

		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: 1000143

Facility Name: Prairie Green Dixie Crossing

Address: 1040 Dixie Highway Chicago Heights 60411

County: Cook

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

Federal Employer ID Number: _____

Date Current Owners were Certified: 5/30/2013

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT Charitable Corp.
☐ Trust
 IRS Exemption Code _____

☒ PROPRIETARY
☐ Individual
☐ 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: Anna Kobrzak 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 1/1/18 to 12/31/18 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) Steve Hippel
 (Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date) _____
 (Print Name and Title) Chris Joos
Partner
 (Firm Name & Address) Plante & Moran, PLLC
250 South High Street, Suite 100
 (Telephone) (614) 222-9040 Fax (614) 221-3535

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

HFS 3745C (N-4-05)

IL478-2471

Facility Name Prairie Green Dixie Crossing Report Period Beginning: 1/1/18 Ending: 12/31/18

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	144	Single Unit Apartment	144	52,560	1
2		Double Unit Apartment			2
3		Other			3
4	144	TOTALS	144	52,560	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	32,388	3,884		36,272	5
6	Double Unit					6
7	Other					7
8	TOTALS	32,388	3,884		36,272	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 69.01%

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: 12/31/18 Fiscal Year: 12/31/18

* 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 principal? 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 principal? N/A
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? N/A
If no, explain. _____

STATE OF ILLINOIS

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Facility Name: Prairie Green Dixie Crossing

Report Period Beginning:

1/1/18

Ending:

12/31/18

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	319,494	215,352	3,753	538,599		538,599	1
2	Housekeeping, Laundry and Maintenance	95,269	171,759	97	267,125		267,125	2
3	Heat and Other Utilities			139,238	139,238		139,238	3
4	Other (specify):			33,799	33,799		33,799	4
5	TOTAL General Services	414,763	387,111	176,887	978,761		978,761	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	720,859	6,286	30,000	757,145		757,145	6
7	Activities and Social Services	47,386	3,325	2,597	53,308	(1,235)	52,073	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	768,245	9,611	32,597	810,453	(1,235)	809,218	9
	C. General Administration							
10	Administrative and Clerical	164,393	11,140	322,431	497,964	(400)	497,564	10
11	Marketing Materials, Promotions and Advertising	75,546	15,926	54,235	145,707		145,707	11
12	Employee Benefits and Payroll Taxes			204,816	204,816		204,816	12
13	Insurance-Property, Liability and Malpractice			115,879	115,879		115,879	13
14	Other (specify):			172,877	172,877	(172,877)		14
15	TOTAL General Administration	239,939	27,066	870,238	1,137,243	(173,277)	963,966	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,422,947	423,788	1,079,722	2,926,457	(174,512)	2,751,945	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			716,886	716,886		716,886	17
18	Interest			852,895	852,895		852,895	18
19	Real Estate Taxes			65,841	65,841		65,841	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			1,635,622	1,635,622		1,635,622	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,422,947	423,788	2,715,344	4,562,079	(174,512)	4,387,567	24

Facility Name: **Prairie Green Dixie Crossing**

Report Period Beginning **1/1/18** Ending: **12/31/18**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.14	\$ 37.01	1
2	Licensed Practical Nurses	5.16	22.91	2
3	Certified Nurse Assistants	13.43	13.40	3
4	Activity Director & Assistants	1.23	18.52	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8.80	13.08	7
8	Dishwashers			8
9	Maintenance Workers	1.49	22.72	9
10	Housekeepers	1.00	11.96	10
11	Laundry			11
12	Managers	0.65	29.73	12
13	Other Administrative	0.40	56.41	13
14	Clerical	3.16	23.95	14
15	Marketing	1.12	33.09	15
16	Other AL Director	1.33	32.52	16
17	Total (lines 1 thru 16)	37.91	\$	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
Available Upon Request			

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

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).

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	\$ 15,976,939	\$	27	\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements			2013	1,006,884		15				6
7	Land Improvements			2016	20,120		20				7
8	Bldg Improvements			2014	5,280		27				8
9	Bldg Improvements			2015	86,180		27				9
10	Bldg Improvements			2016	32,282		27				10
11	Land Improvements			2017	1,295		20				11
12	Bldg Improvements			2017	16,073		27				12
13	Bldg Improvements			2018	8,803		27				13
14											14
15											15
16						654,822		654,822		3,637,092	16
17	TOTAL (lines 1 thru 16)				\$ 17,153,856	\$ 654,822		\$ 654,822	\$	\$ 3,637,092	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	\$ 783,399	\$ 62,063	\$ 62,063	-	5-7	\$ 768,520	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 783,399	\$ 62,063	\$ 62,063	\$		\$ 768,520	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 Dixie Crossing Report Period Beginning: 1/1/18 Ending: 12/31/18

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 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	IHDA		X	Build Property	5/31/12	\$ 18,500,000	\$ 16,623,000	6/1/43	4.3000	\$ 852,895	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 18,500,000	\$ 16,623,000			\$ 852,895	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 18,500,000	\$ 16,623,000			\$ 852,895	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

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Facility Name: **Prairie Green Dixie Crossing**Report Period Beginning: **1/1/18**

Ending:

12/31/18**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/18**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 603,425	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,208,131 (405,195)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,760		6
7	Other Prepaid Expenses	9,142		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,526,263	\$	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	16,125,560		14
15	Leasehold Improvements, at Historical Cost	1,028,298		15
16	Equipment, at Historical Cost	783,399		16
17	Accumulated Depreciation (book methods)	(4,405,613)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,631,638		21
22	Other Long-Term Assets (specify):	90,879		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,254,162	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,780,425	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,786	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,477		30
31	Accrued Taxes Payable	1,915,087		31
32	Accrued Interest Payable	166,473		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Other	19,040		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,411,863	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	16,623,000		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Intercompany	5,754,200		42
43	Deferred Revenues	120,252		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 22,497,452	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 24,909,315	\$	45
46	TOTAL EQUITY	\$ (6,128,890)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 18,780,425	\$	47

*(See instructions.)

Facility Name: Prairie Green Dixie Crossing

Report Period Beginning: 1/1/18

Ending:

12/31/18

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	\$ 3,564,265	1
2	Discounts and Allowances	(641)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,563,624	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	Misc Income	764	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 764	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,564,388	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	978,761	19
20	Health Care/ Personal Care	810,453	20
21	General Administration	1,137,243	21
	B. Capital Expense		
22	Ownership	1,635,622	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)	\$ 4,562,079	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (997,691)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (997,691)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 3,473,222	32
33	Private Pay - Net Inpatient Revenue	90,402	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,563,624	37

Chicago Heights SLF LLC
Automobile Schedule
2018

Year	Make	Model	Lease Costs
2013	Ford	E350 Cutaway	\$ 9,284.80

Chicago Heights SLF LLC
Adjustments
12/31/2018

CLIENT_ACT	DESC	DEBIT	TB Acct	IL Acct
5565350000	Charitable Contributions	1,500.00	9760.00	IS 14.3
5790350000	Bad Debt Expense	408,656.10	9765.00	IS 14.3
5551330000	Entertainment Expense	1,235.00	7125.00	IS 7.2
5890350000	Miscellaneous Expense	4,370.97	9729.20	IS 14.3
5915346000	Special Events (Off-Site)	302.91	9729.20	IS 14.3
6880350000	Transaction Costs	(239,267.01)	9729.20	IS 14.3
5271350000	Holiday Party Expense	400.00	7820.00	IS 12.3
9729.20	Other Non Reimbursable-	(2,685.82)	9729.20	IS 14.3
		174,512.15		

Chicago Heights SLF LLC
Related Part Cost
2018

Description	Amount on pg 3	Cost to Related Party	Adjustment
Management Fees	182,761.00	182,761.00	-
Company Management Fee	20,319.96	20,319.96	-
Asset Management Fee	20,319.96	20,319.96	-