

		FOR BHF USE			

LL2

Supportive Living Facility

2013

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2013)

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: 1000143

Facility Name: Prairie Green at Dixie Crsng

Address: 1040 Dixie Highway Chicago Heights 60411

Number City Zip Code

County: Cook

Telephone Number: (708) 754-5700 Fax # 708 754-5734

Federal Employer ID Number: _____

Date Current Owners were Certified: _____

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ 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: Leticia Gonzalez Telephone Number: (312) 673-4360

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 05/30/2013 to 12/31/2013 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) Timothy J. Adams

(Title) VP of Accounting

Paid Preparer (Signed) _____ (Date) _____

(Print Name and Title) Chris Joos
Partner

(Firm Name & Address) Plante Moran
65 East State Street, Suite 600, Columbus, OH 43215

(Telephone) (614) 849-3000 Fax 248-233-8811

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 Prairie Green at Dixie Crsng

Report Period Beginning: 05/30/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	<u>144</u>	Single Unit Apartment	<u>144</u>	<u>31,104</u>	1
2		Double Unit Apartment			2
3		Other			3
4	<u>144</u>	TOTALS	<u>144</u>	<u>31,104</u>	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	<u>4,689</u>	<u>1,156</u>		<u>5,845</u>	5
6	Double Unit					6
7	Other					7
8	TOTALS	<u>4,689</u>	<u>1,156</u>		<u>5,845</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 18.79%

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 ☒

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES ☐ NO ☒

G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☐ YES ☐ NO

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans
outstanding? Yes If yes, did the facility make all of the
required payments of interest and principle? Yes
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 principle? _____
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 principle? _____
If no, explain. _____

Facility Name: Prairie Green at Dixie Crsng

Report Period Beginning:

05/30/2013

Ending:

12/31/2013

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	180,635	19,467	56,728	256,830		256,830	1
2	Housekeeping, Laundry and Maintenance	69,308		80,317	149,625		149,625	2
3	Heat and Other Utilities			61,943	61,943		61,943	3
4	Other (specify):							4
5	TOTAL General Services	249,943	19,467	198,988	468,398		468,398	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	364,943	1,382	3,270	369,595		369,595	6
7	Activities and Social Services	41,896		7,171	49,067		49,067	7
8	Other (specify): Home Office Expenses					326	326	8
9	TOTAL Health Care and Programs	406,839	1,382	10,441	418,662	326	418,988	9
	C. General Administration							
10	Administrative and Clerical	163,258	51,808	62,117	277,183		277,183	10
11	Marketing Materials, Promotions and Advertising	36,087		101,842	137,929	15,101	153,030	11
12	Employee Benefits and Payroll Taxes			205,801	205,801		205,801	12
13	Insurance-Property, Liability and Malpractice			51,637	51,637		51,637	13
14	Other (specify): Home Office Expenses					87,399	87,399	14
15	TOTAL General Administration	199,345	51,808	421,397	672,550	102,500	775,050	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	856,127	72,657	630,826	1,559,610	102,826	1,662,436	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			390,631	390,631		390,631	17
18	Interest			484,788	484,788		484,788	18
19	Real Estate Taxes			49,500	49,500		49,500	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,395	12,395		12,395	21
22	Other (specify): Home Office Expenses					3,468	3,468	22
23	TOTAL Ownership			937,314	937,314	3,468	940,782	23
24	GRAND TOTAL (Sum of lines 16 and 23)	856,127	72,657	1,568,140	2,496,924	106,294	2,603,218	24

Facility Name: **Prairie Green at Dixie Crsng**

Report Period Beginning **05/30/2013** Ending: **12/31/2013**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 34.87	1
2	Licensed Practical Nurses	3	24.07	2
3	Certified Nurse Assistants	12	10.12	3
4	Activity Director & Assistants	2	15.10	4
5	Social Service Workers			5
6	Head Cook	1	31.26	6
7	Cook Helpers/Assistants	6	11.06	7
8	Dishwashers			8
9	Maintenance Workers	2	11.03	9
10	Housekeepers			10
11	Laundry			11
12	Managers	2	32.66	12
13	Other Administrative	3	18.03	13
14	Clerical			14
15	Marketing	2	19.23	15
16	Other			16
17	Total (lines 1 thru 16)	34	\$	17

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
See Exhibit 4			

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: Senior Lifestyle Corporation If yes, what is the value of those services? \$ 106,294
(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. (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	None			\$	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

Facility Name: Prairie Green at Dixie Crsng

Report Period Beginning:

05/30/2013

Ending:

12/31/2013

VIII. OWNERSHIP COSTS

A. Purchase price of land 1 Year land was acquired 2013

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	144		2013	2013	\$ 17,336,349	\$ 157,603	27	\$ 157,603	\$	\$ 157,603	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvement		2013	2013	22,853	11,426	15	11,426		11,426	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)				\$ 17,359,202	\$ 169,029		\$ 169,029	\$	\$ 169,029	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	\$ 368,385	\$ 221,602	\$ 221,602	\$	5	\$ 221,602	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 368,385	\$ 221,602	\$ 221,602	\$	\$ 221,602	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: Prairie Green at Dixie Crsng

Report Period Beginning: 05/30/2013

Ending: 2/31/2013

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	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 \$ 11,745

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		2		3	4	6		7	8	9			
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense			
		YES	NO			Original	Balance						
	A. Directly Facility Related												
	Long-Term												
1					/ /	\$		/ /		\$	1		
2					/ /			/ /			2		
3					/ /			/ /			3		
	Working Capital												
4					/ /			/ /			4		
5					/ /			/ /			5		
6					/ /			/ /			6		
7	TOTAL Facility Related					\$				\$	7		
	B. Non-Facility Related												
8	IHDA		X	Build Property	5/31/12	18,500,000	18,321,271	6/1/43	4.3000	462,130	8		
9					/ /			/ /			9		
10	TOTALS (lines 7, 8 and 9)					\$	18,500,000	\$	18,321,271		\$	462,130	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: **Prairie Green at Dixie Crsng**Report Period Beginning: **05/30/2013**Ending: **12/31/2013****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,682,505	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	283,177		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,078		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,996,760	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1		13
14	Buildings, at Historical Cost	17,336,349		14
15	Leasehold Improvements, at Historical Cost	22,853		15
16	Equipment, at Historical Cost	368,385		16
17	Accumulated Depreciation (book methods)	(390,631)		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): Deposits	85,369		22
23	Other(specify): CIP	5,227		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 17,427,553	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,424,313	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,746	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,528		30
31	Accrued Taxes Payable	73,279		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	3,856		34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 282,409	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	20,488,497		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)	\$ 20,488,497	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 20,770,906	\$	45
46	TOTAL EQUITY	\$ 653,407	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 21,424,313	\$	47

*(See instructions.)

Facility Name: **Prairie Green at Dixie Crsng**Report Period Beginning: **05/30/2013**

Ending:

12/31/2013**XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)**

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 554,998	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 554,998	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)	\$ 554,998	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	468,398	19
20	Health Care/ Personal Care	418,662	20
21	General Administration	672,550	21
	B. Capital Expense		
22	Ownership	937,314	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)	\$ 2,496,924	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (1,941,926)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (1,941,926)	31

