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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC

Address: 120 NORTH DEERFIELD ROAD (Number) PONTIAC (City) 61764 (Zip Code)

County: LIVINGSTON

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

Federal Employer ID Number: 26-3412997

Date Current Owners were Certified: 03/02/2009

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[X] Limited Liability Co.	
	[ ] Trust	
	[ ] 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 03/02/2009 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) MARSHALL MAUER

(Title) TREASURER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address: KVANSTOCKUM@KBKBCPA.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 WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC Report Period Beginning: 03/02/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	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	50	Single Unit Apartment	50	15,200	1
2	10	Double Unit Apartment	10	3,040	2
3		Other		608	3
4	60	TOTALS	60	18,848	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	4,270	2,901		7,171	5
6	Double Unit	528			528	6
7	Other					7
8	TOTALS	4,798	2,901		7,699	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 40.85%

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 [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)
NA

H. ACCOUNTING BASIS

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

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?** _____
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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PC **Report Period Beginning: 03/02/2009 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		53,375	52,790	106,165		106,165	1
2	Housekeeping, Laundry and Maintenance		13,784	13,949	27,733		27,733	2
3	Heat and Other Utilities			40,298	40,298		40,298	3
4	Other (specify):							4
5	**TOTAL General Services**		67,159	107,037	174,196		174,196	5
	B. Health Care and Programs							
6	Health Care/ Personal Care		544	141,993	142,537		142,537	6
7	Activities and Social Services		1,948	20,030	21,978		21,978	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**		2,492	162,023	164,515		164,515	9
	C. General Administration							
10	Administrative and Clerical		8,375	69,164	77,539		77,539	10
11	Marketing Materials, Promotions and Advertising		10,942		10,942		10,942	11
12	Employee Benefits and Payroll Taxes			10,545	10,545		10,545	12
13	Insurance-Property, Liability and Malpractice			20,050	20,050		20,050	13
14	Other (specify):					4,555	4,555	14
15	**TOTAL General Administration**		19,317	99,759	119,076	4,555	123,631	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**		88,968	368,819	457,787	4,555	462,342	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			2,441	2,441	137,905	140,346	17
18	Interest			227	227	267,694	267,921	18
19	Real Estate Taxes			12,500	12,500		12,500	19
20	Rent -- Facility and Grounds			130,000	130,000	(130,000)		20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			145,168	145,168	275,599	420,767	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**		88,968	513,987	602,955	280,154	883,109	24

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC **Report Period Beginning: 03/02/2009 Ending: 12/31/2009**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	NA	$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**		$	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	NA			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	NA	$	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
SCHEDULE 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** [X] **NO** [ ]

Name of related entity: DYNAMIC HEALTHCARE CONSULTANTS **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** [X] **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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PO Report Period Beginning: 03/02/2009 Ending: 12/31/2009

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ 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	60		2009	2009	$ 3,871,594	$ 111,590	28	$ 111,590	$	$ 111,590	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				$ 3,871,594	$ 111,590		$ 111,590	$	$ 111,590	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	$ 287,559	$ 172,536	$ 28,756	(143,780)	10 YRS	$ 28,756	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 287,559	$ 172,536	$ 28,756	(143,780)		$ 28,756	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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIA Report Period Beginning: 03/02/2009 Ending: 2/31/2009

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NA

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	TOTAL				$			7

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

9. Rental amount for movable equipment $

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	BANK OF PONTIAC		X	MORTGAGE	12/4/08	$ 3,939,300	$ 3,904,309	4/15/14	5.7500	$ 250,075	1
2	BANK OF PONTIAC		X	WORKING CAPITAL	5/1/09	725,000	675,612	/ /		17,619	2
3			X	INSURANCE FINANCING	/ /			/ /		227	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 4,664,300	$ 4,579,921			$ 267,921	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 4,664,300	$ 4,579,921			$ 267,921	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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC **Report Period Beginning:** 03/02/2009 **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)	185,615		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,042		6
7	Other Prepaid Expenses	2,943		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 205,600	$	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	6,206		16
17	Accumulated Depreciation (book methods)	(2,441)		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)**	$ 3,765	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 209,365	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,304	$	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			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)**	$ 166,304	$	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)**	$ 166,304	$	45
46	**TOTAL EQUITY**	$ 43,061	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 209,365	$	47

***(See instructions.)**

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE Ol **Report Period Beginning: 03/02/2009** **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	$ 630,380	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 630,380	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	**FOOD STAMP INCOME**	15,636	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 15,636	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 646,016	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	174,196	19
20	Health Care/ Personal Care	164,515	20
21	General Administration	123,631	21
	B. Capital Expense		
22	Ownership	420,767	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	**RELATED PARTY EXP - SCHED IV - 24-5**	(280,154)	26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 602,955	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 43,061	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 43,061	31