

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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: 1000077

Facility Name: PRAIRIE WINDS OF URBANA

Address: 1905 S PRAIRIE WINDS URBANA 61801

County: CHAMPAIGN

Telephone Number: (217) 344-6400 Fax # 217 344-6444

Federal Employer ID Number:

Date Current Owners were Certified: 9/19/2007

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

X 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: Danel Erickson 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 01/01/2020 to 12/31/2020 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)

(Type or Print Name) Greg Echols

(Title) CFO, Gardant Management Solutions

Paid Preparer

(Signed)

(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

HFS 3745C (N-4-05)

IL478-2471

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	94	Single Unit Apartment	94	34,310	1
2	0	Double Unit Apartment	0	0	2
3		Other			3
4	94	TOTALS	94	34,310	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	25,515	4,361		29,876	5
6	Double Unit				0	6
7	Other				0	7
8	TOTALS	25,515	4,361	0	29,876	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 87.08%

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

428 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. 23 (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2020 Fiscal Year: 2020

* 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? N/A
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. _____

STATE OF ILLINOIS

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Facility Name: PRAIRIE WINDS OF URBANA

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	278,554	186,929	1,691	467,174	0	467,174	1
2	Housekeeping, Laundry and Maintenance	88,614	49,679	48,014	186,307	0	186,307	2
3	Heat and Other Utilities			124,411	124,411	(17,803)	106,608	3
4	Other (specify):	66,007	0	68,412	134,418	0	134,418	4
5	TOTAL General Services	433,175	236,608	242,528	912,310	(17,803)	894,507	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	513,986	17,799	0	531,785	0	531,785	6
7	Activities and Social Services	26,379	5,215	0	31,594	0	31,594	7
8	Other (specify):	0	0	0	0	0	0	8
9	TOTAL Health Care and Programs	540,365	23,014	0	563,379	0	563,379	9
	C. General Administration							
10	Administrative and Clerical	193,718	36,040	299,610	529,368	(18,598)	510,770	10
11	Marketing Materials, Promotions and Advertising	65,258	8,212	50,063	123,533	0	123,533	11
12	Employee Benefits and Payroll Taxes	0	0	226,409	226,409	0	226,409	12
13	Insurance-Property, Liability and Malpractice	0	0	55,691	55,691	0	55,691	13
14	Other (specify):	0	0	147,877	147,877	(110,752)	37,125	14
15	TOTAL General Administration	258,976	44,252	779,650	1,082,878	(129,349)	953,529	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,232,516	303,874	1,022,178	2,558,567	(147,153)	2,411,415	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			208,881	208,881	0	208,881	17
18	Interest			228,672	228,672	(12,436)	216,236	18
19	Real Estate Taxes			103,140	103,140	0	103,140	19
20	Rent -- Facility and Grounds			0	0	0	0	20
21	Rent -- Equipment			9,690	9,690	0	9,690	21
22	Other (specify):	0	0	60,676	60,676	0	60,676	22
23	TOTAL Ownership	0	0	611,059	611,059	(12,436)	598,623	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,232,516	303,874	1,633,236	3,169,626	(159,588)	3,010,038	24

Facility Name: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 12	1
2	Licensed Practical Nurses	1	27.50	2
3	Certified Nurse Assistants	15	13.52	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers	0	0.00	5
6	Head Cook	0	0.00	6
7	Cook Helpers/Assistants	9	12.27	7
8	Dishwashers	0	0.00	8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	3	10.59	10
11	Laundry	0	0.00	11
12	Managers	5	25.26	12
13	Other Administrative	3	26.22	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other	0	0.00	16
17	Total (lines 1 thru 16)	35	\$	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

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				\$ 0	6

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

1	Gardant Management Solutions	\$ 212,331	1
2			2
Total		\$ 212,331	3

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

Facility Name: PRAIRIE WINDS OF URBANA Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 566,500 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	94			2007	\$ 5,797,553	\$ 142,933	40	\$ 144,939	\$ 2,006	\$ 1,869,269	1
2									0		2
3									0		3
4									0		4
5									0		5
	Improvement Type										
6	Leasehold Improvements				718,277	35,914	20	35,914	0	484,979	6
7									0		7
8									0		8
9									0		9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)				\$ 6,515,829	\$ 178,847		\$ 180,853	\$ 2,006	\$ 2,354,248	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	\$ 1,264,958	\$ 23,599	\$ 180,708	157,109	7	\$ 1,188,704	18
19	Vehicles	45,039	6,434	6,434	(0)	7	32,707	19
20	TOTAL (lines 18 and 19)	\$ 1,309,997	\$ 30,033	\$ 187,142	157,109		\$ 1,221,412	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 WINDS OF URBANA

Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		0		\$ 0			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	WALKER DUNLAP		X	FIRST MORTGAGE	3/1/12	\$ 7,909,200	\$ 6,713,525	4/1/47	0.0335	\$ 227,317	1	
2											2	
3											3	
	Working Capital											
4	BUSEY BANK		X	SBA PAYROLL PROTECTION PROGRAM	4/15/20	237,900	0	4/15/22	0.0100	1,354	4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 8,147,100	\$ 6,713,525				\$ 228,672	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 8,147,100	\$ 6,713,525				\$ 228,672	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: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,436,976	\$	1
2	Cash-Patient Deposits	0		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (184,186))	398,237		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	61,395		6
7	Other Prepaid Expenses	25,957		7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify): See Page 7 Attachment	73,914		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,996,478	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	566,500		13
14	Buildings, at Historical Cost	5,797,553		14
15	Leasehold Improvements, at Historical Cost	718,277		15
16	Equipment, at Historical Cost	1,309,997		16
17	Accumulated Depreciation (book methods)	(3,575,660)		17
18	Deferred Charges	310		18
19	Organization & Pre-Operating Costs	11,579		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,579)		20
21	Restricted Funds	358,693		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): See Page 7 Attachment	20,300		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,195,969	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,192,447	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 52,970	\$	26
27	Officer's Accounts Payable	0		27
28	Accounts Payable-Patient Deposits	0		28
29	Short-Term Notes Payable	0		29
30	Accrued Salaries Payable	64,192		30
31	Accrued Taxes Payable	104,629		31
32	Accrued Interest Payable	18,742		32
33	Deferred Compensation	0		33
34	Federal and State Income Taxes	0		34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	486,720		35
36		0		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 727,254	\$ 0	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	0		38
39	Mortgage Payable	6,603,687		39
40	Bonds Payable	0		40
41	Deferred Compensation	0		41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 6,603,687	\$ 0	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,330,941	\$ 0	45
46	TOTAL EQUITY	\$ (138,494)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,192,447	\$ 0	47

*(See instructions.)

Facility Name: PRAIRIE WINDS OF URBANA

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	\$ 3,588,609	1
2	Discounts and Allowances	(4,240)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,584,369	3
	B. Other Operating Revenue		
4	Special Services	162,029	4
5	Other Health Care Services	0	5
6	Special Grants	522,979	6
7	Gift and Coffee Shop	0	7
8	Barber and Beauty Care	2,073	8
9	Non-Resident Meals	856	9
10	Laundry	0	10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 687,937	11
	C. Non-Operating Revenue		
12	Contributions	0	12
13	Interest and Other Investment Income	12,436	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 12,436	14
	D. Other Revenue (specify):		
15	See Page 8 Attachment	1,079	15
16		0	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,079	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,285,821	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	912,310	19
20	Health Care/ Personal Care	563,379	20
21	General Administration	1,082,878	21
	B. Capital Expense		
22	Ownership	611,059	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)	\$ 3,169,626	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 1,116,195	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 1,116,195	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,893,221	32
33	Private Pay - Net Inpatient Revenue	1,691,148	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,584,369	37

Balance Sheet PG 7 Other

Balance Sheet

Other Current Assets Detail		Amt
1102-9971-0-0	A/R-Employee Advance	191
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-
1102-9973-0-0	A/R-Insurance Reimbursement	70,289
1102-9974-0-0	A/R-Subscription Receivable	-
1102-9975-0-0	A/R-CIP	-
1102-9976-0-0	A/R-Other	3,433
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
PG7-9.1		73,914
Other Long Term Assets Detail		
1201-0020-0-0	CIP	20,300
1201-0021-0-0	CIP- Land Option Addition	-
1201-0022-0-0	CIP- Other Addition	-
PG7-23.1		20,300.00

Current Liabilities Detail		Amt
2111-0040-0-0	Construction Account Payable	-
2112-0100-0-0	Accrued Asset Management Fee	-
2112-0101-0-0	Accrued Partnership Mgmt Fee	-
2112-0102-0-0	Accrued Incentive Mgmt Fee	-
2112-0102-1-0	Accrued Incentive Asset Mgmt Fee	-
2112-0105-0-0	Accrued Liabilities	289,688
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
2112-0130-0-0	Accrued MIP	-
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	1,160
2112-0155-0-0	Reservation Deposit	3,300
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	41,735
2112-0159-1-0	Medicaid Prepayments	150,838
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
PG7-35.1		486,720
		973440.78

Income Statement PG 8 Other

Income Statement		
	Other Revenue	Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	1,079 Late fees; NSF fees; Call Pendants
3300-3391-0-0	Property Tax Adjustments	-
3300-3392-0-0	Property Lease Income	-
3300-3393-0-0	Insurance Adjustments	-
3300-3395-0-0	Developer Fee Income	-
3300-3396-0-0	Home Office Rent Income	-
3300-3202-0-0	Food & Meal Prep	-
PG8-15.1		1,079