

		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: Springfield SLC

Address: 2034 Clearlake Avenue Springfield 62702  
Number City Zip Code

County: Sangamon

Telephone Number: (217) 522-8843 Fax # \_\_\_\_\_

Federal Employer ID Number: \_\_\_\_\_

Date Current Owners were Certified: 8/3/2005

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 type="checkbox"/> Other _____	

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2009 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) Jeff Singer, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.  
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax (847) 236-1155

In the event there are further questions about this report, please contact:  
 Name: Steve Lavenda Telephone Number: (847) 236 - 1111  
 Email Address: slavenda@frronline.com

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 Springfield Slc

Report Period Beginning: 1/1/2009 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	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	123	Single Unit Apartment	123	44,895	1
2	13	Double Unit Apartment	13	4,745	2
3		Other			3
4	136	TOTALS	136	49,640	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	17,695	3,874		21,569	5
6	Double Unit	1,870	409		2,279	6
7	Other					7
8	TOTALS	19,565	4,283		23,848	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 48.04%

D. Indicate the number of paid bed-hold days the SLF had during this year

not tracked Also, indicate the number of unpaid bed-hold days the SLF had during this year. Not Tracked (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)

H. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

I. Is your fiscal year identical to your tax year?  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: Springfield Slc

Report Period Beginning:

1/1/2009

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 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	141,575	171,209	967	313,751	(1,150)	312,601	1
2	Housekeeping, Laundry and Maintenance	92,126	22,571	58,411	173,108	(10,974)	162,134	2
3	Heat and Other Utilities			146,781	146,781		146,781	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	233,701	193,780	206,159	633,640	(12,124)	621,516	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	343,358	3,967	3,981	351,306		351,306	6
7	Activities and Social Services	32,904	5,860	7,798	46,562		46,562	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	376,262	9,827	11,779	397,868		397,868	9
<b>C. General Administration</b>								
10	Administrative and Clerical	130,629	11,766	244,595	386,990	(91,397)	295,593	10
11	Marketing Materials, Promotions and Advertising	44,067		50,015	94,082	(29,386)	64,696	11
12	Employee Benefits and Payroll Taxes			159,848	159,848		159,848	12
13	Insurance-Property, Liability and Malpractice			55,395	55,395		55,395	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	174,696	11,766	509,853	696,315	(120,783)	575,532	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	784,659	215,373	727,791	1,727,823	(132,907)	1,594,916	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			12,539	12,539	244,846	257,385	17
18	Interest			40,737	40,737	411,899	452,636	18
19	Real Estate Taxes			99,991	99,991		99,991	19
20	Rent -- Facility and Grounds			734,196	734,196	(734,196)		20
21	Rent -- Equipment			3,126	3,126		3,126	21
22	Other (specify):					11,390	11,390	22
23	<b>TOTAL Ownership</b>			890,589	890,589	(66,061)	824,528	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	784,659	215,373	1,618,380	2,618,412	(198,968)	2,419,444	24

Facility Name: Springfield Slc

Report Period Beginning 1/1/2009

Ending: 12/31/2009

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.92	\$ 22.56	1
2	Licensed Practical Nurses	1.01	16.62	2
3	Certified Nurse Assistants	11.47	9.14	3
4	Activity Director & Assistants	1.45	10.89	4
5	Social Service Workers			5
6	Head Cook	1.00	16.14	6
7	Cook Helpers/Assistants	5.77	8.99	7
8	Dishwashers			8
9	Maintenance Workers	1.25	17.65	9
10	Housekeepers	2.68	8.33	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.00	26.24	13
14	Clerical	3.29	11.11	14
15	Marketing	1.00	21.19	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>31.85</b>	<b>\$ 11.84</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	\$ 52,927	1
2		2
<b>Total</b>		<b>3</b>
\$ 52,927		

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 Attached			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
See Attached					
Springfield Property LLC				Building Co.	

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: N/A If yes, what is the value of those services? \$ N/A

(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: Springfield Slc

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

VIII. OWNERSHIP COSTS

A. Purchase price of land 115,071 Year land was acquired \_\_\_\_\_

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	136		2005	2005	\$ 8,063,935	\$ 293,234	35	\$ 230,398	\$ (62,836)	\$ 1,220,063	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Total From Supplemental Page 5's				25,161	12,539		708	(11,831)	1,809	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)				\$ 8,089,096	\$ 305,773		\$ 231,106	\$ (74,667)	\$ 1,221,872	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	\$ 225,144	\$ 29,226	\$ 22,515	(6,711)	10	\$ 98,757	18
19	Vehicles	43,071		3,764	3,764	5	22,368	19
20	TOTAL (lines 18 and 19)	\$ 268,215	\$ 29,226	\$ 26,279	(2,947)		\$ 121,125	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 Springfield Slc

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**XI. OWNERSHIP COSTS (continued)**

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

1	2	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	Fence	2005	1,750		20	88	88	357	2
3	Window Treatments	2006	2,370		20	119	119	464	3
4	Shelving	2006	951		20	48	48	170	4
5	Carbon Monoxide Detectors	2007	2,632		20	132	132	395	5
6	Elevator - Upgrade To Code	2008	4,900		20	245	245	347	6
7	Concrete Sidewalk	2009	6,762		20	28	28	28	7
8	Paint, Wall Paper	2009	5,796		20	48	48	48	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	<b>Total Book Depreciation</b>			<b>12,539</b>			<b>(12,539)</b>		<b>33</b>
34	<b>TOTAL (lines 1 thru 33)</b>		<b>\$ 25,161</b>	<b>\$ 12,539</b>		<b>\$ 708</b>	<b>\$ (11,831)</b>	<b>\$ 1,809</b>	<b>34</b>

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

Facility Name & ID Number Springfield Slc

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**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 & ID Number Springfield Slc

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**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: Springfield Slc

Report Period Beginning: 1/1/2009

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			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>				\$			7

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

9. Rental amount for movable equipment \$ 3,126

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	Cambridge Realty		X	Mortgage	/ /	\$	7,583,157	/ /		\$ 452,758	1
2	N/P - SigLefkovitz				/ /		2,464,263	/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4	Venture Fund	X		Working Capital	/ /			/ /		40,737	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$	10,047,420			\$ 493,495	7
	<b>B. Non-Facility Related</b>										
8	Interest Income				/ /			/ /		-122	8
9	Non-Allowable Interest				/ /			/ /		-40,737	9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	10,047,420			\$ 452,636	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: Springfield Slc

Report Period Beginning: 1/1/2009

Ending:

12/31/2009

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 32,656	\$ 52,011	1
2	Cash-Patient Deposits	7,786	7,786	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	174,345	174,345	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,953	25,953	6
7	Other Prepaid Expenses	1,514	1,514	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	238,012	343,611	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 480,266	\$ 605,220	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,071	13
14	Buildings, at Historical Cost		8,063,935	14
15	Leasehold Improvements, at Historical Cost	1,750	1,750	15
16	Equipment, at Historical Cost	69,585	274,167	16
17	Accumulated Depreciation (book methods)	(51,797)	(1,466,213)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		233,795	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(43,988)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 19,538	\$ 7,178,517	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 499,804	\$ 7,783,737	25

\*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 665,321	\$ 665,321	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1	1	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,337	28,337	30
31	Accrued Taxes Payable	156,725	156,725	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36			1,711,629	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 850,384	\$ 2,562,013	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	2,464,263	2,464,263	38
39	Mortgage Payable		7,583,157	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>	\$ 2,464,263	\$ 10,047,420	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,314,647	\$ 12,609,433	45
46	<b>TOTAL EQUITY</b>	\$ (2,814,843)	\$ (4,825,696)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 499,804	\$ 7,783,737	47

Facility Name: Springfield Slc

Report Period Beginning: 1/1/2009

Ending:

12/31/2009

**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	\$ 1,828,083	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 1,828,083	3
<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
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,828,083	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	633,640	19
20	Health Care/ Personal Care	397,868	20
21	General Administration	696,315	21
<b>B. Capital Expense</b>			
22	Ownership	890,589	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 2,618,412	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ (790,329)	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ (790,329)	31