

		FOR BHF USE				

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

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>Victory Centre Of River Oaks</u></p> <p>Address: <u>1370 Ring Road</u> <u>Calumet City</u> <u>60409</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 730-0994</u> Fax # _____</p> <p>Federal Employer ID Number: <u>36-4336170</u></p> <p>Date Current Owners were Certified: <u>7/2/2002</u></p> <p>Type of Ownership:</p> <table border="0"> <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>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 checked="" type="checkbox"/> Other <u>Limited Partnership</u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></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	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 checked="" type="checkbox"/> Other <u>Limited Partnership</u>		<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>1/1/2005</u> to <u>12/31/2005</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 colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u></td> <td></td> </tr> </table> <p align="center">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) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax <u>(847) 236-1155</u>	
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Facility Name Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	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	103	Single Unit Apartment	103	37,595	1
2	6	Double Unit Apartment	6	4,380	2
3		Other			3
4	109	TOTALS	109	41,975	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	34,251	2,663		36,913	5
6	Double Unit	3,990	310		4,301	6
7	Other					7
8	TOTALS	38,241	2,973		41,214	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.19%

D. Indicate the number of paid bed-hold days the SLF had during this year 1,208 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 731 (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)

None

H. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* 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: Victory Centre Of River Oaks

Report Period Beginning:

1/1/2005

Ending: 12/31/2005

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	192,099	197,694	3,171	392,964	(60)	392,904	1
2	Housekeeping, Laundry and Maintenance	69,894	19,131	48,597	137,622	959	138,581	2
3	Heat and Other Utilities			102,781	102,781	660	103,441	3
4	Other (specify):							4
5	TOTAL General Services	261,993	216,825	154,549	633,367	1,559	634,926	5
B. Health Care and Programs								
6	Health Care/ Personal Care	435,568		27,550	463,118		463,118	6
7	Activities and Social Services	37,833		6,332	44,165		44,165	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	473,401		33,882	507,283		507,283	9
C. General Administration								
10	Administrative and Clerical	225,431	12,593	962,471	1,200,495	(552,447)	648,048	10
11	Marketing Materials, Promotions and Advertising	89,265		23,494	112,759	(112,759)		11
12	Employee Benefits and Payroll Taxes			229,781	229,781	20,741	250,522	12
13	Insurance-Property, Liability and Malpractice			58,582	58,582	6,502	65,084	13
14	Other (specify):							14
15	TOTAL General Administration	314,696	12,593	1,274,328	1,601,617	(637,963)	963,654	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,050,090	229,418	1,462,759	2,742,267	(636,404)	2,105,863	16
Capital Expenses								
D. Ownership								
17	Depreciation			447,259	447,259	(28,957)	418,302	17
18	Interest			440,800	440,800	(11,317)	429,483	18
19	Real Estate Taxes			116,205	116,205		116,205	19
20	Rent -- Facility and Grounds					13,630	13,630	20
21	Rent -- Equipment			2,480	2,480	2,358	4,838	21
22	Other (specify): MIP, Amortization			47,580	47,580		47,580	22
23	TOTAL Ownership			1,054,324	1,054,324	(24,286)	1,030,038	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,050,090	229,418	2,517,083	3,796,591	(660,690)	3,135,901	24

Facility Name: Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.06	\$ 26.44	1
2	Licensed Practical Nurses	2.24	19.76	2
3	Certified Nurse Assistants	15.63	10.46	3
4	Activity Director & Assistants	1.70	10.70	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	8.16	11.32	7
8	Dishwashers			8
9	Maintenance Workers	1.16	15.05	9
10	Housekeepers	2.70	5.99	10
11	Laundry			11
12	Managers			12
13	Other Administrative	2.56	42.10	13
14	Clerical	0.06	6.84	14
15	Marketing	2.00	21.45	15
16	Other			16
17	Total (lines 1 thru 16)	36.28	\$ 13.91	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	Brian Cloch	29	8.74	\$ 58,626	1
2	Jerry Finis	29	8.74	74,209	2
3	Robert Helle	13	8.74	64,578	3
4	E. Keledijian	29	8.74	58,826	4
5					5
Total				\$ 256,239	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 <u>1</u>	City <u>2</u>
See Attached	

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

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: Victory Centre Of River Oaks

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

VIII. OWNERSHIP COSTS

A. Purchase price of land 541,601 Year land was acquired 2002

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	109		2002	2002	\$ 9,842,367	\$ 357,868	27.5	\$ 357,868	\$	\$ 1,267,499	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Page 5A				-	-		-	-	-	6
7	Land Improvement			2002	246,335		20	12,317	12,317	43,109	7
8	Carpet			2005	1,039		20	52	52	52	8
9	A/C			2005	11,778		20	589	589	589	9
10	A/C			2005	957		20	48	48	48	10
11	A/C			2005	1,412		20	71	71	71	11
12	Leasehold Improvement Book Depreciation					34,922		-	(34,922)	-	12
13	Allocation from Pathway Senior Living					2,174		2,174	-	-	13
14								-	-	-	14
15								-	-	-	15
16								-	-	-	16
17	TOTAL (lines 1 thru 16)				\$ 10,103,888	\$ 394,964		\$ 373,118	\$ (21,846)	\$ 1,311,368	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	\$ 418,549	\$ 51,140	\$ 41,855	(9,285)	10	\$ 143,898	18
19	Vehicles	16,646	3,329	3,329	0	5	3,329	19
20	TOTAL (lines 18 and 19)	\$ 435,195	\$ 54,469	\$ 45,184	(9,285)		\$ 147,227	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 & ID Number Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005

Ending: 2/31/2005

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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	Allocation from Pathway Senior Living		/ /	13,630			6
7	TOTAL			\$ 13,630			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ 4,838

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				
		YES	NO			Original	Balance				
A. Directly Facility Related Long-Term											
1	IHDA		X	1st Mortgage	5/1/01	\$ 6,150,000	\$ 6,045,606	12/1/42	6.7000	\$ 421,548	1
2	Cook County		X	2nd Mortgage	5/29/01	2,000,000	1,865,654	10/1/42	1.0000	18,880	2
3					/ /			/ /			3
Working Capital											
4	Misc Interest				/ /			/ /		372	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 8,150,000	\$ 7,911,260			\$ 440,800	7
B. Non-Facility Related											
8	Interest Income				/ /			/ /		-11,158	8
9	Allocation from Pathway Senior Living				/ /			/ /		-159	9
10	TOTALS (lines 7, 8 and 9)					\$ 8,150,000	\$ 7,911,260			\$ 429,483	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.

STATE OF ILLINOIS

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Facility Name: Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

12/31/2005

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 745,531	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	654,461		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,292		6
7	Other Prepaid Expenses	31,813		7
8	Accounts Receivable (owners or related parties)	6,864		8
9	Other(specify): See Attached	477,095		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,942,056	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	541,601		13
14	Buildings, at Historical Cost	10,088,702		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	450,382		16
17	Accumulated Depreciation (book methods)	(2,009,691)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	618,061		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	97,267		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	11,016		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,797,338	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,739,394	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 894,296	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,890		30
31	Accrued Taxes Payable	147,977		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35				35
36	See Attached	20,328		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,106,491	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,911,260		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)	\$ 7,911,260	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,017,751	\$	45
46	TOTAL EQUITY	\$ 2,721,643	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,739,394	\$	47

*(See instructions.)

Facility Name: Victory Centre Of River Oaks

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

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	\$ 3,267,697	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,267,697	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		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	11,158	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 11,158	14
D. Other Revenue (specify):			
15	See Attached	23,562	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 23,562	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,302,417	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	633,367	19
20	Health Care/ Personal Care	507,283	20
21	General Administration	1,601,617	21
B. Capital Expense			
22	Ownership	1,054,324	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,796,591	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (494,174)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (494,174)	31