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: 1000061

Facility Name: Pioneer Gardens

Address: 3800 South MLK Drive (Number) Chicago (City) 60653 (Zip Code)

County: Cook

Telephone Number: (773) 420-4100 **Fax #** (773) 420-4118

Federal Employer ID Number:

Date Current Owners were Certified:

Type of Ownership:

- [ ] VOLUNTARY, NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [x] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Cheri Murff-Harris **Telephone Number:** (773)420-4105
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 1/1/20 to 12/31/20 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) 6/30/2021 (Date)
(Type or Print Name) Rev. Craig D. Williams
(Title) Management/Agent

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 Pioneer Gardens Report Period Beginning: 1/1/20 Ending: 12/31/20

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	108	Single Unit Apartment	108	39,420	1
2	12	Double Unit Apartment	12	4,380	2
3		Other			3
4	120	TOTALS	120	43,800	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	34,397			31,600	5
6	Double Unit	4,380			3,250	6
7	Other					7
8	TOTALS	38,777			34,850	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 79.57%

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 [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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2020 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? No If yes, did the facility make all of the required payments of interest and principal?
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? Yes If yes, did the facility make all of the required payments of interest and principal?
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?
If no, explain.

Facility Name: Pioneer Gardens **Report Period Beginning: 1/1/20 Ending: 12/31/20**

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	**343,199**	**260,456**		**603,655**		**603,655**	1
2	Housekeeping, Laundry and Maintenance	**195,338**	**24,131**	**244,876**	**464,345**		**464,345**	2
3	Heat and Other Utilities			**127,265**	**127,265**		**127,265**	3
4	Other (specify):							4
5	**TOTAL General Services**	**538,537**	**284,587**	**372,141**	**1,195,265**		**1,195,265**	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	**791,122**	**10,773**		**801,895**		**801,895**	6
7	Activities and Social Services	**37,944**			**37,944**		**37,944**	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	**829,066**	**10,773**		**839,839**		**839,839**	9
	C. General Administration							
10	Administrative and Clerical	**215,730**	**129,118**	**742,972**	**1,087,820**		**1,087,820**	10
11	Marketing Materials, Promotions and Advertising	**49,161**			**49,161**		**49,161**	11
12	Employee Benefits and Payroll Taxes	**161,152**			**161,152**		**161,152**	12
13	Insurance-Property, Liability and Malpractice			**123,311**	**123,311**		**123,311**	13
14	Other (specify) Security	**164,595**			**164,595**		**164,595**	14
15	**TOTAL General Administration**	**590,638**	**129,118**	**866,283**	**1,586,039**		**1,586,039**	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	**1,958,241**	**424,478**	**1,238,424**	**3,621,143**		**3,621,143**	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			**727,319**	**727,319**		**727,319**	17
18	Interest			**381,801**	**381,801**		**381,801**	18
19	Real Estate Taxes			**140,004**	**140,004**		**140,004**	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify) Asset fees			**231,796**	**231,796**		**231,796**	22
23	**TOTAL Ownership**			**1,480,920**	**1,480,920**		**1,480,920**	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	**1,958,241**	**424,478**	**2,719,344**	**5,102,063**		**5,102,063**	24

Facility Name: Pioneer Gardens **Report Period Beginning: 1/1/20 Ending: 12/31/20**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 25.00	1
2	Licensed Practical Nurses	5	$27.00	2
3	Certified Nurse Assistants	16	$14.00	3
4	Activity Director & Assistants	1	$17.00	4
5	Social Service Workers			5
6	Head Cook	1	$15.00	6
7	Cook Helpers/Assistants	11	$15.00	7
8	Dishwashers			8
9	Maintenance Workers	3	15.00	9
10	Housekeepers	3	14.00	10
11	Laundry			11
12	Managers	1	25.10	12
13	Other Administrative	1	24.08	13
14	Clerical	1	14.00	14
15	Marketing	1	22.76	15
16	Other	1	12.50	16
17	Total (lines 1 thru 16)	46	$ 240.44	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		$	1
2			2
	Total	$	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** [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: Pioneer Gardens Report Period Beginning: 1/1/20 Ending: 12/31/20

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				2006	$ 19,602,654	$ 727,319	28	$ 700,095	$ (27,224)	$ 10,103,611	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				$ 19,602,654	$ 727,319		$ 700,095	$ (27,224)	$ 10,103,611	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	$	$	$	$		$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$	$	$	$		$	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: Pioneer Gardens Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Midland Bank		X	Mortgage	8/1/04	$ 11,340,000	$ 9,725,753	3/1/46	5.6500	$ 381,801	1
2	City of Chicago		X	Mortgage	8/1/04	1,828,000	1,828,000	8/1/46			2
3	Federal Home Loan		X	Mortgage	8/1/04	500,000	500,000	/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 13,668,000	$ 12,053,753			$ 381,801	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 13,668,000	$ 12,053,753			$ 381,801	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: Pioneer Gardens **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,874	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,133,487		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,505		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	44,425		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,277,291	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	230,000		13
14	Buildings, at Historical Cost	19,263,927		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	713,677		16
17	Accumulated Depreciation (book methods)	(10,848,863)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	701,194		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,059,935	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,337,226	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,852	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	222,806		29
30	Accrued Salaries Payable	77,515		30
31	Accrued Taxes Payable	141,797		31
32	Accrued Interest Payable	31,489		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Management fee	2,110,490		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 2,806,949	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	5,181,897		38
39	Mortgage Payable	9,271,358		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)**	$ 14,453,255	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 17,260,204	$	45
46	**TOTAL EQUITY**	$ (5,922,978)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,337,226	$	47

***(See instructions.)**

Facility Name: Pioneer Gardens **Report Period Beginning: 1/1/20 Ending: 12/31/20**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 4,611,351	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 4,611,351	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			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 4,611,351	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,195,265	19
20	Health Care/ Personal Care	839,839	20
21	General Administration	1,586,039	21
	B. Capital Expense		
22	Ownership	1,480,920	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)**	$ 5,102,063	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (490,712)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (490,712)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$	37