

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2018  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2018)**

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> 1000147</p> <p><b>Facility Name:</b> <u>Prairie Green at Fays Point</u></p> <hr/> <p><b>Address:</b> <u>1546 W Water Street</u> <u>Blue Island</u> <u>60406</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> ( <u>708</u> ) <u>489-1503</u> Fax # <u>708</u> <u>489-1506</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>10/29/14</u></p> <p><b>Type of Ownership:</b></p> <table border="0" 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></p> <p><b>Name:</b> <u>Anna Kobrzak</u> <b>Telephone Number:</b> ( <u>312</u> ) <u>673-4360</u></p> <p><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>1/1/18</u> to <u>12/31/18</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" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steve Hippel</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> <td></td> </tr> </table> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Chris Joos Partner</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</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>Steve Hippel</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Chris Joos Partner</u>			(Firm Name & Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u>			(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u>	
<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	_____																																												
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																												
	(Type or Print Name) <u>Steve Hippel</u>																																													
	(Title) <u>Chief Financial Officer</u>																																													
Paid Preparer	(Signed) _____	(Date) _____																																												
	(Print Name and Title) <u>Chris Joos Partner</u>																																													
	(Firm Name & Address) <u>Plante &amp; Moran, PLLC 250 South High Street, Suite 100</u>																																													
	(Telephone) <u>(614) 222-9040</u> Fax <u>(614) 221-3535</u>																																													



Facility Name: Prairie Green at Fays Point

Report Period Beginning:

1/1/18

Ending:

12/31/18

## 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	360,055	244,317	2,476	606,848		606,848	1
2	Housekeeping, Laundry and Maintenance	138,242	180,357	748	319,347		319,347	2
3	Heat and Other Utilities			117,317	117,317		117,317	3
4	Other (specify):			11,641	11,641		11,641	4
5	<b>TOTAL General Services</b>	498,297	424,674	132,182	1,055,153		1,055,153	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	454,922	3,949	4,916	463,787		463,787	6
7	Activities and Social Services	56,102	4,756	2,892	63,750	(1,033)	62,717	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	511,024	8,705	7,808	527,537	(1,033)	526,504	9
<b>C. General Administration</b>								
10	Administrative and Clerical	183,990	2,383	365,919	552,292		552,292	10
11	Marketing Materials, Promotions and Advertising	68,189	10,511	86,504	165,204		165,204	11
12	Employee Benefits and Payroll Taxes			251,151	251,151	(786)	250,365	12
13	Insurance-Property, Liability and Malpractice			95,771	95,771		95,771	13
14	Other (specify):			104,302	104,302	(104,302)		14
15	<b>TOTAL General Administration</b>	252,179	12,894	903,647	1,168,720	(105,088)	1,063,632	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,261,500	446,273	1,043,637	2,751,410	(106,121)	2,645,289	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			720,616	720,616		720,616	17
18	Interest			801,939	801,939		801,939	18
19	Real Estate Taxes			459,720	459,720		459,720	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,242	8,242		8,242	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			1,990,517	1,990,517		1,990,517	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,261,500	446,273	3,034,154	4,741,927	(106,121)	4,635,806	24

Facility Name: **Prairie Green at Fays Point**

Report Period Beginning: **1/1/18**

Ending: **12/31/18**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.02	\$ 28.83	1
2	Licensed Practical Nurses	3.05	23.05	2
3	Certified Nurse Assistants	9.70	12.74	3
4	Activity Director & Assistants	1.54	17.51	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	9.54	13.31	7
8	Dishwashers			8
9	Maintenance Workers	2.44	18.66	9
10	Housekeepers	1.76	11.89	10
11	Laundry			11
12	Managers	0.46	48.21	12
13	Other Administrative	0.46	58.99	13
14	Clerical	3.74	22.80	14
15	Marketing	0.89	37.83	15
16	Other AL Director	0.81	29.28	16
17	<b>Total (lines 1 thru 16)</b>	<b>34.41</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				\$	1
2					2
3					3
4					4
5					5
				<b>Total</b>	<b>6</b>
				\$	

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

		Amount of Fee	
1	Senior LifeStyle Corporation	\$ 223,077	1
2			2
		<b>Total</b>	<b>3</b>
		\$ 223,077	

**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
Available upon request			

**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: \_\_\_\_\_ 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 Green at Fays Point**

Report Period Beginning:

1/1/18

Ending:

12/31/18

**VIII. OWNERSHIP COSTS**

A. Purchase price of land 750,677 Year land was acquired 2014

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		2014	2014	\$ 14,831,544	\$	27	\$	\$	\$	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Building Improvement		2017	42,952		27				6
7		Disposal		2018	(10,499)						7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16						560,960		560,960		2,350,769	16
17	TOTAL (lines 1 thru 16)				\$ 14,863,997	\$ 560,960		\$ 560,960	\$	\$ 2,350,769	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	\$ 1,412,768	\$ 159,656	\$ 159,656		5-7	\$ 1,275,716	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,412,768	\$ 159,656	\$ 159,656	\$		\$ 1,275,716	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 Fays Point**Report Period Beginning: **1/1/18**

Ending:

**12/31/18****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/18

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,422,872	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,338,162 (316,685)		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,388		6
7	Other Prepaid Expenses	9,885		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>	\$ 2,546,622	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	750,677		13
14	Buildings, at Historical Cost	14,171,610		14
15	Leasehold Improvements, at Historical Cost	692,388		15
16	Equipment, at Historical Cost	1,412,768		16
17	Accumulated Depreciation (book methods)	(3,626,485)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	633,510		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(166,558)		20
21	Restricted Funds	197,893		21
22	Other Long-Term Assets (specify):	1,023,890		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,089,693	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 17,636,315	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 109,319	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,170		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,596		30
31	Accrued Taxes Payable	287,725		31
32	Accrued Interest Payable	130,084		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Accrued Other	17,156		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 624,050	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	17,088,218		38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	Intercompany	2,120,268		42
43	Deferred Revenues	147,464		43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 19,355,950	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 19,980,000	\$	45
46	<b>TOTAL EQUITY</b>	\$ (2,343,685)	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 17,636,315	\$	47

\*(See instructions.)

Facility Name: Prairie Green at Fays Point

Report Period Beginning: 1/1/18

Ending:

12/31/18

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,568,533	1
2	Discounts and Allowances	9,716	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,578,249</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>\$ 3,578,249</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,055,153	19
20	Health Care/ Personal Care	527,537	20
21	General Administration	1,168,720	21
<b>B. Capital Expense</b>			
22	Ownership	1,990,517	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>\$ 4,741,927</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (1,163,678)</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>\$ (1,163,678)</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
32	Medicaid - Net Inpatient Revenue	\$ 3,386,142	32
33	Private Pay - Net Inpatient Revenue	192,107	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$ 3,578,249</b>	<b>37</b>

Blue Island SLF, LLC  
Automobile Schedule  
2018

Year	Make	Model	Lease Costs
2014	Ford	E350/KSIR 230	\$ 17,795.94 <i>All offset with rental income</i>

**Blue Island SLF LLC**  
**Adjustments**  
**12/31/2018**

<b>CLIENT_ACT</b>	<b>DESC</b>	<b>DEBIT</b>	<b>TB Acct</b>	<b>IL Acct</b>
5565350000	Charitable Contributions	1,500.00	9760.00 IS 14.3	
5790350000	Bad Debt Expense	106,692.00	9765.00 IS 14.3	
5890350000	Miscellaneous Expense	(1,509.49)	9729.20 IS 14.3	
5551330000	Entertainment Expense	1,032.60	7125.00 IS 7.2	
5271350000	Holiday Party Expense	786.15	7820.00 IS 12.3	
5915346000	Special Events (Off-Site)	629.49	9729.20 IS 14.3	
5771350000	Penalties	1,077.89	9730.00 IS 14.3	
	9729.20 Non-Allowable AJE	(4,087.57)	9729.20 IS 14.3	
		106,121.07		

Blue Island SLF, LLC  
Related Party Schedule  
2018

Service	Cost on pg 3	Cost to Related Party	Adjustment
Management Fees	183,077.00	183,077.00	-
Company Management Fee	19,999.92	19,999.92	-
Asset Management Fee	19,999.92	19,999.92	-