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: 1000083

Facility Name: Supportive Living Washington

Address: 1150 New Castle Road (Number) Washington (City) 61571 (Zip Code)

County: Tazewell

Telephone Number: (309) 444-3641 **Fax #** 309 444-8763

Federal Employer ID Number:

Date Current Owners were Certified: 9/24/07

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		

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 # ( )

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

Name: Kenna Hudson Telephone Number: (314 587-7924

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**

Facility Name Supportive Living Washington 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 / /

	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	59	Single Unit Apartment	56	20,440	1
2	1	Double Unit Apartment	4	1,460	2
3		Other			3
4	60	TOTALS	60	21,900	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	10,951	6,158		17,109	5
6	Double Unit	365	315		680	6
7	Other					7
8	TOTALS	11,316	6,473		17,789	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.23%

D. Indicate the number of paid bed-hold days the SLF had during this year 145 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 2 **(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 Washington **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	103,354	131,683	1,326	236,363	(313)	236,050	1
2	Housekeeping, Laundry and Maintenance	63,372	12,078	42,103	117,553		117,553	2
3	Heat and Other Utilities			78,544	78,544		78,544	3
4	Other (specify): Trash			4,235	4,235		4,235	4
5	**TOTAL General Services**	166,726	143,761	126,208	436,694	(313)	436,381	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	333,789	1,154	1,393	336,336		336,336	6
7	Activities and Social Services	19,293	2,120	5,173	26,586		26,586	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	353,082	3,274	6,566	362,922		362,922	9
	C. General Administration							
10	Administrative and Clerical	93,250	4,206	211,610	309,066	(18,570)	290,496	10
11	Marketing Materials, Promotions and Advertising	2,035	3,112	7,207	12,354		12,354	11
12	Employee Benefits and Payroll Taxes			117,298	117,298		117,298	12
13	Insurance-Property, Liability and Malpractice			17,833	17,833		17,833	13
14	Other (specify):							14
15	**TOTAL General Administration**	95,285	7,318	353,947	456,551	(18,570)	437,981	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	615,093	154,353	486,721	1,256,167	(18,883)	1,237,284	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			305,576	305,576		305,576	17
18	Interest			210,662	210,662	(388)	210,275	18
19	Real Estate Taxes			58,173	58,173		58,173	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			27,586	27,586		27,586	22
23	**TOTAL Ownership**			601,997	601,997	(388)	601,610	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	615,093	154,353	1,088,718	1,858,164	(19,271)	1,838,894	24

Facility Name: Supportive Living Washington **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		$	1
2	Licensed Practical Nurses	0.98	18.95	2
3	Certified Nurse Assistants	10.18	10.99	3
4	Activity Director & Assistants	0.72	11.23	4
5	Social Service Workers			5
6	Head Cook	1.10	14.54	6
7	Cook Helpers/Assistants	3.31	9.19	7
8	Dishwashers			8
9	Maintenance Workers	0.67	15.20	9
10	Housekeepers	2.02	9.63	10
11	Laundry			11
12	Managers	1.00	27.35	12
13	Other Administrative	1.03	15.84	13
14	Clerical			14
15	Marketing			15
16	Other **Wellness Manager**	0.88	25.07	16
17	**Total (lines 1 thru 16)**	22	$	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 Washington **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land 89,000 **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			2013 & Prior	2006	$ 7,852,067	$ 264,632	VARIOUS	$ 264,632	$	$ 2,690,013	1
2			2014		33,473	6,142	5-15	6,142		23,551	2
3			2015		14,153	2,316	5-10	2,316		6,081	3
4			2016		51,022	5,780	5-10	5,780		9,961	4
5			2017		61,120	1,665	43,169	1,665		1,665	5
	Improvement Type										
6	Landscaping, Staking, Paving, Surfacing, Dumping Fees			2007	110,621	7,375	15	7,375		75,591	6
7	Signage			2011	6,208	621	10	621		3,828	7
8	Patio			2011	5,706	380	15	380		2,409	8
9	Landscaping			2011	6,968	465	15	465		2,787	9
10	Mulch			2012	1,660		3			1,660	10
11	Ramp			2012	2,640	176	12	176		997	11
12	Parking			2013	2,280		2			2,280	12
13	Sprinkler System			2016	28,650	1,910	15	1,910		2,547	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 8,176,567	$ 291,462		$ 291,462	$	$ 2,823,370	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	$ 314,994	$ 14,114	$ 14,114	$	7	$ 271,182	18
19	Vehicles	6,000				3	6,000	19
20	TOTAL (lines 18 and 19)	$ 320,994	$ 14,114	$ 14,114	$		$ 277,182	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 Washington **Report Period Beginning:** 1/1/2017 **Ending:** 2/31/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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			X	Refinance - Construction	9/1/13	$ 5,840,000	$ 5,466,587	10/1/48	3.7300	$ 205,798	1
2			X	Deferred Tax Cred Fees & Org Costs	/ /	-93,218	-64,624	/ /		4,864	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 5,746,782	$ 5,401,963			$ 210,662	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 5,746,782	$ 5,401,963			$ 210,662	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 Washington **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	$ 576,366	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,293)	142,308		3
4	Supply Inventory (priced at)	1,264		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,774		6
7	Other Prepaid Expenses	7,924		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 752,636	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	89,000		13
14	Buildings, at Historical Cost	8,011,835		14
15	Leasehold Improvements, at Historical Cost	164,733		15
16	Equipment, at Historical Cost	320,994		16
17	Accumulated Depreciation (book methods)	(3,100,552)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	588,652		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,074,661	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,827,297	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,069	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,446		30
31	Accrued Taxes Payable	58,016		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Liabilities	11,713		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 194,243	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,466,587		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred Org Costs	(64,624)		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 5,401,963	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 5,596,206	$	45
46	**TOTAL EQUITY**	$ 1,231,091	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 6,827,297	$	47

***(See instructions.)**

Facility Name: Supportive Living Washington **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	$ 1,755,469	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,755,469	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	155	8
9	Non-Resident Meals	313	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 468	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	388	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 388	14
	D. Other Revenue (specify):		
15	**Mescellaneous Revenue**	401	15
16	**Space Rental/G/L On Sale/Discounts**	123	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 524	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,756,849	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	436,694	19
20	Health Care/ Personal Care	362,922	20
21	General Administration	456,551	21
	B. Capital Expense		
22	Ownership	601,997	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)**	$ 1,858,164	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (101,315)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (101,315)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,059,378	32
33	Private Pay - Net Inpatient Revenue	312,626	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Tax Credit**	383,465	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,755,469	37