

		FOR BHF USE			

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2016)

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: 1000125

Facility Name: GRAND PRAIRIE SUPPORTIVE LVG

Address: 1307 MEADOWLARK LANE MACOMB 61455

Number City Zip Code

County: MCDONOUGH

Telephone Number: (309) 833-5000 Fax # 309 833-5005

Federal Employer ID Number:

Date Current Owners were Certified: 07/20/2010

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: Thomas Staszak Telephone Number: (815) 935-1992

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 01/01/2016 to 12/31/2016 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)	David J. Mitchell		
	(Title)	CFO, Gardant Management Solutions		
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 GRAND PRAIRIE ASSISTED LIVING, LLC

ID#:

Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	86	Single Unit Apartment	86	31,476	1
2		Double Unit Apartment			2
3		Other			3
4	86	TOTALS	86	31,476	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	17,408	9,963		27,371	5
6	Double Unit					6
7	Other					7
8	TOTALS	17,408	9,963		27,371	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.96%

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

183 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: 2016 Fiscal Year: 2016

* 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? 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.

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Facility Name: GRAND PRAIRIE ASSISTED LIVING, LLC

ID#:

Report Period Beginning:

01/01/2016

Ending: 12/31/2016

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	214,032	149,165	1,946	365,143		365,143	1
2	Housekeeping, Laundry and Maintenance	89,980	32,563	28,532	151,075		151,075	2
3	Heat and Other Utilities			132,478	132,478	(13,721)	118,757	3
4	Other (specify): See Page 3 Attachment			29,107	29,107		29,107	4
5	TOTAL General Services	304,012	181,728	192,063	677,803	(13,721)	664,082	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	394,661	10,384		405,045		405,045	6
7	Activities and Social Services	32,288	3,792		36,080		36,080	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	426,949	14,176		441,125		441,125	9
	C. General Administration							
10	Administrative and Clerical	126,724	17,571	1,417,167	1,561,462	(26,177)	1,535,285	10
11	Marketing Materials, Promotions and Advertising	48,450	5,951	58,172	112,573		112,573	11
12	Employee Benefits and Payroll Taxes			220,225	220,225		220,225	12
13	Insurance-Property, Liability and Malpractice			39,423	39,423		39,423	13
14	Other (specify): See Page 3 Attachment			30,847	30,847	(18,870)	11,977	14
15	TOTAL General Administration	175,174	23,522	1,765,834	1,964,530	(45,047)	1,919,483	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	906,135	219,426	1,957,897	3,083,458	(58,768)	3,024,690	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			2,882	2,882		2,882	17
18	Interest					(112)	(112)	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,687	6,687		6,687	21
22	Other (specify): See Page 3 Attachment			101	101		101	22
23	TOTAL Ownership			9,670	9,670	(112)	9,558	23
24	GRAND TOTAL (Sum of lines 16 and 23)	906,135	219,426	1,967,567	3,093,128	(58,880)	3,034,248	24

Facility Name: GRAND PRAIRIE ASSISTED LIVING, LLC

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Report Period Beginning: 01/01/2016

Ending:

12/31/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	\$ Inc line 1	1
2	Licensed Practical Nurses	1	19.80	2
3	Certified Nurse Assistants	12	10.52	3
4	Activity Director & Assistants	Inc line 12	Inc line 1	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	9	9.74	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 1	9
10	Housekeepers	2	9.46	10
11	Laundry			11
12	Managers	4	20.42	12
13	Other Administrative	3	19.26	13
14	Clerical	Inc line 13	Inc line 1	14
15	Marketing	Inc line 12	Inc line 1	15
16	Other			16
17	Total (lines 1 thru 16)	31	\$	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	Gardant Management Solutions	\$	148,171	1
2				2
Total		\$	148,171	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

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? \$

(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).

Facility Name: GRAND PRAIRIE ASSISTED LIVING, LLC ID#: Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VIII. OWNERSHIP COSTS

A. Purchase price of land Year land was acquired 2007

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								\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Leasehold Improvements				3,000	200	15	200	(0)	1,500	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)				\$ 3,000	\$ 200		\$ 200	\$ (0)	\$ 1,500	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	\$ 280,252	\$ 2,198	\$ 56,050	53,852	5	\$ 247,425	18
19	Vehicles	39,149	484		(484)		39,149	19
20	TOTAL (lines 18 and 19)	\$ 319,401	\$ 2,682	\$ 56,050	53,368		\$ 286,574	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

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	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 \$ _____

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					/ / \$	-	\$	/ /	.0000	\$	1
2					/ /	-		/ /	.0000		2
3					/ /	-		/ /	.0000		3
4						-			.0000		
5						-			.0000		
	Working Capital										
6											4
7	TOTAL Facility Related					\$	\$			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$	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.

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Facility Name: GRAND PRAIRIE ASSISTED LIVING, LLC

ID#:

Report Period Beginning: 01/01/2016

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 94,543	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (23,665))	715,894		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,048		6
7	Other Prepaid Expenses	14,630		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Page 7 Attachment	15,246		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 864,361	\$	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	3,000		15
16	Equipment, at Historical Cost	319,401		16
17	Accumulated Depreciation (book methods)	(288,074)		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)	\$ 34,327	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 898,687	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,937	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,209		30
31	Accrued Taxes Payable			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	63,896		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 132,042	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	950,654		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)	\$ 950,654	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,082,696	\$	45
46	TOTAL EQUITY	\$ (184,009)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 898,687	\$	47

*(See instructions.)

Facility Name: GRAND PRAIRIE ASSISTED LIVING, LLC

ID#:

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,967,889	1
2	Discounts and Allowances	(43,728)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,924,161	3
	B. Other Operating Revenue		
4	Special Services	87,050	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	13,088	8
9	Non-Resident Meals	4,900	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 105,038	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	112	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 112	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	6,165	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,165	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,035,476	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	677,803	19
20	Health Care/ Personal Care	441,125	20
21	General Administration	1,964,530	21
	B. Capital Expense		
22	Ownership	9,670	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)	\$ 3,093,128	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (57,652)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (57,652)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,026,082	32
33	Private Pay - Net Inpatient Revenue	1,898,079	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,924,161	37

Expenses PG 3 Other

[illegible]

Balance Sheet

Other Current Assets Detail			Current Liabilities Detail		
		Amt			Amt
1102-9971-0-0	A/R-Employee Advance	-	2111-0040-0-0	Construction Account Payable	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-	2112-0100-0-0	Accrued Asset Management Fee	-
1102-9973-0-0	A/R-Insurance Reimbursement	-	2112-0101-0-0	Accrued Partnership Mgmt Fee	-
1102-9974-0-0	A/R-Subscription Receivable	-	2112-0102-0-0	Accrued Incentive Mgmt Fee	-
1102-9975-0-0	A/R-CIP	-	2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
1102-9976-0-0	A/R-Other	14,980	2112-0105-0-0	Accrued Liabilities	53,897
1102-9978-0-0	A/R-TIF/Abatement	-	2112-0110-0-0	Accrued Insurance	-
1105-0006-0-0	Security Deposit-Equip & Util	266	2112-0115-0-0	Accrued Developer Fee	-
1105-0009-0-0	Transfer Account	-	2112-0130-0-0	Accrued MIP	-
1105-0012-0-0	Undeposited Funds	-	2112-0140-0-0	Accrued Vacation	-
			2112-0144-0-0	Payroll Union Dues	-
			2112-0146-0-0	Payroll Benefits	-
			2112-0150-0-0	Security Deposits	-
			2112-0154-0-0	Unclaimed Property	1,983
			2112-0155-0-0	Reservation Deposit	-
			2112-0156-0-0	Buy Down Credit	-
			2112-0157-0-0	Unapplied Last Month Rent	-
			2112-0158-0-0	Deferred Gain on Sale	-
			2112-0159-0-0	Unearned Revenue	8,016
			2112-0159-1-0	Medicaid Prepayments	-
			2112-0159-2-0	Prepaid Medicaid Clearing	-
			2112-0159-3-0	Prepaid Rent	-
		15,246			63,896
Other Long Term Assets Detail					
1201-0020-0-0	CIP	-			
1201-0021-0-0	CIP- Land Option Addition	-			
1201-0022-0-0	CIP- Other Addition	-			
		-			

Income Statement		
Other Revenue		Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	945
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	5,220
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
		6,165