

		FOR BHF USE			

LL2

Supportive Living Facility

**2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2006)**

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>THE FORT ARMSTRONG</u></p> <p>Address: <u>1900 3RD AVE</u> <u>ROCK ISLAND</u> <u>61201</u> <small>Number City Zip Code</small></p> <p>County: <u>ROCK ISLAND</u></p> <p>Telephone Number: (<u>309-</u>) Fax # ()</p> <p>Federal Employer ID Number: <u>364455063</u></p> <p>Date Current Owners were Certified: <u>2/20/06</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 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 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>In the event there are further questions about this report, please contact: Name: <u>VICTOR HOROWITZ</u> Telephone Number: (<u>77/16</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 checked="" 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>2/20/06</u> to <u>12/31/06</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>VICTOR HOROWITZ</u> (Title) <u>MANAGER</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 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>VICTOR HOROWITZ</u> (Title) <u>MANAGER</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 THE FORT ARMSTRONG

Report Period Beginning: 2/20/06 Ending: 12/31/06

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	116	Single Unit Apartment	116	42,340	1
2	14	Double Unit Apartment	14	5,110	2
3		Other			3
4	130	TOTALS	130	47,450	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	4,652	15,868		20,520	5
6	Double Unit		547		547	6
7	Other					7
8	TOTALS	4,652	16,415		21,067	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 44.40%

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

N/A

H. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 1/1/06 Fiscal Year: 12/31/06

* 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: THE FORT ARMSTRONG

Report Period Beginning:

2/20/06

Ending:

12/31/06

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	168,500	192,350		360,850		360,850	1
2	Housekeeping, Laundry and Maintenance	110,250	73,652		183,902		183,902	2
3	Heat and Other Utilities			169,544	169,544		169,544	3
4	Other (specify):							4
5	TOTAL General Services	278,750	266,002	169,544	714,296		714,296	5
B. Health Care and Programs								
6	Health Care/ Personal Care	336,522	50,265		386,787		386,787	6
7	Activities and Social Services	63,588	27,685		91,273		91,273	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	400,110	77,950		478,060		478,060	9
C. General Administration								
10	Administrative and Clerical	190,502	60,487		250,989		250,989	10
11	Marketing Materials, Promotions and Advertising		28,566		28,566		28,566	11
12	Employee Benefits and Payroll Taxes			192,566	192,566		192,566	12
13	Insurance-Property, Liability and Malpractice			110,544	110,544		110,544	13
14	Other (specify):							14
15	TOTAL General Administration	190,502	89,053	303,110	582,665		582,665	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	869,362	433,005	472,654	1,775,021		1,775,021	16
Capital Expenses								
D. Ownership								
17	Depreciation			8,740	8,740		8,740	17
18	Interest			16,522	16,522		16,522	18
19	Real Estate Taxes			75,840	75,840		75,840	19
20	Rent -- Facility and Grounds			330,000	330,000		330,000	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			431,102	431,102		431,102	23
24	GRAND TOTAL (Sum of lines 16 and 23)	869,362	433,005	903,756	2,206,123		2,206,123	24

Facility Name: THE FORT ARMSTRONG

Report Period Beginning 2/20/06

Ending:

12/31/06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 18.00	1
2	Licensed Practical Nurses	3	14.00	2
3	Certified Nurse Assistants	10	9.50	3
4	Activity Director & Assistants	2	13.00	4
5	Social Service Workers			5
6	Head Cook	2	12.00	6
7	Cook Helpers/Assistants	4	8.00	7
8	Dishwashers	2	8.00	8
9	Maintenance Workers	2	19.00	9
10	Housekeepers	4	12.00	10
11	Laundry	1	12.00	11
12	Managers	2	30.00	12
13	Other Administrative			13
14	Clerical	2	8.00	14
15	Marketing	1	35.00	15
16	Other			16
17	Total (lines 1 thru 16)	37	\$ 12.76	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 <u>1</u>	City <u>2</u>
JACKSON HEIGHTS NURSING	FARMER CITY
HERITAGE NURSING	CHAMPAIGN
WOODBINE NURSING	OAK PARK

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: _____ 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: THE FORT ARMSTRONG

Report Period Beginning: 2/20/06

Ending: 12/31/06

VIII. OWNERSHIP COSTS

A. Purchase price of land 2,500,000 Year land was acquired 2001

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	130		2001		\$ 2,500,000	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
		Improvement Type									
6		IMPROVMENTS TO SLF	2005		1,600,000						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)				\$ 4,100,000	\$		\$	\$	\$	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: **THE FORT ARMSTRONG**

Report Period Beginning: **2/20/06**

Ending: **12/31/06**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: **THE FORT ARMSTRONG, LLC**

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	1916		/ /	\$			3
4	Additions	2005	130	/ /	27,500	5	UNLIMITED	4
5				/ /				5
6				/ /				6
7	TOTAL		130		\$ 27,500			7

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

9. Rental amount for movable equipment \$ N/A

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	LASALLE BANK		X	MORTGAGE	9/12/02	\$ 1,875,000	\$ 1,705,000	9/12/08	P+1	\$
2	LASALLE BANK		X	REMODELLING LOAN	9/12/02	1,300,000	1,275,000	9/12/08	P+1	
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 3,175,000	\$ 2,980,000			\$
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 3,175,000	\$ 2,980,000			\$

* 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

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 2/20/06

Ending:

12/31/06

12/31/06

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 5,560	\$ 5,560	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	36,397	36,397	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 41,957	\$ 41,957	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 41,957	\$ 41,957	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 290,083	\$ 290,083	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	62,284	62,284	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 352,367	\$ 352,367	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 352,367	\$ 352,367	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 352,367	\$ 352,367	47

*(See instructions.)

Facility Name: THE FORT ARMSTRONG

Report Period Beginning: 2/20/06

Ending:

12/31/06

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	\$ 1,177,124	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,177,124	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		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,177,124	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	714,296	19
20	Health Care/ Personal Care	478,060	20
21	General Administration	582,665	21
B. Capital Expense			
22	Ownership		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)	\$ 1,775,021	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (597,897)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (597,897)	31