

		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><b>I. Facility ID Number:</b> <u>1000143</u></p> <p><b>Facility Name:</b> <u>Prairie Green at Dixie Crsng</u></p> <p><b>Address:</b> <u>1040 Dixie Highway</u> <u>Chicago Heights</u> <u>60411</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> ( <u>708</u> ) <u>754-5700</u> Fax # <u>708 754-5734</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> _____</p> <p><b>Type of Ownership:</b></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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</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 checked="" 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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Leticia Gonzalez</u> <b>Telephone Number:</b> ( <u>312</u> ) <u>673-4360</u>  <b>Email Address:</b> _____</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 type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/30/2013</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%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) <u>Timothy J. Adams</u>                  (Title) <u>VP of Accounting</u> </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____                  (Print Name and Title) <u>Chris Joos Partner</u>                  (Firm Name &amp; Address) <u>Plante Moran 65 East State Street, Suite 600, Columbus, OH 43215</u>                  (Telephone) <u>(614 849-3000</u> Fax <u>248-233-8811</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>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Timothy J. Adams</u> (Title) <u>VP of Accounting</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Chris Joos Partner</u> (Firm Name & Address) <u>Plante Moran 65 East State Street, Suite 600, Columbus, OH 43215</u> (Telephone) <u>(614 849-3000</u> Fax <u>248-233-8811</u>
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Facility Name: Prairie Green at Dixie Crsng

Report Period Beginning:

05/30/2013

Ending: 12/31/2013

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	180,635	19,467	56,728	256,830		256,830	1
2	Housekeeping, Laundry and Maintenance	69,308		80,317	149,625		149,625	2
3	Heat and Other Utilities			61,943	61,943		61,943	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>249,943</b>	<b>19,467</b>	<b>198,988</b>	<b>468,398</b>		<b>468,398</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	364,943	1,382	3,270	369,595		369,595	6
7	Activities and Social Services	41,896		7,171	49,067		49,067	7
8	Other (specify): Home Office Expenses					326	326	8
9	<b>TOTAL Health Care and Programs</b>	<b>406,839</b>	<b>1,382</b>	<b>10,441</b>	<b>418,662</b>	<b>326</b>	<b>418,988</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	163,258	51,808	62,117	277,183		277,183	10
11	Marketing Materials, Promotions and Advertising	36,087		101,842	137,929	15,101	153,030	11
12	Employee Benefits and Payroll Taxes			205,801	205,801		205,801	12
13	Insurance-Property, Liability and Malpractice			51,637	51,637		51,637	13
14	Other (specify): Home Office Expenses					87,399	87,399	14
15	<b>TOTAL General Administration</b>	<b>199,345</b>	<b>51,808</b>	<b>421,397</b>	<b>672,550</b>	<b>102,500</b>	<b>775,050</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>856,127</b>	<b>72,657</b>	<b>630,826</b>	<b>1,559,610</b>	<b>102,826</b>	<b>1,662,436</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			390,631	390,631		390,631	17
18	Interest			484,788	484,788		484,788	18
19	Real Estate Taxes			49,500	49,500		49,500	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,395	12,395		12,395	21
22	Other (specify): Home Office Expenses					3,468	3,468	22
23	<b>TOTAL Ownership</b>			<b>937,314</b>	<b>937,314</b>	<b>3,468</b>	<b>940,782</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>856,127</b>	<b>72,657</b>	<b>1,568,140</b>	<b>2,496,924</b>	<b>106,294</b>	<b>2,603,218</b>	<b>24</b>

Facility Name: **Prairie Green at Dixie Crsng**

Report Period Beginning **05/30/2013**

Ending:

**12/31/2013**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 34.87	1
2	Licensed Practical Nurses	3	24.07	2
3	Certified Nurse Assistants	12	10.12	3
4	Activity Director & Assistants	2	15.10	4
5	Social Service Workers			5
6	Head Cook	1	31.26	6
7	Cook Helpers/Assistants	6	11.06	7
8	Dishwashers			8
9	Maintenance Workers	2	11.03	9
10	Housekeepers			10
11	Laundry			11
12	Managers	2	32.66	12
13	Other Administrative	3	18.03	13
14	Clerical			14
15	Marketing	2	19.23	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>34</b>	<b>\$</b>	<b>17</b>

**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	None			\$	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

**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
See Exhibit 4			

**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

Name of related entity: Senior Lifestyle Corporation If yes, what is the value of those services? \$ 106,294

(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 Green at Dixie Crsng

Report Period Beginning:

05/30/2013

Ending:

12/31/2013

VIII. OWNERSHIP COSTS

A. Purchase price of land 1 Year land was acquired 2013

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	144		2013	2013	\$ 17,336,349	\$ 157,603	27	\$ 157,603	\$	\$ 157,603	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Land Improvement		2013	2013	22,853	11,426	15	11,426		11,426	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)				\$ 17,359,202	\$ 169,029		\$ 169,029	\$	\$ 169,029	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	\$ 368,385	\$ 221,602	\$ 221,602	\$	5	\$ 221,602	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 368,385	\$ 221,602	\$ 221,602	\$		\$ 221,602	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 Green at Dixie CrsngReport Period Beginning: 05/30/2013Ending: 2/31/2013**IX. RENTAL COSTS****A. Building and Fixed Equipment**1. Name of Party Holding Lease: N/A2. 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	<b>TOTAL</b>				\$			7

8. Is movable equipment rental included in building rental?

 YES  NO9. Rental amount for movable equipment \$ 11,745

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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1				/ /	\$	\$	/ /		\$	1	
2				/ /			/ /			2	
3				/ /			/ /			3	
	<b>Working Capital</b>										
4				/ /			/ /			4	
5				/ /			/ /			5	
6				/ /			/ /			6	
7	<b>TOTAL Facility Related</b>				\$	\$			\$	7	
	<b>B. Non-Facility Related</b>										
8	IHDA		X	Build Property	5/31/12	18,500,000	18,321,271	6/1/43	4.3000	462,130	8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>				\$	18,500,000	\$ 18,321,271			\$ 462,130	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 Green at Dixie Crsng**Report Period Beginning: **05/30/2013**

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,682,505	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	283,177		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,078		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,996,760	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1		13
14	Buildings, at Historical Cost	17,336,349		14
15	Leasehold Improvements, at Historical Cost	22,853		15
16	Equipment, at Historical Cost	368,385		16
17	Accumulated Depreciation (book methods)	(390,631)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Deposits	85,369		22
23	Other(specify): <b>CIP</b>	5,227		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 17,427,553	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 21,424,313	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 121,746	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,528		30
31	Accrued Taxes Payable	73,279		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	3,856		34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 282,409	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	20,488,497		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 20,488,497	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 20,770,906	\$	45
46	<b>TOTAL EQUITY</b>	\$ 653,407	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 21,424,313	\$	47

\*(See instructions.)

Facility Name: Prairie Green at Dixie Crsng

Report Period Beginning: 05/30/2013

Ending:

12/31/2013

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 554,998	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 554,998</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 554,998</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	468,398	19
20	Health Care/ Personal Care	418,662	20
21	General Administration	672,550	21
<b>B. Capital Expense</b>			
22	Ownership	937,314	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 2,496,924</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (1,941,926)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (1,941,926)</b>	<b>31</b>



