		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: 1000022

Facility Name: Quincy Sen & Fam Resource Ct

Address: 639 York (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 592-3668 **Fax #** 217 592-3732

Federal Employer ID Number:

Date Current Owners were Certified: ####

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Marcia Strother **Telephone Number:** (217 223-7904 ext 123
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 01/01/2018 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)
(Date)
(Type or Print Name) Michael Drew
(Title) General and managing partner

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 Quincy Sen & Fam Resource Ct Report Period Beginning: 01/01/2018 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	51	Single Unit Apartment	51	18,615	1
2	6	Double Unit Apartment	6	2,190	2
3		Other			3
4	57	TOTALS	57	20,805	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	15,098	1,843		16,941	5
6	Double Unit	1,694			1,694	6
7	Other					7
8	TOTALS	16,792	1,843		18,635	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.57%

D. Indicate the number of paid bed-hold days the SLF had during this year 266 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 183 (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: Jan-Dec Fiscal Year: Jan-Dec
* 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: Quincy Sen & Fam Resource Ct **Report Period Beginning: 01/01/2018 Ending: 12/31/2018**

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	5	6	
	A. General Services							
1	Dietary and Food Purchase		127,484		127,484		127,484	1
2	Housekeeping, Laundry and Maintenance	33,249	64,932	28,355	126,535		126,535	2
3	Heat and Other Utilities			75,200	75,200	(12,411)	62,788	3
4	Other (specify): waste removal and pest control			5,796	5,796		5,796	4
5	**TOTAL General Services**	33,249	192,416	109,350	335,015	(12,411)	322,604	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	430,807	5,143	4,649	440,598		440,598	6
7	Activities and Social Services	24,960	27,510	27,419	79,889		79,889	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	455,767	32,653	32,068	520,487		520,487	9
	C. General Administration							
10	Administrative and Clerical	60,397	29,678	84,074	174,149		174,149	10
11	Marketing Materials, Promotions and Advertising			7,077	7,077		7,077	11
12	Employee Benefits and Payroll Taxes	257,909			257,909		257,909	12
13	Insurance-Property, Liability and Malpractice		34,227		34,227		34,227	13
14	Other (specify): Legal fees associated with sole ownership beginning process			60,755	60,755		60,755	14
15	**TOTAL General Administration**	318,306	63,905	151,906	534,117		534,117	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	807,321	288,974	293,324	1,389,619	(12,411)	1,377,208	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			251,650	251,650		251,650	17
18	Interest			215,247	215,247		215,247	18
19	Real Estate Taxes			110,000	110,000		110,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): mortgage insurance amortization			25,057	25,057		25,057	22
23	**TOTAL Ownership**			601,953	601,953		601,953	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	807,321	288,974	895,277	1,991,573	(12,411)	1,979,161	24

Facility Name: Quincy Sen & Fam Resource Ct Report Period Beginning: 01/01/2018 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	4	15.33	2
3	Certified Nurse Assistants	13	9.57	3
4	Activity Director & Assistants	1	12.00	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2	8.75	10
11	Laundry			11
12	Managers	1	20.60	12
13	Other Administrative	1	11.25	13
14	Clerical			14
15	Marketing			15
16	Other CGA	4	8.70	16
17	Total (lines 1 thru 16)	26	$	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	West Central Illinois Area Agency on Aging	$ 80,092	1
2			2
		Total $ 80,092	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
NDC Equity Funds IV	New York, NY			
West Central Illinois Area Agency on Aging	Quincy, IL			

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 [ ] NO [X]
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: Quincy Sen & Fam Resource Ct Report Period Beginning: 01/01/2018 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	57		2002	2002	$ 7,006,426	$		$ 251,650	$ 251,650	$ 3,802,901	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)				$ 7,006,426	$		$ 251,650	$ 251,650	$ 3,802,901	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	$	$	$	$		$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$	$	$	$		$	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: Quincy Sen & Fam Resource Ct Report Period Beginning: 01/01/2018 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	PR Mortgage			Mortgage Loan	11/26/13	$ 4,195,900	$ 3,971,946	12/1/53	0.0422	$ 168,735	1
2	General Partner			Surplus	4/23/03	500,000	1,180,232	/ /	0.0800	46,511	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 4,695,900	$ 5,152,178			$ 215,247	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 4,695,900	$ 5,152,178			$ 215,247	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: Quincy Sen & Fam Resource Ct **Report Period Beginning:** 01/01/2018 **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	$ 70,219	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	16,330		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,841		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	85,046		8
9	Other(specify): Medicaid	92,176		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 285,611	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,920,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	164,345		16
17	Accumulated Depreciation (book methods)	(4,054,551)		17
18	Deferred Charges	736,635		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(627,654)		20
21	Restricted Funds	417,860		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,556,997	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,842,608	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 254,095	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	445,561		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	1,718		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 701,374	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,220,233		38
39	Mortgage Payable	3,971,946		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Development Fee	122,629		42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 5,314,808	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,016,182	$	45
46	**TOTAL EQUITY**	$ (2,173,573)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 3,842,609	$	47

***(See instructions.)**

Facility Name: Quincy Sen & Fam Resource Ct Report Period Beginning: 01/01/2018 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	$ 1,368,546	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,368,546	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	1,230	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 1,230	14
	D. Other Revenue (specify):		
15	**Office Rent Revenue**	32,075	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 32,075	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,401,851	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	322,604	19
20	Health Care/ Personal Care	520,487	20
21	General Administration	534,117	21
	B. Capital Expense		
22	Ownership	601,793	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)**	$ 1,979,001	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (577,150)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (577,150)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 690,929	32
33	Private Pay - Net Inpatient Revenue	677,617	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,368,546	37