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: 100X043

Facility Name: PRAIRIE LVG AT CHAUTAUQUA II

Address: 955 VILLA COURT (Number) CARBONDALE (City) 62901 (Zip Code)

County: JACKSON

Telephone Number: (618) 351-7955 **Fax #** 618 351-6955

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.		
		X	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 01/01/2015 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) 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 PRAIRIE LIVING WEST LLC Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	47	Single Unit Apartment	47	17,155	1
2	3	Double Unit Apartment	3	1,095	2
3		Other			3
4	50	TOTALS	50	18,250	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,593	7,136		13,729	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,593	7,136		13,729	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 75.23%

D. Indicate the number of paid bed-hold days the SLF had during this year 134 **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: 2015 Fiscal Year: 2015
* 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. _____

Facility Name: PRAIRIE LIVING WEST LLC **Report Period Beginning:** 01/01/2015 **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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase		83,723	678	84,401		84,401	1
2	Housekeeping, Laundry and Maintenance		13,022	27,502	40,524		40,524	2
3	Heat and Other Utilities			64,418	64,418	(7,789)	56,629	3
4	Other (specify): See Attachment			8,818	8,818		8,818	4
5	**TOTAL General Services**		96,745	101,416	198,161	(7,789)	190,372	5
	B. Health Care and Programs							
6	Health Care/ Personal Care		3,451		3,451		3,451	6
7	Activities and Social Services		3,353		3,353		3,353	7
8	Other (specify): See Attachment							8
9	**TOTAL Health Care and Programs**		6,804		6,804		6,804	9
	C. General Administration							
10	Administrative and Clerical		16,694	99,757	116,451	(13,026)	103,425	10
11	Marketing Materials, Promotions and Advertising		4,053	18,908	22,961		22,961	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			12,959	12,959		12,959	13
14	Other (specify): See Attachment			455,440	455,440		455,440	14
15	**TOTAL General Administration**		20,747	587,064	607,811	(13,026)	594,785	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**		124,296	688,480	812,776	(20,816)	791,961	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			284,249	284,249		284,249	17
18	Interest			409,245	409,245		409,245	18
19	Real Estate Taxes			45,723	45,723		45,723	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): See Attachment			11,960	11,960		11,960	22
23	**TOTAL Ownership**			751,177	751,177		751,177	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**		124,296	1,439,657	1,563,953	(20,816)	1,543,138	24

Facility Name: PRAIRIE LIVING WEST LLC Report Period Beginning 01/01/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	Inc line 12	$ Inc line 12	1
2	Licensed Practical Nurses		18.34	2
3	Certified Nurse Assistants	5	9.73	3
4	Activity Director & Assistants	Inc line 12	Inc line 12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	3	9.06	7
8	Dishwashers			8
9	Maintenance Workers	Inc line 12	Inc line 12	9
10	Housekeepers	1	9.05	10
11	Laundry			11
12	Managers	2	18.81	12
13	Other Administrative	2	17.67	13
14	Clerical	Inc line 13	Inc line 13	14
15	Marketing	Inc line 12	Inc line 12	15
16	Other			16
17	Total (lines 1 thru 16)	13	$	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	$ 57,651	1
2			2
		Total $ 57,651	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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
CARBONDALE SLF	CARBONDALE			

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 [X]
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 [X]
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: PRAIRIE LIVING WEST LLC Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land 412,032 Year land was acquired 2009

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	50			2010	$ 5,360,377	$ 194,903	28	$ 194,923	$ 20	$ 1,047,631	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	LAND IMPROVEMENTS				409,950	27,344	15	27,330	(14)	150,004	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)				$ 5,770,327	$ 222,247		$ 222,253	$ 6	$ 1,197,635	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	$ 613,543	$ 62,002	$ 122,709	$ 60,707	5	$ 612,893	18
19	Vehicles				$			19
20	TOTAL (lines 18 and 19)	$ 613,543	$ 62,002	$ 122,709	60,707		$ 612,893	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 LIVING WEST LLC Report Period Beginning: 01/01/2015 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	PEOPLES NATIONAL BANI		X	FIRST MORTGAGE	10/09/09	$ 6,210,000	$ 6,041,405	10/09/34	.0675	$ 409,245	1
2					/ /			/ /	.0000	$	2
3					/ /			/ /	.0000	$	3
4					/ /			/ /	.0000	$	4
5					/ /			/ /	.0000	$	5
	Working Capital										
6					/ /			/ /	.0000	$	6
7	TOTAL Facility Related					$ 6,210,000	$ 6,041,405			$ 409,245	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 6,210,000	$ 6,041,405			$ 409,245	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: PRAIRIE LIVING WEST LLC **Report Period Beginning:** 01/01/2015 **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	$ 165,696	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,300))	119,836		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,348		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,060		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 294,940	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	412,032		13
14	Buildings, at Historical Cost	5,360,377		14
15	Leasehold Improvements, at Historical Cost	409,950		15
16	Equipment, at Historical Cost	613,543		16
17	Accumulated Depreciation (book methods)	(1,810,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	186,547		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,374)		20
21	Restricted Funds	489,082		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,635,628	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,930,567	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 21,235	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	44,731		31
32	Accrued Interest Payable	24,579		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Attachment	6,305		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 96,851	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,041,405		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)**	$ 6,041,405	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,138,257	$	45
46	**TOTAL EQUITY**	$ (207,689)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,930,567	$	47

***(See instructions.)**

Facility Name: PRAIRIE LIVING WEST LLC **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,405,654	1
2	Discounts and Allowances	(9,401)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,396,253	3
	B. Other Operating Revenue		
4	Special Services	25,631	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	4,901	8
9	Non-Resident Meals	102	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 30,634	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	48	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 48	14
	D. Other Revenue (specify):		
15	**See Attachment**	1,067	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 1,067	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,428,002	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	198,161	19
20	Health Care/ Personal Care	6,804	20
21	General Administration	607,811	21
	B. Capital Expense		
22	Ownership	751,177	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)**	$ 1,563,953	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (135,952)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (135,952)	31

	General Services Other	
5200-5000-0-0	Operating Allocation	-
5200-5124-0-0	Exterminating	714
5200-5127-0-0	Rubbish Removal	2,263
5200-5130-0-0	Vehicle Expense	-
5200-5131-0-0	Transportation Service	113
5300-5140-0-0	Security & Monitoring	5,728

Health Care & Programs

5160-5060-0-0
5160-5063-0-0
5160-5064-0-0
5160-5066-0-0
5160-5067-0-0
5160-5068-0-0
5190-5000-0-0
5180-5079-0-0
5180-5079-1-0
5180-5080-0-0
5180-5081-0-0
5180-5081-1-0
5180-5082-0-0

8,818		-

3 Other

General Administration Other	Amt
Consulting	-
Legal	445
Accounting	88
Audit	10,644
Contract Labor-Serv Prov	448,560
Contract Labor	504
Other Admin Allocation	0
Bad Debt - Resident	11,990
Bad Debt - Resident - Recovery	-
Bad Debt - Resident Prior Period	-
Bad Debt - Medicaid Pending Deni	(16,791)
Bad Debt - Medicaid Pending - Rec	-
Bad Debt - Medicaid Denial Prior F	-

	Ownership Other	Amt
9100-9101-0-0	Interest & Dividend Income	-
9100-9102-0-0	Assessment Income	-
9100-9103-0-0	Assessment Expense	-
9200-9202-0-0	Financing Fees	-
9200-9204-0-0	Mortgage Service Fee	-
9200-9205-0-0	Mortgage Insurance Prem	-
9200-9206-0-0	Participation Fee	-
9200-9207-0-0	Letter of Credit Fee	-
9200-9208-0-0	Bond & Draw Fee	-
9200-9209-0-0	Remarketing and Trustee Fee	-
9200-9210-0-0	Interest Expense-Note	-
9200-9211-0-0	Interest Expense-LP	-
9200-9212-0-0	Debt Write-Off	-
9300-9301-0-0	Partnership Management Fee	-
9300-9302-0-0	Asset Management Fee	-
9300-9303-0-0	Incentive Management	-
9300-9303-1-0	Incentive Asset Mgmt Fee	-
9300-9304-0-0	Tax Credit Fees & Incentive Fee	-
9300-9305-0-0	Organizational Expense	-
9300-9306-0-0	Developer Fees	-
9300-9307-0-0	Closing Costs	-
9700-9702-0-0	Amortization Expense	6,960
9900-9901-0-0	Prior Period Adjustments	-
9900-9902-0-0	Dissolution of Business	-
9900-9903-0-0	Loss (Gain) on Sale of Assets	-
9900-9904-0-0	Business Interruption	-
9900-9905-0-0	Settlement	-
9900-9906-0-0	Property Damage Loss	5,000
9900-9907-0-0	Abandonment Loss	-
9900-9908-0-0	Grant Income	-
9900-9909-0-0	Misc: Title, Recording, Transfer	-

455,440	11,960

Balance Sheet

	Other Current Assets Detail	Amt
1102-9971-0-0	A/R-Employee Advance	-
1102-9972-0-0	A/R-Gardant Mgmt Solutions	-
1102-9973-0-0	A/R-Insurance Reimbursement	-
1102-9974-0-0	A/R-Subscription Receivable	-
1102-9975-0-0	A/R-CIP	-
1102-9976-0-0	A/R-Other	1,560
1102-9978-0-0	A/R-TIF/Abatement	-
1105-0006-0-0	Security Deposit-Equip & Util	500
1105-0009-0-0	Transfer Account	-
1105-0012-0-0	Undeposited Funds	-
		2,060

	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	-
		-

	Current Liabilities Detail	Amt
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	2,752
2112-0110-0-0	Accrued Insurance	-
2112-0115-0-0	Accrued Developer Fee	-
2112-0130-0-0	Accrued MIP	-
2112-0140-0-0	Accrued Vacation	-
2112-0146-0-0	Payroll Benefits	-
2112-0154-0-0	Unclaimed Property	2,071
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	1,482
2112-0159-1-0	Medicaid Prepayments	-
2112-0159-2-0	Prepaid Medicaid Clearing	-
2112-0159-3-0	Prepaid Rent	-
2111-0040-0-0	Construction Account Payable	-
2112-0140-0-0	Accrued Vacation	0
2112-0144-0-0	Payroll Union Dues	0
		6,305

Income Statement

	Other Revenue	Amt
3300-3388-0-0	Contract Service-Serv Prov	-
3300-3390-0-0	Other	1,067
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	-
		1,067