

		FOR BHF USE			

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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.

<p>I. Facility ID Number: <u>1000141</u></p> <p>Facility Name: <u>Katys Cottage</u></p> <p>Address: <u>200 W International</u> <u>Rantoul</u> <u>61866</u> <small>Number City Zip Code</small></p> <p>County: <u>Champaign</u></p> <p>Telephone Number: (<u>217</u>) <u>892-1023</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ian Wang</u> Telephone Number: <u>(217) 892-1023</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/2014</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Stuart R. Trumbo</u> <u>CPA</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Stuart R. Trumbo, CPA</u> <u>2101 Belmore Court</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 841-4370</u></td> <td>Fax # ()</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Stuart R. Trumbo</u> <u>CPA</u>			(Firm Name & Address) <u>Stuart R. Trumbo, CPA</u> <u>2101 Belmore Court</u>			(Telephone) <u>(217) 841-4370</u>	Fax # ()
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Facility Name: Katys Cottage

Report Period Beginning:

01/01/2014

Ending: 12/31/2014

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		3,465	1,336	4,801		4,801	1
2	Housekeeping, Laundry and Maintenance		2,747	2,106	4,853		4,853	2
3	Heat and Other Utilities			31,712	31,712		31,712	3
4	Other (specify):							4
5	TOTAL General Services		6,212	35,154	41,366		41,366	5
B. Health Care and Programs								
6	Health Care/ Personal Care	325,421	1,554		326,975		326,975	6
7	Activities and Social Services			1,142	1,142		1,142	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	325,421	1,554	1,142	328,117		328,117	9
C. General Administration								
10	Administrative and Clerical		2,953	4,483	7,436		7,436	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration		2,953	4,483	7,436		7,436	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	325,421	10,719	40,779	376,919		376,919	16
Capital Expenses								
D. Ownership								
17	Depreciation			23,070	23,070		23,070	17
18	Interest			9,322	9,322		9,322	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			32,392	32,392		32,392	23
24	GRAND TOTAL (Sum of lines 16 and 23)	325,421	10,719	73,171	409,311		409,311	24

Facility Name: Katys Cottage

Report Period Beginning 01/01/2014 Ending: 12/31/2014

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	2	10.75	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	1	10.00	10
11	Laundry			11
12	Managers	1	14.00	12
13	Other Administrative	1	19.23	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	5	\$	17

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

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
Prairie Village Retirement		Rantoul, IL	
Preferred Care		Rantoul, IL	

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. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$
		3

Facility Name: Katys Cottage

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	19		2012	2011	\$ 893,408	\$ 22,908	39	\$ 22,908	\$	\$ 56,315	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				\$ 893,408	\$ 22,908		\$ 22,908	\$	\$ 56,315	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	\$ 1,136	\$ 162	\$ 162	\$	7	\$ 402	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,136	\$ 162	\$ 162	\$		\$ 402	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: Katys Cottage

Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Bank of Rantoul		x	Construction	11/01/12	\$ 893,408	\$ 736,250	/ /	6.5000	\$ 9,322	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 893,408	\$ 736,250			\$ 9,322	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 893,408	\$ 736,250			\$ 9,322	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.

Facility Name: **Katys Cottage**Report Period Beginning: **01/01/2014**

Ending:

12/31/2014**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,139	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)	98		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): Advances to Affiliates	231,396		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 237,633	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	893,408		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,136		16
17	Accumulated Depreciation (book methods)	(56,717)		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)	\$ 837,827	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,075,460	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,975	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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	Advances from Affiliates			35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,975	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	736,250		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)	\$ 736,250	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 739,225	\$	45
46	TOTAL EQUITY	\$ 336,235	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,075,460	\$	47

*(See instructions.)

Facility Name: Katys Cottage

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 552,765	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 552,765	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)	\$	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			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)	\$ 552,765	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	41,366	19
20	Health Care/ Personal Care	328,117	20
21	General Administration	7,436	21
B. Capital Expense			
22	Ownership	32,392	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)	\$ 409,311	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 143,454	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 143,454	31