

		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: 1000065

Facility Name: Plum Creek SLF

Address: 2801 W Algonquin Rd Rolling Meadows 60008
 Number City Zip Code

County: Cook

Telephone Number: (847) 670-8080 **Fax #** (847) 368-1330

Federal Employer ID Number:

Date Current Owners were Certified: 10/23/06

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: Reuel Crook / Sue McTague **Telephone Number:** (847) 670-8080

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) Reuel Crook

(Title) Financial Director - Management Company

**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 Plum Creek SLFReport Period Beginning: 1/1/16 Ending: 12/31/16

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	77	Single Unit Apartment	77	28,182	1
2	25	Double Unit Apartment	25	9,150	2
3		Other			3
4	102	TOTALS	102	37,332	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	24,938	1,676		26,614	5
6	Double Unit	6,501	1,779		8,280	6
7	Other					7
8	TOTALS	31,439	3,455		34,894	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.47%D. Indicate the number of paid bed-hold days the SLF had during this year 637 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 327 (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: _____ 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? _____ 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? _____ 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? _____ If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

Facility Name: Plum Creek SLF

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	260,734	263,186		523,920		523,920	1
2	Housekeeping, Laundry and Maintenance	63,990	11,152	121,452	196,594	(17,722)	178,872	2
3	Heat and Other Utilities			114,511	114,511		114,511	3
4	Other (specify):							4
5	TOTAL General Services	324,724	274,338	235,963	835,025	(17,722)	817,303	5
B. Health Care and Programs								
6	Health Care/ Personal Care	402,592	9,653		412,245		412,245	6
7	Activities and Social Services	31,723	19,121		50,844	(6,740)	44,104	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	434,315	28,774		463,089	(6,740)	456,349	9
C. General Administration								
10	Administrative and Clerical	220,868	67,083		287,951		287,951	10
11	Marketing Materials, Promotions and Advertising	36,538	39,539		76,077		76,077	11
12	Employee Benefits and Payroll Taxes	85,109	12,116		97,225		97,225	12
13	Insurance-Property, Liability and Malpractice			155,082	155,082		155,082	13
14	Other (specify): Professional & Management Fees			472,262	472,262		472,262	14
15	TOTAL General Administration	342,515	118,738	627,344	1,088,597		1,088,597	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,101,554	421,850	863,307	2,386,711	(24,462)	2,362,249	16
Capital Expenses								
D. Ownership								
17	Depreciation			492,618	492,618		492,618	17
18	Interest			672,507	672,507		672,507	18
19	Real Estate Taxes			100,000	100,000		100,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Amortization of Prepaid Closing Costs			27,185	27,185		27,185	22
23	TOTAL Ownership			1,292,310	1,292,310		1,292,310	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,101,554	421,850	2,155,617	3,679,021	(24,462)	3,654,559	24

Facility Name: Plum Creek SLF

Report Period Beginning 1/1/16

Ending:

12/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 25.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	10	10.70	3
4	Activity Director & Assistants	1	14.42	4
5	Social Service Workers			5
6	Head Cook	1	17.30	6
7	Cook Helpers/Assistants	9	9.80	7
8	Dishwashers			8
9	Maintenance Workers	1	10.00	9
10	Housekeepers	2	8.25	10
11	Laundry			11
12	Managers	1	30.00	12
13	Other Administrative	3	26.89	13
14	Clerical	4	9.12	14
15	Marketing	1	16.82	15
16	Other			16
17	Total (lines 1 thru 16)	35	\$ 13.45	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? \$ _____

(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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties**Amount of Fee**

1	Royal Care Management Company	\$ 227,500	1
2			2
Total		\$ 227,500	3

Facility Name: Plum Creek SLF

Report Period Beginning:

1/1/16

Ending:

12/31/16

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					\$	\$		\$	\$	\$	1
2	102		2006	2006	12,602,734	492,056	40	315,068	(176,988)	4,741,814	2
3											3
4											4
5											5
6	Improvement Type										
7	Building Improvement			2007	2,007	263	40	263			6
8	Building Improvement			2007	2,007	85	40	85			7
9	Building Improvement			2007	2,007	214	40	214			8
10	Building Improvement			2007	2,007						9
11	Building Improvement			2007	2,007						10
12	Building Improvement			2007	2,007						11
13	Building Improvement			2007	2,007						12
14	Building Improvement			2007	2,007						13
15	Building Improvement			2007	2,007						14
16	Building Improvement			2007	2,007						15
17	TOTAL (lines 1 thru 16)				\$ 12,608,755	\$ 492,618		\$ 315,630	\$ (176,988)	\$ 4,741,814	16

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	\$ 580,139	\$ 26,269	\$ 64,207	37,938	7	\$ 540,735	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 580,139	\$ 26,269	\$ 64,207	37,938		\$ 540,735	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: Plum Creek SLF

Report Period Beginning: 1/1/16

Ending: 12/31/16

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1					/ /	\$		/ /		\$	1
2			X	Building Purchase / Remodel	4/1/06	11,600,000	10,140,000	12/1/37	0.0650	672,507	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,600,000	\$ 10,140,000			\$ 672,507	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,600,000	\$ 10,140,000			\$ 672,507	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: Plum Creek SLF

Report Period Beginning: 1/1/16

Ending:

12/31/16

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	\$ 315,817	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	534,476		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,811		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)	\$ 862,104	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	849,401		13
14	Buildings, at Historical Cost	12,508,851		14
15	Leasehold Improvements, at Historical Cost	129,195		15
16	Equipment, at Historical Cost	580,139		16
17	Accumulated Depreciation (book methods)	(5,282,548)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	815,538		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(292,236)		20
21	Restricted Funds	1,737,667		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,046,007	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,908,111	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,821	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,140		30
31	Accrued Taxes Payable	97,105		31
32	Accrued Interest Payable	54,925		32
33	Deferred Compensation	193,414		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)	\$ 388,405	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable	10,140,000		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)	\$ 10,140,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,528,405	\$	45
46	TOTAL EQUITY	\$ 1,379,706	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,908,111	\$	47

*(See instructions.)

Facility Name: Plum Creek SLF

Report Period Beginning: 1/1/16

Ending: 12/31/16

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	\$ 3,564,577	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,564,577	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	95	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 95	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	7,390	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 7,390	14
	D. Other Revenue (specify):		
15	Ancillary Telephone Service	18,615	15
16	Food Stamp Allowance	117,260	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 135,875	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,707,937	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	817,303	19
20	Health Care/ Personal Care	456,349	20
21	General Administration	1,088,597	21
	B. Capital Expense		
22	Ownership	1,292,310	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)	\$ 3,654,559	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 53,378	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 53,378	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 662,700	32
33	Private Pay - Net Inpatient Revenue	1,585,628	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Managed Care MCO's</u>	1,316,249	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,564,577	37