

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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 ID Number: 1000106

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG

Address: 261 NORTH LINWOOD ROAD GALESBURG 61401
Number City Zip Code

County: KNOX

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

Federal Employer ID Number: _____

Date Current Owners were Certified: 10/15/2008

Type of Ownership:

<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 _____	

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

Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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) <u>MARSHALL MAUER</u>	
	(Title) <u>TREASURER</u>	
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	
	(Firm Name & Address) <u>KPUPNICK, BOKOR, KAGDA & BROOKS, LTD.</u> <u>3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</u>	
	(Telephone) <u>(847) 675-3585</u> Fax <u>(847) 675-5777</u>	

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 GA

Report Period Beginning:

01/01/2010

Ending: 12/31/2010

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	47,665	97,968	45,954	191,587		191,587	1
2	Housekeeping, Laundry and Maintenance	27,281	29,157	29,660	86,098		86,098	2
3	Heat and Other Utilities			66,789	66,789		66,789	3
4	Other (specify):							4
5	TOTAL General Services	74,946	127,125	142,403	344,474		344,474	5
B. Health Care and Programs								
6	Health Care/ Personal Care	137,919	2,062	162,480	302,461		302,461	6
7	Activities and Social Services	10,637	2,708	9,599	22,944		22,944	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	148,556	4,770	172,079	325,405		325,405	9
C. General Administration								
10	Administrative and Clerical	30,268	7,639	55,248	93,155		93,155	10
11	Marketing Materials, Promotions and Advertising			14,382	14,382		14,382	11
12	Employee Benefits and Payroll Taxes			43,552	43,552		43,552	12
13	Insurance-Property, Liability and Malpractice			22,513	22,513		22,513	13
14	Other (specify):							14
15	TOTAL General Administration	30,268	7,639	135,695	173,602		173,602	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	253,770	139,534	450,177	843,481		843,481	16
Capital Expenses								
D. Ownership								
17	Depreciation			9,648	9,648		9,648	17
18	Interest			6,437	6,437		6,437	18
19	Real Estate Taxes			30,000	30,000		30,000	19
20	Rent -- Facility and Grounds			336,000	336,000		336,000	20
21	Rent -- Equipment			11,820	11,820		11,820	21
22	Other (specify):							22
23	TOTAL Ownership			393,905	393,905		393,905	23
24	GRAND TOTAL (Sum of lines 16 and 23)	253,770	139,534	844,082	1,237,386		1,237,386	24

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBU

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.01	1
2	Licensed Practical Nurses	3	16.61	2
3	Certified Nurse Assistants	10	9.13	3
4	Activity Director & Assistants	1	19.91	4
5	Social Service Workers			5
6	Head Cook	3	9.68	6
7	Cook Helpers/Assistants	3	8.61	7
8	Dishwashers			8
9	Maintenance Workers	1	12.00	9
10	Housekeepers	2	8.62	10
11	Laundry			11
12	Managers	1	26.91	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	25	\$ 5.26	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	N/A			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	N/A	\$ 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	1	City	2
SCHEDULE ATTACHED			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: DYNAMIC HEALTH CARE CONSULTANTS If yes, what is the value of those services? \$ 18,000

(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: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GAI

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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		2008	2008	\$ 4,279,498	\$ 155,618	28	\$ 155,618	\$	\$ 339,411	1
2											2
3											3
4											4
5											5
Improvement Type											
6		CONCRETE FOR SIDEWAKS		2010	3,300	55	28	55		55	6
7		CARPETING		2010	3,268	55	28	55		55	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)				\$ 4,286,066	\$ 155,728		\$ 155,728	\$	\$ 339,521	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	\$ 240,651	\$ 36,089	\$ 24,065	(12,024)	10YRS	\$ 42,670	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 240,651	\$ 36,089	\$ 24,065	(12,024)		\$ 42,670	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 GALES**

Report Period Beginning: **01/01/2001**

Ending: **2/31/2010**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A-RELATED PARTY

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				/ /				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

	Name of Lender	2		3	4	6		7	8	9						
		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	MB FINANCIAL		X	MORTGAGE	12/28/07	\$ 4,576,600	\$ 4,444,052	6/1/34	5.2500	\$ 259,374	1					
2											2					
3					/ /			/ /			3					
	Working Capital															
4	MB FINANCIAL		X	WORKING CAPITAL	11/17/09	125,000	97,917	11/5/14	5.5000	6,224	4					
5				INSURANCE FINANCING	/ /			/ /		213	5					
6					/ /			/ /			6					
7	TOTAL Facility Related					\$ 4,701,600	\$ 4,541,969			\$ 265,811	7					
	B. Non-Facility Related															
8					/ /			/ /			8					
9					/ /			/ /			9					
10	TOTALS (lines 7, 8 and 9)					\$ 4,701,600	\$ 4,541,969			\$ 265,811	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 GALESBU**Report Period Beginning: **01/01/2010**

Ending:

12/31/2010**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2010**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 376,223	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	22,729		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,687		6
7	Other Prepaid Expenses	3,195		7
8	Accounts Receivable (owners or related parties)	513,120		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 940,954	\$	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	15,785		15
16	Equipment, at Historical Cost	23,551		16
17	Accumulated Depreciation (book methods)	(14,727)		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)	\$ 24,609	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 965,563	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,243	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	97,917		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)	\$ 180,160	\$	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)	\$ 180,160	\$	45
46	TOTAL EQUITY	\$ 785,403	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 965,563	\$	47

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	\$ 1,743,865	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,743,865	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	1,588	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 1,588	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	FOOD STAMP INCOME	4,135	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 4,135	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,749,588	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	344,474	19
20	Health Care/ Personal Care	325,405	20
21	General Administration	173,602	21
B. Capital Expense			
22	Ownership	393,905	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 1,237,386	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 512,202	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 512,202	31