103		315,103	23
24	GRAND TOTAL (Sum of lines 16 and 23)	603,927	87,575	228,751	1,235,356		1,235,356	24

Facility Name: Fox Meadows

Report Period Beginning 01/01/2021

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6		3
4	Activity Director & Assistants	1		4
5	Social Service Workers			5
6	Head Cook	1		6
7	Cook Helpers/Assistants	8		7
8	Dishwashers			8
9	Maintenance Workers	1		9
10	Housekeepers	1		10
11	Laundry			11
12	Managers	1		12
13	Other Administrative			13
14	Clerical	1		14
15	Marketing	1		15
16	Other			16
17	Total (lines 1 thru 16)	22	\$	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

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: Fox Meadows

Report Period Beginning: 01/01/2021

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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	\$	40	\$	\$	\$ 1,600,097	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land 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	\$		\$	\$	\$ 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	\$	\$	\$	10	\$ 528,349	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 561,111	\$	\$	\$		\$ 528,349	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

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IX. RENTAL COSTS**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: NA

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 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	\$ 2,212,804	9/1/39	6.0000	\$ 132,385	1
2	IHDA		X	SECOND MORTGAGE	2/28/08	2,000,000	2,000,000	9/1/29	0.1000	20,000	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 4,760,000	\$ 4,212,804			\$ 152,385	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 4,760,000	\$ 4,212,804			\$ 152,385	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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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/21

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 16,508	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	144,221		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,445		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 169,174	\$	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	4,950,233		14
15	Leasehold Improvements, at Historical Cost	352,520		15
16	Equipment, at Historical Cost	561,111		16
17	Accumulated Depreciation (book methods)	(2,590,027)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	392,078		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	52,626		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,863,541	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,032,715	\$	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	1,220		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			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):	116,304		
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 173,928	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,144,777		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	ILF	8,349		42
43	NFP	90,000		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,243,126	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,417,054	\$	45
46	TOTAL EQUITY	\$ (384,339)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,032,715	\$	47

*(See instructions.)

Facility Name: Fox Meadows

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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	\$ 1,034,118	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,034,118	3
	B. Other Operating Revenue		
4	Special Services	13,742	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)	\$ 13,742	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	137	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 137	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)	\$ 1,047,997	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	453,563	19
20	Health Care/ Personal Care	211,731	20
21	General Administration	254,959	21
	B. Capital Expense		
22	Ownership	315,103	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)	\$ 1,235,356	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (187,359)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (187,359)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 344,923	32
33	Private Pay - Net Inpatient Revenue	689,195	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,034,118	37