

		FOR BHF USE			

LL2

Supportive Living Facility

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)

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. Facility ID Number: 1000061</p> <p>Facility Name: <u>Pioneer Gardens</u></p> <p>Address: <u>3800 South Martin Luther King Driv Chicago</u> <u>60653</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u> <u>420-4100</u> Fax # <u>773</u> <u>536-0720</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>4/25/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <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>Rev. E.R. Williams</u> Telephone Number: (<u>815</u> <u>739-6841</u> Email Address: _____</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>1/1/2010</u> to <u>12/31/2010</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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Rev. E.R. Williams</u> (Title) <u>President</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p style="text-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) _____ (Type or Print Name) <u>Rev. E.R. Williams</u> (Title) <u>President</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____																												

Facility Name: Pioneer Gardens

Report Period Beginning:

1/1/2010

Ending: 12/31/2010

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	216,132	259,178	5,762	481,072		481,072	1
2	Housekeeping, Laundry and Maintenance	154,602	43,270	99,068	296,940		296,940	2
3	Heat and Other Utilities			252,193	252,193	(29,070)	223,123	3
4	Other (specify): Security & Waste Removable	89,707	165	11,101	100,973		100,973	4
5	TOTAL General Services	460,441	302,613	368,124	1,131,178	(29,070)	1,102,108	5
B. Health Care and Programs								
6	Health Care/ Personal Care	735,824	3,740	3,980	743,544		743,544	6
7	Activities and Social Services	26,910		14,965	41,875		41,875	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	762,734	3,740	18,945	785,419		785,419	9
C. General Administration								
10	Administrative and Clerical	249,792	18,424	106,041	374,257		374,257	10
11	Marketing Materials, Promotions and Advertising	69,089	5,287	14,304	88,680		88,680	11
12	Employee Benefits and Payroll Taxes	157,192		33,698	190,890		190,890	12
13	Insurance-Property, Liability and Malpractice			77,247	77,247		77,247	13
14	Other (specify): Property Management Fee			227,562	227,562		227,562	14
15	TOTAL General Administration	476,073	23,711	458,852	958,636		958,636	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,699,248	330,064	845,921	2,875,233	(29,070)	2,846,163	16
Capital Expenses								
D. Ownership								
17	Depreciation			767,832	767,832		767,832	17
18	Interest			637,870	637,870		637,870	18
19	Real Estate Taxes			90,839	90,839		90,839	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Management Fees/Deferred Amort./MIP			166,319	166,319		166,319	22
23	TOTAL Ownership			1,662,860	1,662,860		1,662,860	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,699,248	330,064	2,508,781	4,538,093	(29,070)	4,509,023	24

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	32.00	1
2	Licensed Practical Nurses	3	25.50	2
3	Certified Nurse Assistants	21	10.77	3
4	Activity Director & Assistants	1	13.13	4
5	Social Service Workers			5
6	Head Cook	1	11.55	6
7	Cook Helpers/Assistants	6	9.32	7
8	Dishwashers	2	8.25	8
9	Maintenance Workers	4	11.02	9
10	Housekeepers	2	9.02	10
11	Laundry			11
12	Managers	2	26.33	12
13	Other Administrative	2	20.34	13
14	Clerical	3	8.68	14
15	Marketing	2	21.13	15
16	Other	3	10.22	16
17	Total (lines 1 thru 16)	53	\$	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
South Parkway Management		Chicago		Property Mgmt.	

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: Pioneer Gardens

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land 230,000 Year land was acquired 2004

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	120			2006	\$ 19,565,567	\$ 767,338	28	\$ 698,770	\$ (68,568)	\$ 3,714,403	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)				\$ 19,565,567	\$ 767,338		\$ 698,770	\$ (68,568)	\$ 3,714,403	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	FURNITURE & FIXTURES	\$ 4,288	\$ \$ 494	\$ \$ 4,041	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 4,288	\$ 494	\$ 4,041	24

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2010 Ending:

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
A. Directly Facility Related												
Long-Term												
1		MIDLAND BANK		X	MORTGAGE	8/1/04	11,340,000	\$ 10,931,962	3/1/46	5.6500	\$ 620,146	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	8/1/46			3
Working Capital												
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 13,668,000	\$ 13,259,962			\$ 620,146	7
B. Non-Facility Related												
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 13,668,000	\$ 13,259,962			\$ 620,146	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: 1/1/2010

Ending:

12/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 380,910	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,170		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,531		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 406,611	\$	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	19,038,373		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	531,482		16
17	Accumulated Depreciation (book methods)	(3,718,444)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	635,037		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,724,305		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,440,753	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,847,364	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,883	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	198,775		29
30	Accrued Salaries Payable	23,905		30
31	Accrued Taxes Payable	73,000		31
32	Accrued Interest Payable	51,471		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Management Fees	257,000		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 653,034	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,431,322		38
39	Mortgage Payable	13,159,234		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Accrued Management Fees	894,336		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 15,484,892	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 16,137,926	\$	45
46	TOTAL EQUITY	\$ 2,709,438	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 18,847,364	\$	47

Facility Name: Pioneer Gardens

Report Period Beginning: 1/1/2010

Ending:

12/31/2010

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	\$ 3,793,447	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,793,447	3
B. Other Operating Revenue			
4	Special Services	11,000	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 11,000	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,075	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 3,075	14
D. Other Revenue (specify):			
15	Real Estate Tax Reduction	57,468	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 57,468	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,864,990	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	1,102,108	19
20	Health Care/ Personal Care	785,419	20
21	General Administration	958,636	21
B. Capital Expense			
22	Ownership	1,662,860	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 4,509,023	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (644,033)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (644,033)	31

IV. COST CENTER EXPENSES

A. GENERAL SERVICES

4 OTHER SECURITY SALARY	89,707
SECURITY SUPPLIES	165
SECURITY - OTHER	2,451
WASTE MANAGEMENT	8,650
TOTAL	<u>100,973</u>

C. GENERAL ADMINISTRATION

14 OTHER PROPERTY MANAGEMENT FEES	\$227,562
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D. OWNERSHIP

22 OTHER ASSET AND PARTNERSHIP	
MANAGEMENT FEES	84,000
AMORTIZATION-DEFERRED	
COSTS	<u>27,559</u>
MIP	<u>54,760</u>
TOTAL	<u>166,319</u>

VII. RELATED ORGANIZATIONS

C. SERVICE	PROPERTY MANAGEMENT SERVICES
COST	\$227,562
MARKUP	NONE