

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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: 1000061

Facility Name: Pioneer Gardens

Address: 3800 South MLK Drive Chicago 60653

Number City Zip Code

County: Cook

Telephone Number: (773) 420-4100 Fax # (776) 420-4118

Federal Employer ID Number:

Date Current Owners were Certified:

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input checked="" type="checkbox"/>	Partnership	<input type="checkbox"/>	County
		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

IRS Exemption Code

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

Name: Cheri Murff Telephone Number: 773-420-4105

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 1/1/2015 to 12/31/2015 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) Rev. Craig D. Williams

(Title) Director

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 **Pioneer Gardens**

Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	108	Single Unit Apartment	108	39,420	1		
2	12	Double Unit Apartment	12	4,380	2		
3		Other			3		
4	120	TOTALS	120	43,800	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
Resident Days by Unit and Primary Source of Payment						
5	Single Unit	34,397			34,397	5
6	Double Unit	4,380			4,380	6
7	Other					7
8	TOTALS	38,777			38,777	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **88.53%**

D. Indicate the number of paid bed-hold days the SLF had during this year

170 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

ACCUAL		MODIFIED	
CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>

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

Tax Year: 12/31/2015 **Fiscal Year:**

* 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? _____
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? YES **If yes, did the facility make all of the required payments of interest and principle?** YES
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.

STATE OF ILLINOIS

Page 3

Facility Name: Pioneer Gardens

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	233,173	291,920	20,190	545,283		545,283	1
2	Housekeeping, Laundry and Maintenance	128,775	19,021	75,300	223,096		223,096	2
3	Heat and Other Utilities			247,954	247,954		247,954	3
4	Other (specify):							4
5	TOTAL General Services	361,948	310,941	343,444	1,016,333		1,016,333	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	701,520	14,928	3,362	719,810		719,810	6
7	Activities and Social Services	28,392	1,752	14,175	44,319		44,319	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	729,912	16,680	17,537	764,129		764,129	9
	C. General Administration							
10	Administrative and Clerical	227,066	24,270	114,420	365,756		365,756	10
11	Marketing Materials, Promotions and Advertising	50,347		2,398	52,746		52,746	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration	277,414	24,270	116,819	418,502		418,502	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,369,273	351,891	477,799	2,198,964		2,198,964	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			706,788	706,788		706,788	17
18	Interest			589,597	589,597		589,597	18
19	Real Estate Taxes			92,484	92,484		92,484	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): MIP,MGMT,AMORTZ)			162,149	162,149		162,149	22
23	TOTAL Ownership			1,551,018	1,551,018		1,551,018	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,369,273	351,891	2,028,817	3,749,982		3,749,982	24

Facility Name: Pioneer Gardens

Report Period Beginning 1/1/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 19.76	1
2	Licensed Practical Nurses	5	25.94	2
3	Certified Nurse Assistants	19	13.91	3
4	Activity Director & Assistants	1	13.65	4
5	Social Service Workers			5
6	Head Cook	1	23.36	6
7	Cook Helpers/Assistants	6	8.57	7
8	Dishwashers	2	8.67	8
9	Maintenance Workers	3	10.57	9
10	Housekeepers	4	8.82	10
11	Laundry			11
12	Managers	1	35.64	12
13	Other Administrative	5	21.88	13
14	Clerical	2	10.00	14
15	Marketing	2	21.90	15
16	Other	10	10.00	16
17	Total (lines 1 thru 16)	62	\$	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

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: If yes, what is the value of 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				\$	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

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				2006	\$ 19,602,654	\$ 710,400	28	\$ 700,095	\$ (10,305)	\$ 7,277,186	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)				\$ 19,602,654	\$ 710,400		\$ 700,095	\$ (10,305)	\$ 7,277,186	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		\$ 4,288	\$	\$ 4,288	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 4,288	\$	\$ 4,288	24

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2015

Ending: 2/31/2015

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	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	Midland Bank		X	Mortgage	8/1/04	\$ 11,340,000	\$ 10,333,751	3/1/46	5.6500	\$ 595,955	1
2	City of Chicago		X	Mortgage	8/1/04	1,828,000	1,828,000	8/1/46			2
3	Federal Home Loan		X	Mortgage	8/1/04	500,000	500,000	/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 13,668,000	\$ 12,661,751			\$ 595,955	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 13,668,000	\$ 12,661,751			\$ 595,955	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.

STATE OF ILLINOIS

Page 7

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 167,839	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	550,451		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,556		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)	\$ 751,846	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	230,000		13
14	Buildings, at Historical Cost	19,038,373		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	568,569		16
17	Accumulated Depreciation (book methods)	(6,572,786)		17
18	Deferred Charges	527,398		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,223,716		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,015,270	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,767,116	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	98,047		29
30	Accrued Salaries Payable	49,697		30
31	Accrued Taxes Payable	92,000		31
32	Accrued Interest Payable	49,403		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)	\$ 289,147	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,797,370		38
39	Mortgage Payable	10,492,632		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Management Fees	1,224,662		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 15,514,664	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 15,803,811	\$	45
46	TOTAL EQUITY	\$ (864,195)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 14,939,616	\$	47

*(See instructions.)

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2015

Ending:

12/31/2015

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	\$ 4,467,646	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,467,646	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	656	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 656	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)	\$ 4,468,302	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,016,333	19
20	Health Care/ Personal Care	764,129	20
21	General Administration	418,502	21
	B. Capital Expense		
22	Ownership	1,551,018	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)	\$ 3,749,982	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 718,321	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 718,321	31