

		FOR BHF USE			

LL2

Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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.

<p>I.</p> <p>Facility Name: <u>Prairie Living at Chautauqua</u></p> <p>Address: <u>955 Villa Court</u> <u>Carbondale</u> <u>62901</u> <small>Number City Zip Code</small></p> <p>County: <u>Jackson</u></p> <p>Telephone Number: (<u>618</u>) <u>351-7955</u> Fax # <u>618-351-6955</u></p> <p>Federal Employer ID Number: <u>65-1160917</u></p> <p>Date Current Owners were Certified: <u>05/05/05</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Selena Edgington</u> Telephone Number: <u>815-935-1992</u> <u>232</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</td> <td></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	
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Facility Name Prairie Living at Chautauqua

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	71	Single Unit Apartment	71	25,915	1
2	4	Double Unit Apartment	4	3,650	2
3		Other			3
4	75	TOTALS	75	29,565	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	21,048	4,659		25,707	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,048	4,659		25,707	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.95%

D. Indicate the number of paid bed-hold days the SLF had during this year 604 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 320 (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: 12/31/07 Fiscal Year: 12/31/07

* 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 principle? 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 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 at Chautauqua

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	144,062	105,162	1,559	250,783		250,783	1
2	Housekeeping, Laundry and Maintenance	59,611	17,185	31,120	107,916		107,916	2
3	Heat and Other Utilities			90,536	90,536	(8,055)	82,481	3
4	Other (specify):			5,205	5,205		5,205	4
5	TOTAL General Services	203,673	122,347	128,420	454,440	(8,055)	446,385	5
B. Health Care and Programs								
6	Health Care/ Personal Care	319,631	1,863		321,494		321,494	6
7	Activities and Social Services	26,271	7,117		33,388		33,388	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	345,902	8,980		354,882		354,882	9
C. General Administration								
10	Administrative and Clerical	85,055	14,173	159,868	259,096	(17,495)	241,601	10
11	Marketing Materials, Promotions and Advertising	33,889	7,441	37,740	79,070		79,070	11
12	Employee Benefits and Payroll Taxes			134,272	134,272		134,272	12
13	Insurance-Property, Liability and Malpractice			49,668	49,668		49,668	13
14	Other (specify):			38,534	38,534		38,534	14
15	TOTAL General Administration	118,944	21,614	420,082	560,640	(17,495)	543,145	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	668,519	152,941	548,502	1,369,962	(25,550)	1,344,412	16
Capital Expenses								
D. Ownership								
17	Depreciation			422,172	422,172		422,172	17
18	Interest			282,450	282,450		282,450	18
19	Real Estate Taxes			60,662	60,662		60,662	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			59,784	59,784		59,784	22
23	TOTAL Ownership			825,068	825,068		825,068	23
24	GRAND TOTAL (Sum of lines 16 and 23)	668,519	152,941	1,373,570	2,195,030	(25,550)	2,169,480	24

Facility Name: Prairie Living at Chautauqua

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.13	1
2	Licensed Practical Nurses	1	15.47	2
3	Certified Nurse Assistants	12	9.43	3
4	Activity Director & Assistants	1	12.19	4
5	Social Service Workers			5
6	Head Cook	1	14.32	6
7	Cook Helpers/Assistants	7	8.00	7
8	Dishwashers			8
9	Maintenance Workers	1	12.47	9
10	Housekeepers	2	7.48	10
11	Laundry			11
12	Managers	1	25.64	12
13	Other Administrative	1	10.74	13
14	Clerical			14
15	Marketing	1	15.60	15
16	Other			16
17	Total (lines 1 thru 16)	30	\$	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	BMA Management, LTD.	\$ 96,158 1
2		
Total		\$ 96,158 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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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).

Facility Name: **Prairie Living at Chautauqua**

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

VIII. OWNERSHIP COSTS

A. Purchase price of land **400,000** Year land was acquired **2003**

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	75			2004	\$ 7,514,459	\$ 273,169	28	\$ 273,169	\$	\$ 825,368	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			83,733	6,704	15	6,704		23,463	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)				\$ 7,598,192	\$ 279,873		\$ 279,873	\$	\$ 848,831	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	\$ 892,198	\$ 124,834	\$	(124,834)	5	\$ 691,580	18
19	Vehicles	44,552	17,465		(17,465)	5	31,721	19
20	TOTAL (lines 18 and 19)	\$ 936,750	\$ 142,299	\$	(142,299)		\$ 723,301	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 at Chautauqua

Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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			\$			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	
		Related**	YES			NO	Amount of Note				
	A. Directly Facility Related										
	Long-Term										
1	IHDA		X	First Mortgage	12/1/03	\$ 4,438,000	\$ 4,361,293	5/1/45	0.0615	\$ 269,208	1
2	IHDA		X	Second Mortgage	12/1/03	702,032	658,184	6/1/38	0.0100	6,891	2
3	Villa Park, INC		X	Third Mortgage	12/8/03	335,000	335,000	1/1/44	None	None	
4	Villa Land Trust		X	Fourth Mortgage	1/31/03	110,000	110,000	12/31/23	0.0500	5,500	
5	South Pointe Bank		X	Vehicle Loan	2/10/05	44,552	8,269	10/10/07	0.0633	851	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,629,584	\$ 5,472,746			\$ 282,450	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,629,584	\$ 5,472,746			\$ 282,450	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 at Chautauqua**Report Period Beginning: **01/01/2007**

Ending:

12/31/2007**12/31/2007****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2007**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 132,396	\$ 153,038	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	326,417	369,345	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,595	48,595	6
7	Other Prepaid Expenses	4,349	4,439	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Utility Sec Deposit</u>	500	500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 512,257	\$ 575,917	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	400,000	400,000	13
14	Buildings, at Historical Cost	7,514,459	7,514,459	14
15	Leasehold Improvements, at Historical Cost	83,733	83,733	15
16	Equipment, at Historical Cost	936,750	936,750	16
17	Accumulated Depreciation (book methods)	(1,572,132)	(1,572,132)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	315,447	315,447	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(111,205)	(111,205)	20
21	Restricted Funds	431,179	431,179	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,998,231	\$ 7,998,231	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,510,488	\$ 8,574,148	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,974	\$ 128,241	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		23,393	30
31	Accrued Taxes Payable	60,778	60,778	31
32	Accrued Interest Payable	27,500	27,500	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Accrued Liabilities & Unearned Rev</u>	19,800	19,800	35
36	<u>Accrued Developer Fee</u>	304,444	304,444	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 500,496	\$ 564,156	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	8,269	8,269	38
39	Mortgage Payable	5,464,477	5,464,477	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)	\$ 5,472,746	\$ 5,472,746	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,973,242	\$ 6,036,902	45
46	TOTAL EQUITY	\$ 2,537,246	\$ 2,537,246	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,510,488	\$ 8,574,148	47

*(See instructions.)

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,819,278	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,819,278	3
B. Other Operating Revenue			
4	Special Services	69,956	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	14,382	8
9	Non-Resident Meals	4,711	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 89,049	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	16,453	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 16,453	14
D. Other Revenue (specify):			
15	Contract Services - offset by expenses	803,911	15
16	Worker's Comp Dividends/Assessment Income	3,443	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 807,354	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,732,134	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	454,440	19
20	Health Care/ Personal Care	354,882	20
21	General Administration	560,640	21
B. Capital Expense			
22	Ownership	825,068	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	Contract Labor offset by Contract Services	803,911	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,998,941	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (266,807)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (266,807)	31

Cost Center Expenses

A. General Services - Other

Exterminating	1,080
Rubbish Removal	2,139
Vehicle Expense	1,986
Misc Operating Expenses	
Total	5,205

C. General Administration - Other

Consulting	
Legal	781
Accounting	175
Audit	9,500
Bad Debt	28,078
Total	38,534

D. Ownership

Mortgage Service Fee	10,943
Mortgage Insurance Premium	21,812
Letter of Credit Fee	525
Asset Management Fee	15,914
Tax Credit Fees	1,700
Property Damage Loss	
Amortization Expense	8,890
Total	59,784

Reclassifications and Adjustments

Heat & Other Utilities (8,055) Cable Expense

Administrative and Clerical (17,495) Telephone Revenue