FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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.

I.

Facility Name: Shabbona Supportive Living Facility

Address: 407 West Comanche Ave. (Number) Shabbona (City) 60550 (Zip Code)

County: DeKalb

Telephone Number: (815) 824-4800 **Fax #**

Federal Employer ID Number: 20-4590974

Date Current Owners were Certified: 3/30/06

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☐ Corporation	☐ Other
	☐ "Sub-S" Corp.	
	X Limited Liability Co.	
	☐ Trust	
	☐ Other	

In the event there are further questions about this report, please contact:

Name: Michael W. Martin **Telephone Number:** (217) 258-8888

Email Address: Michael.Martin@rsmi.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2009 to 12/31/2009 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	**(Signed)** (Date)
	(Type or Print Name)
	(Title)
Paid Preparer	**(Signed)** (Date)
	(Print Name and Title) See Accountants' Compilation Report
	(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale, Suite 500, Schaumburg, IL 60173
	(Telephone) (847) 517-7070 **Fax** (847) 517-7067

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**

Facility Name Shabbona Supportive Living Facility Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

Date of change in certified units N/A

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	29	Single Unit Apartment	29	10,585	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	36	TOTALS	36	13,140	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	4,289	4,452		8,741	5
6	Double Unit	730	2,528		3,258	6
7	Other					7
8	TOTALS	5,019	6,980		11,999	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.32%

D. Indicate the number of paid bed-hold days the SLF had during this year N/A **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** N/A **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)
None

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/09 Fiscal Year: 12/31/09
* 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?** N/A
If no, explain. N/A

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?** N/A
If no, explain. N/A

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?** N/A
If no, explain. N/A

Facility Name: Shabbona Supportive Living Facility **Report Period Beginning: 01/01/2009 Ending: 12/31/2009**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	122,227	110,862	1,511	234,600		234,600	1
2	Housekeeping, Laundry and Maintenance	76,611	42,239	1,795	120,645		120,645	2
3	Heat and Other Utilities			43,819	43,819		43,819	3
4	Other (specify):							4
5	**TOTAL General Services**	198,838	153,101	47,125	399,064		399,064	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	245,337	299		245,636		245,636	6
7	Activities and Social Services	57,390	2,729		60,119		60,119	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	302,727	3,028		305,755		305,755	9
	C. General Administration							
10	Administrative and Clerical	17,894		33,059	50,953	552	51,505	10
11	Marketing Materials, Promotions and Advertising			12,331	12,331	(12,331)		11
12	Employee Benefits and Payroll Taxes			64,929	64,929		64,929	12
13	Insurance-Property, Liability and Malpractice			23,030	23,030		23,030	13
14	Other (specify):							14
15	**TOTAL General Administration**	17,894		133,349	151,243	(11,779)	139,464	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	519,459	156,129	180,474	856,062	(11,779)	844,283	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			3,698	3,698	105,821	109,519	17
18	Interest			45,594	45,594	143,348	188,942	18
19	Real Estate Taxes			27,659	27,659		27,659	19
20	Rent -- Facility and Grounds			168,000	168,000	(168,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			244,951	244,951	81,169	326,120	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	519,459	156,129	425,425	1,101,013	69,390	1,170,403	24

Facility Name: Shabbona Supportive Living Facility Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.48	$ 22.90	1
2	Licensed Practical Nurses	0.74	23.88	2
3	Certified Nurse Assistants	8.77	10.18	3
4	Activity Director & Assistants	0.58	9.61	4
5	Social Service Workers	1.04	21.16	5
6	Head Cook	1.05	11.69	6
7	Cook Helpers/Assistants	5.65	8.21	7
8	Dishwashers			8
9	Maintenance Workers	0.97	13.12	9
10	Housekeepers	2.22	7.00	10
11	Laundry	0.99	8.70	11
12	Managers			12
13	Other Administrative			13
14	Clerical	0.96	8.94	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	23	$ 13.22	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	Albert Milstein	45%		$ N/A	1
2	Sheldon Wolfe	43%	1.5	N/A	2
3	Mo Herman	10%	1.5	N/A	3
4	Jeremy Amster	2%		N/A	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Business	5
See attached schedule 4A									

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 [X]
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 [X]
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: Shabbona Supportive Living Facility Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VIII. OWNERSHIP COSTS

A. Purchase price of land 33,632 Year land was acquired 2006

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	36		2006	2006	$ 2,605,419	$	27.5	$ 95,501	$ 95,501	$ 351,956	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Laundry Room			2007	12,716	462	27.50	462		1,252	6
7	Carpet			2007	4,998	182	27.50	182		387	7
8	Check Valve			2008	5,435	198	27.50	198		223	8
9	Fence			2008	2,434	120	15	120		135	9
10	Elevator Motor			2009	8,133	136	27.50	136		136	10
11	Carpet			2009	2,799	89	27.50	89		89	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 2,641,934	$ 1,187		$ 96,688	$ 95,501	$ 354,178	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	$ 100,912	$ 2,511	$ 12,831	10,320	5	$ 81,087	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 100,912	$ 2,511	$ 12,831	10,320		$ 81,087	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	N/A	$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: Shabbona Supportive Living Facility **Report Period Beginning:** 01/01/2009 **Ending:** 2/31/2009

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	$ N/A			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 $** 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	MB Financial Bank		X	Mortgage	12/24/07	$ 2,320,000	$ 2,259,502	1/15/08	8.2500	$ 162,723	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank		X	Working Capital	6/30/06	500,000	329,765	Demand	8.2500	45,594	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 2,820,000	$ 2,589,267			$ 208,317	7
	B. Non-Facility Related										
8					/ /	Amortization of mortgage cost		/ /		3,654	8
9					/ /	Interest Income offset		/ /		-23,029	9
10	TOTALS (lines 7, 8 and 9)					$ 2,820,000	$ 2,589,267			$ 188,942	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: Shabbona Supportive Living Facility **Report Period Beginning:** 01/01/2009 **Ending:** 12/31/2009

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	115,373	115,373	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,729	5,729	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)**	$ 121,102	$ 121,102	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		2,605,419	14
15	Leasehold Improvements, at Historical Cost	36,515	36,515	15
16	Equipment, at Historical Cost	16,884	100,912	16
17	Accumulated Depreciation (book methods)	(16,557)	(436,482)	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): Mortgage Costs		18,272	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,842	$ 2,324,636	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 157,944	$ 2,445,738	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,556	$ 40,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,132	9,132	30
31	Accrued Taxes Payable	87,728	87,728	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Schedule 7A	331,583	833,152	35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 469,999	$ 970,203	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	329,765	329,765	38
39	Mortgage Payable		2,259,502	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)**	$ 329,765	$ 2,589,267	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 799,764	$ 3,559,470	45
46	**TOTAL EQUITY**	$ (641,820)	$ (1,113,732)	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 157,944	$ 2,445,738	47

***(See instructions.)**

Facility Name: Shabbona Supportive Living Facility **Report Period Beginning: 01/01/2009 Ending: 12/31/2009**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,074,878	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,074,878	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	23,029	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 23,029	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)**	$ 1,097,907	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	399,064	19
20	Health Care/ Personal Care	305,755	20
21	General Administration	151,243	21
	B. Capital Expense		
22	Ownership	244,951	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)**	$ 1,101,013	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (3,106)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (3,106)	31

Shabbona SLF
12/31/2009
Related Organizations

See Accountants' Compilation Report

Related Nursing Homes	**City**
In State	
Cahokia Nursing and Rehab,Inc.	Cahokia
Caseyville Nursing and Rehab,Inc.	Caseyville
Franklin Grove Nursing Center,Inc.	Franklin Grove
Kenwood Healthcare Center,Inc.	Chicago
Oregon Healthcare Center,Inc.	Oregon
Shabbona Healthcare Center,Inc.	Shabbona
Towerhill Healthcare Center,LLC	South Elgin
Virgil Calvert Nursing and Rehab,Inc.	East St. Louis
Out of State	
Hillside Manor Healthcare and Rehab,LLC	St. Louis, MO
Rancho Manor Healthcare and Rehab,LLC	Florissant, MO
Beauvais Manor Healthcare and Rehabilitation,LLC	St. Louis, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S & E Medical Supply Co.	Skokie	Medical Supplies
*SFO Associates	Skokie	Finance Company
**Unity Hospice	Skokie	Hospice Services

*This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center and Oregon Healthcare Center.

Shabbona Supportive Living Facility
12/31/2009
Schedule 7A **See Accountants' Compilation Report**

XI. Line 35

Description	**Amount**	**Consolidated**
Reimbursement Due	1,272	1,272
Due to Shabbona Healthcare	564,783	564,783
FICA Withholding	598	598
Short Term Loan Exchange		10,000
Due to Public Aid	1,499	1,499
N/P Auto		491,569
Due/From SLF Building Partnerhsip	(491,569)	(491,569)
Due to/From Partners	255,000	255,000
	331,583	833,152