FOR BHF USE

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Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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 (Number) Carmi (City) 62821 (Zip Code)

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 1/1/2017 to 12/31/2017 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) Chuck Schmitz

(Title) Chief Financial Officer

Paid Preparer

(Signed)

(Date)

(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

Facility Name Supportive Living of Wabash Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

Date of change in certified units 6/26/2007

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	49	Single Unit Apartment	49	17,885	1
2		Double Unit Apartment			2
3		Other			3
4	49	TOTALS	49	17,885	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	8,505	7,302		15,807	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,505	7,302		15,807	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.38%

D. Indicate the number of paid bed-hold days the SLF had during this year 98 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 5 **(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

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] 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 principle?** 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 principle?** 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 principle?** N/A
If no, explain. N/A

Facility Name: Supportive Living of Wabash **Report Period Beginning: 1/1/2017 Ending: 12/31/2017**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	69,541	111,765	3,527	184,833	(1,764)	183,069	1
2	Housekeeping, Laundry and Maintenance	51,244	9,716	24,780	85,741		85,741	2
3	Heat and Other Utilities			104,915	104,915	(6,236)	98,679	3
4	Other (specify): Trash			1,316	1,316		1,316	4
5	**TOTAL General Services**	120,785	121,482	134,538	376,805	(8,000)	368,805	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	203,214	904	1,514	205,631		205,631	6
7	Activities and Social Services	34,221	1,422	1,749	37,393		37,393	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	237,435	2,326	3,263	243,024		243,024	9
	C. General Administration							
10	Administrative and Clerical	98,557	2,168	130,163	230,888	(6,244)	224,644	10
11	Marketing Materials, Promotions and Advertising		3,482	9,821	13,303		13,303	11
12	Employee Benefits and Payroll Taxes			95,826	95,826		95,826	12
13	Insurance-Property, Liability and Malpractice			33,022	33,022		33,022	13
14	Other (specify):							14
15	**TOTAL General Administration**	98,557	5,650	268,831	373,038	(6,244)	366,794	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	456,777	129,458	406,632	992,867	(14,244)	978,623	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			245,411	245,411		245,411	17
18	Interest			173,152	173,152	(232)	172,920	18
19	Real Estate Taxes			25,185	25,185		25,185	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			22,673	22,673		22,673	22
23	**TOTAL Ownership**			466,421	466,421	(232)	466,189	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	456,777	129,458	873,053	1,459,287	(14,476)	1,444,811	24

Facility Name: Supportive Living of Wabash **Report Period Beginning: 1/1/2017 Ending: 12/31/2017**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.18	$ 23.58	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.27	10.62	3
4	Activity Director & Assistants	0.94	11.67	4
5	Social Service Workers			5
6	Head Cook	0.99	13.09	6
7	Cook Helpers/Assistants	2.20	9.29	7
8	Dishwashers			8
9	Maintenance Workers	0.93	16.47	9
10	Housekeepers	0.97	9.58	10
11	Laundry			11
12	Managers	1.00	27.90	12
13	Other Administrative	1.03	12.08	13
14	Clerical			14
15	Marketing			15
16	Other AL Coordinator	1.00	22.99	16
17	Total (lines 1 thru 16)	16	$	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

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	1
2			2
	Total	$	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
Midwest Christian Villages, Inc	Lincoln			

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 [X]

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 [X] 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: 1/1/2017 Ending: 12/31/2017

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	$ 5,985,540	$ 199,743	10-30	$ 199,743	$	$ 2,092,825	1
2			2012		5,240	458	5-10	458		3,236	2
3			2013		5,812	1,013	5	1,013		4,180	3
4			2014		10,917	2,019	5-10	2,019		7,510	4
5			2015/2016/2017		85,968	15,535	5-10	15,535		23,395	5
	Improvement Type										
6	VARIOUS			2007 & 2010	89,579	5,888		5,888		63,081	6
7	Concrete Walking Path			2013	4,150	277		277		1,268	7
8	Landscaping			2013	2,959	592		592		2,515	8
9	Landscaping			2014	5,804	1,161		1,161		4,353	9
10	Concrete Slab for Gazebo			2014	1,552	103		103		371	10
11	Asphalt Reseal & Striping			2014		193		193			11
12	Gazebo			2014	4,890	611		611		2,191	12
13	Concrete & Landscaping			2015	1,996	100		100		208	13
14	Bocce Ball Court			2016	8,954	448		448		634	14
15	Asphalt Surface Parking Lot			2017	1,500	31		31		31	15
16	New Logo Dryvit Monument			2017	7,996	167		167		167	16
17	TOTAL (lines 1 thru 16)				$ 6,222,856	$ 228,340		$ 228,340	$	$ 2,205,964	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	$ 411,918	$ 17,071	$ 17,071	$	VARIOUS	$ 336,681	18
19	Vehicles	50,639				VARIOUS	50,639	19
20	TOTAL (lines 18 and 19)	$ 462,557	$ 17,071	$ 17,071	$		$ 387,320	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:** 1/1/2017 **Ending:** 2/31/2017

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** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	HUD - MORTGAGE		X	Refinance - Construction	9/1/13	$ 4,800,000	$ 4,493,085	10/1/48	3.7300	$ 169,149	1
2	HUD - NOTE PAY	X		Refinance - Startup Construction	9/1/13	750,000	400,000	10/1/48			2
3			X	Deferred Tax Cred Fees & Org Costs	/ /	-86,840	-61,169	/ /		4,002	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 5,463,160	$ 4,831,916			$ 173,152	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 5,463,160	$ 4,831,916			$ 173,152	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: Supportive Living of Wabash **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 510,279	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,700)	105,180		3
4	Supply Inventory (priced at)	2,088		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,855		6
7	Other Prepaid Expenses	10,757		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 654,160	$	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	6,093,477		14
15	Leasehold Improvements, at Historical Cost	129,380		15
16	Equipment, at Historical Cost	462,557		16
17	Accumulated Depreciation (book methods)	(2,593,285)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	460,553		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	1,829		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,571,510	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,225,670	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,560	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,277		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	25,237		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 78,074	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	400,000		38
39	Mortgage Payable	4,493,085		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Liabilies/Deferred Org Costs	(51,294)		42
43	Security Deposit Payable	495		43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 4,842,286	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 4,920,360	$	45
46	**TOTAL EQUITY**	$ 305,310	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,225,670	$	47

***(See instructions.)**

Facility Name: Supportive Living of Wabash **Report Period Beginning: 1/1/2017 Ending: 12/31/2017**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,519,269	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,519,269	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	1,145	8
9	Non-Resident Meals	1,764	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 2,909	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	232	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 232	14
	D. Other Revenue (specify):		
15			15
16	**Other Miscellaneous Revenue**	(861)	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ (861)	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,521,549	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	376,805	19
20	Health Care/ Personal Care	243,024	20
21	General Administration	373,038	21
	B. Capital Expense		
22	Ownership	466,421	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)**	$ 1,459,287	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 62,262	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 62,262	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 824,789	32
33	Private Pay - Net Inpatient Revenue	534,547	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Tax Credit**	159,932	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,519,269	37