

		FOR BHF USE			

LL2

Supportive Living Facility
2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)

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: <u>1000065</u></p> <p>Facility Name: <u>Plum Creek SLF</u></p> <p>Address: <u>2801 W Algonquin Rd</u> <u>Rolling Meadows</u> <u>60008</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>847</u>) <u>670-8080</u> Fax # (<u>847</u>) <u>368-1330</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/23/06</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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>Reuel Crook / Sue McTague</u> Telephone Number: (<u>847</u>) <u>670-8080</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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>1/1/2013</u> to <u>12/31/2013</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Reuel Crook</u> (Title) <u>Financial Director - Management Company</u></td> </tr> <tr> <td></td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</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) _____ (Type or Print Name) <u>Reuel Crook</u> (Title) <u>Financial Director - Management Company</u>		(Signed) _____ (Date)	Paid Preparer	(Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
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Facility Name Plum Creek SLF

Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	77	Single Unit Apartment	77	28,105	1
2	25	Double Unit Apartment	25	9,125	2
3		Other			3
4	102	TOTALS	102	37,230	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	24,199	2,511		26,710	5
6	Double Unit	5,558	602		6,160	6
7	Other					7
8	TOTALS	29,757	3,113		32,870	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.29%

D. Indicate the number of paid bed-hold days the SLF had during this year 296 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 931 (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: _____ 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 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: Plum Creek SLF

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	262,650	277,279		539,929		539,929	1
2	Housekeeping, Laundry and Maintenance	73,382	14,636	75,918	163,936	(13,022)	150,914	2
3	Heat and Other Utilities			71,664	71,664		71,664	3
4	Other (specify):							4
5	TOTAL General Services	336,032	291,915	147,582	775,529	(13,022)	762,507	5
B. Health Care and Programs								
6	Health Care/ Personal Care	368,493	7,197		375,690		375,690	6
7	Activities and Social Services	28,581	12,769		41,350	(5,675)	35,675	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	397,074	19,966		417,040	(5,675)	411,365	9
C. General Administration								
10	Administrative and Clerical	180,787	63,062	7,427	251,276		251,276	10
11	Marketing Materials, Promotions and Advertising	41,888	26,677		68,565		68,565	11
12	Employee Benefits and Payroll Taxes	111,003	15,031		126,034		126,034	12
13	Insurance-Property, Liability and Malpractice			151,267	151,267		151,267	13
14	Other (specify): Professional & Management Fees			250,797	250,797		250,797	14
15	TOTAL General Administration	333,678	104,770	409,491	847,939		847,939	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,066,784	416,651	557,073	2,040,508	(18,697)	2,021,811	16
Capital Expenses								
D. Ownership								
17	Depreciation			469,666	469,666		469,666	17
18	Interest			711,397	711,397		711,397	18
19	Real Estate Taxes			72,000	72,000		72,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Amortization of Prepaid Closing Costs			27,185	27,185		27,185	22
23	TOTAL Ownership			1,280,248	1,280,248		1,280,248	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,066,784	416,651	1,837,321	3,320,756	(18,697)	3,302,059	24

Facility Name: Plum Creek SLF

Report Period Beginning 1/1/2013 Ending: 12/31/2013

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 24.25	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	11	10.72	3
4	Activity Director & Assistants	1	15.00	4
5	Social Service Workers			5
6	Head Cook	1	15.00	6
7	Cook Helpers/Assistants	10	9.41	7
8	Dishwashers			8
9	Maintenance Workers	1	10.00	9
10	Housekeepers	2	8.25	10
11	Laundry			11
12	Managers	1	27.50	12
13	Other Administrative	2	13.50	13
14	Clerical	4	18.14	14
15	Marketing	1	21.00	15
16	Other			16
17	Total (lines 1 thru 16)	36	\$ 12.92	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	Royal Care Management	\$ 210,000	1
2			2
Total		\$ 210,000	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: N/A 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: Plum Creek SLF

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	102		2006	2006	\$ 12,602,734	\$ 465,764	40	\$ 315,068	\$ (150,696)	\$ 3,292,595	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Building Improvement			2007	10,518	263	40	263			6
7	Building Improvement			2007	3,392	85	40	85			7
8	Building Improvement			2009	8,575	214	40	214			8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 12,625,219	\$ 466,326		\$ 315,630	\$ (150,696)	\$ 3,292,595	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	\$ 472,832	\$ 3,340	\$ 67,547	64,207	7	\$ 487,847	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 472,832	\$ 3,340	\$ 67,547	64,207		\$ 487,847	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: Plum Creek SLF

Report Period Beginning: 1/1/2013

Ending: 2/31/2013

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			
	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			X	Building Purchase / Remodel	4/1/06	\$ 11,600	\$ 10,775,000	12/1/37	0.0650	\$ 711,397	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,600	\$ 10,775,000			\$ 711,397	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,600	\$ 10,775,000			\$ 711,397	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: Plum Creek SLF

Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 82,732	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	480,323		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,670		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 572,725	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	849,401		13
14	Buildings, at Historical Cost	12,508,851		14
15	Leasehold Improvements, at Historical Cost	127,906		15
16	Equipment, at Historical Cost	489,588		16
17	Accumulated Depreciation (book methods)	(3,830,611)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	815,538		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(210,681)		20
21	Restricted Funds	1,897,013		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,647,005	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,219,730	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 24,674	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,511		28
29	Short-Term Notes Payable	8,333		29
30	Accrued Salaries Payable	7,885		30
31	Accrued Taxes Payable	69,962		31
32	Accrued Interest Payable	58,364		32
33	Deferred Compensation			33
34	Federal and State Income Taxes	14,594		34
Other Current Liabilities(specify):				
35	Accrued Audit Fees	9,000		35
36	Accrued Asset Management Fees	51,244		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 315,567	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable	10,775,000		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)	\$ 10,775,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,090,567	\$	45
46	TOTAL EQUITY	\$ 2,129,163	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 13,219,730	\$	47

*(See instructions.)

Facility Name: Plum Creek SLF

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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	\$ 3,138,381	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 3,138,381	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	525	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 525	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	127	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 127	14
D. Other Revenue (specify):			
15	Ancillary Telephone Service	25,734	15
16	Food Stamp Allowances	123,127	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 148,861	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,287,894	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	762,507	19
20	Health Care/ Personal Care	411,365	20
21	General Administration	847,939	21
B. Capital Expense			
22	Ownership	1,280,248	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)	\$ 3,302,059	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (14,165)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (14,165)	31