FOR BHF USE

LL2

Supportive Living Facility

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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: 1000141

Facility Name: Eagles View Memory Care

Address: 200 W International (Number) Rantoul (City) 61866 (Zip Code)

County: Champaign

Telephone Number: (217) 892-2800 **Fax #** (217)892-2833

Federal Employer ID Number:

Date Current Owners were Certified: 2/21/17

Type of Ownership:

	VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Shlomo Brisk **Telephone Number:** (845) 746-5074
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 1/1/2018 to 12/31/2018 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) 3/29/2019 (Date)
(Type or Print Name) Ari Haas
(Title)

Paid Preparer
(Signed) 3/29/2019 (Date)
(Print Name and Title) Jacob Karmel
(Firm Name & Address) Apex Global Solutions
(Telephone) (845) 490-6060 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 Eagles View Supportive Living and Memory Care Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	100	Single Unit Apartment	100	36,500	1
2	16	Double Unit Apartment	16	5,840	2
3		Other		1,825	3
4	116	TOTALS	116	44,165	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	11,171	6,020		17,191	5
6	Double Unit	298	742		1,040	6
7	Other	311	548		859	7
8	TOTALS	11,780	7,310		19,090	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 43.22%

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 2018 Fiscal Year: 2018
* 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. _____

Facility Name: Eagles View Supportive Living and Memory Care **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	A. General Services							
1	Dietary and Food Purchase	135,652	121,017	15,645	272,314		272,314	1
2	Housekeeping, Laundry and Maintenance	88,519	68,369	16,336	173,224		173,224	2
3	Heat and Other Utilities			266,758	266,758		266,758	3
4	Other (specify): See Page 3 Attachment			12,277	12,277		12,277	4
5	**TOTAL General Services**	224,171	189,386	311,016	724,573		724,573	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	566,997	6,776	1,474	575,247		575,247	6
7	Activities and Social Services	35,381	6,303	1,503	43,187		43,187	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	602,377	13,079	2,977	618,434		618,434	9
	C. General Administration							
10	Administrative and Clerical	153,569	7,912	295,735	457,216	(3,803)	453,413	10
11	Marketing Materials, Promotions and Advertising	38,976	9,011	13,746	61,732		61,732	11
12	Employee Benefits and Payroll Taxes	43,222		146,069	189,290		189,290	12
13	Insurance-Property, Liability and Malpractice			43,473	43,473		43,473	13
14	Other (specify): See Page 3 Attachment			24,420	24,420	(24,420)		14
15	**TOTAL General Administration**	235,767	16,922	523,442	776,132	(28,223)	747,908	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,062,315	219,387	837,436	2,119,139	(28,223)	2,090,915	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			3,884	3,884		3,884	17
18	Interest			11,290	11,290		11,290	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			697,500	697,500	(7,500)	690,000	20
21	Rent -- Equipment			7,973	7,973		7,973	21
22	Other (specify):							22
23	**TOTAL Ownership**			720,647	720,647	(7,500)	713,147	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,062,315	219,387	1,558,083	2,839,785	(35,723)	2,804,062	24

Facility Name: Eagles View Supportive Living and Memory Care Report Period Beginning 1/1/2018 Ending: 12/31/2018

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	23.39	2
3	Certified Nurse Assistants	14	11.96	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	18.40	5
6	Head Cook			6
7	Cook Helpers/Assistants	4	11.11	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	1	9.99	10
11	Laundry			11
12	Managers	4	30.85	12
13	Other Administrative	1	18.27	13
14	Clerical	1	12.70	14
15	Marketing	1	26.44	15
16	Other			16
17	Total (lines 1 thru 16)	29	$	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
Landlord is a related party. Their financials were not available at the time of completion of this report.								
Management Fees is a related party. The financials were not available at the time of completion of this report.								

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: Eagles View Supportive Living and Memory Care Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	116				$	$	28	$	$	$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements						15				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)				$	$		$	$	$	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	$ 16,544	$ 1,489	$	(1,489)	10	$ 15,733	18
19								19
20	TOTAL (lines 18 and 19)	$ 16,544	$ 1,489	$	(1,489)		$ 15,733	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: Eagles View Supportive Living and Memory Care Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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*	
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					/ /	$	$	/ /		$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Line of Credit		x		/ /		182,275	/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 182,275			$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 182,275			$	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: Eagles View Supportive Living and Memory Care **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 144,571	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (63,115))	559,866		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,406		6
7	Other Prepaid Expenses	10,795		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 733,638	$	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	22,710		15
16	Equipment, at Historical Cost	20,765		16
17	Accumulated Depreciation (book methods)	(16,580)		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)**	$ 26,895	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 760,534	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 82,241	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,037		28
29	Short-Term Notes Payable	242,667		29
30	Accrued Salaries Payable	121,026		30
31	Accrued Taxes Payable	193,459		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	193,901		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 852,331	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,504,313		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)**	$ 2,504,313	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 3,356,644	$	45
46	**TOTAL EQUITY**	$ (2,596,110)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 760,534	$	47

***(See instructions.)**

Facility Name: Eagles View Supportive Living and Memory Care Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,028,091	1
2	Discounts and Allowances	(2,975)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,025,116	3
	B. Other Operating Revenue		
4	Special Services	34,033	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	372	8
9	Non-Resident Meals	20	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 34,425	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	(1,520)	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ (1,520)	14
	D. Other Revenue (specify):		
15	**See Page 8 Attachment**		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)**	$ 2,058,021	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	724,573	19
20	Health Care/ Personal Care	618,434	20
21	General Administration	776,132	21
	B. Capital Expense		
22	Ownership	720,647	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)**	$ 2,839,785	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (781,764)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (781,764)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,311,008	32
33	Private Pay - Net Inpatient Revenue	714,108	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 2,025,116	37

Expenses PG 3 Other

General Services Other	
8010-116-00 Admin Exp>Auto	383
8250-024-61 Maintenance Exp>Contracted Service>Security	-
8250-040-00 Maintenance Exp>Sanitation & Incineration	9,359
8250-041-00 Maintenance Exp>Extermination	2,535
	12,277

General Administration Other	
8410-000-00 Bad Debt Exp	24,420
	24,420

Reclassifications & Adjustments	
8010-060-00 Admin Exp>Fines & Penalties	20
8010-076-00 Admin Exp>Bank Fees	3,783
8410-000-00 Bad Debt Exp	24,420
	28,223

PG 4 Related Parties

Related Party Management Fees	
8911-024-89	85,500
	85,500

Related Party Realty	
9376-000-00 Rent Exp	690,000
	690,000

Balance Sheet PG 7 Other

Current Liabilities	
2011-209-00 AR Related Payables>Other Payor	30,922
2025-000-00 Other Accrued	92,458
2025-208-00 Other Accrued>Insurance	1,901
2040-000-00 Due To/(From)	620
2040-000-90 Due To/(From)>Realty	53,000
2040-940-00 Due To/(From)>Related Parties	15,000
	193,901