

		FOR BHF USE			

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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. Facility ID Number: <u>1000098</u></p> <p>Facility Name: <u>WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO</u></p> <p>Address: <u>620 OLIVIA COURT</u> <u>GENESEO</u> <u>61254</u> <small>Number City Zip Code</small></p> <p>County: <u>HENRY</u></p> <p>Telephone Number: (<u>847</u>) <u>679-8219</u> Fax # (<u>847</u>) <u>679-7377</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>07/02/2008</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>SANFORD BOKOR</u> Telephone Number: (<u>847</u>) <u>675-3585</u> Email Address: _____</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>01/01/2012</u> to <u>12/31/2012</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>MARSHALL MAUER</u> (Title) <u>TREASURER</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS</u> <u>3750 W DEVON LINCOLNWOOD, IL 60712</u> (Telephone) (<u>847</u>) <u>675-3585</u> Fax # (<u>847</u>) <u>675-5777</u> </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>MARSHALL MAUER</u> (Title) <u>TREASURER</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>SANFORD BOKOR</u> <u>PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS</u> <u>3750 W DEVON LINCOLNWOOD, IL 60712</u> (Telephone) (<u>847</u>) <u>675-3585</u> Fax # (<u>847</u>) <u>675-5777</u>
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Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GE

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

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	116,015	133,654	1,659	251,328		251,328	1
2	Housekeeping, Laundry and Maintenance	71,080	32,347	6,968	110,395	1,693	112,088	2
3	Heat and Other Utilities			73,342	73,342	2,491	75,833	3
4	Other (specify):							4
5	TOTAL General Services	187,095	166,001	81,969	435,065	4,184	439,249	5
B. Health Care and Programs								
6	Health Care/ Personal Care	252,770	1,455		254,225		254,225	6
7	Activities and Social Services	27,547	6,587		34,134		34,134	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	280,317	8,042		288,359		288,359	9
C. General Administration								
10	Administrative and Clerical	90,636	6,256	91,733	188,625	8,459	197,084	10
11	Marketing Materials, Promotions and Advertising			29,543	29,543		29,543	11
12	Employee Benefits and Payroll Taxes			123,709	123,709	1,950	125,659	12
13	Insurance-Property, Liability and Malpractice			21,465	21,465		21,465	13
14	Other (specify):							14
15	TOTAL General Administration	90,636	6,256	266,450	363,342	10,409	373,751	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	558,048	180,299	348,419	1,086,766	14,594	1,101,360	16
Capital Expenses								
D. Ownership								
17	Depreciation			10,907	10,907	160,645	171,552	17
18	Interest			3,657	3,657	224,260	227,917	18
19	Real Estate Taxes			45,000	45,000	(13,946)	31,054	19
20	Rent -- Facility and Grounds			372,000	372,000	(372,000)		20
21	Rent -- Equipment					1,633	1,633	21
22	Other (specify):							22
23	TOTAL Ownership			431,564	431,564	592	432,156	23
24	GRAND TOTAL (Sum of lines 16 and 23)	558,048	180,299	779,983	1,518,330	15,186	1,533,516	24

Facility Name: **WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO**

Report Period Beginning **01/01/2012** Ending: **12/31/2012**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 19.50	1
2	Licensed Practical Nurses	1	16.75	2
3	Certified Nurse Assistants	9	9.75	3
4	Activity Director & Assistants	2	12.00	4
5	Social Service Workers			5
6	Head Cook	2	11.90	6
7	Cook Helpers/Assistants	4	9.00	7
8	Dishwashers			8
9	Maintenance Workers	1	16.80	9
10	Housekeepers	2	8.75	10
11	Laundry			11
12	Managers	1	26.00	12
13	Other Administrative	1	20.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	24	\$	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	E MARYLES - CLERICAL		8	\$ 4,580	1
2					2
3					3
4					4
5					5
				Total	\$ 4580 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

Name	1	City	2
WOODRIDGE OF GALESBURG			
WOODRIDGE OF PONTIAC			
SEE ATTACHED			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
SEE 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 NO

Name of related entity: DYNAMIC HEALTHCARE CONSULTANTS If yes, what is the value of those services? \$ 17,947

(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 G...

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VIII. OWNERSHIP COSTS

A. Purchase price of land 251,148 Year land was acquired 2007

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	\$ 4,064,630	\$ 148,701	28	\$ 148,701	\$	\$ 665,764	1
2											2
3											3
4											4
5											5
Improvement Type											
6		PLUMBING WORK		2010	2,938	107	28	107		227	6
7		DOOR		2011	1,925	70	28	70		114	7
8		CARPENTRY AND LABOR		2011	6,219	226	28	226		273	8
9		REPAIR WALLPAPER		2012	1,122	12	28	12		12	9
10		SIDEWALK		2012	11,344	5,861	15	5,861		5,861	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,088,178	\$ 154,977		\$ 154,977	\$	\$ 672,251	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	\$ 233,589	\$ 16,076	\$ 23,359	7,283	10 YRS	\$ 90,216	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 233,589	\$ 16,076	\$ 23,359	7,283		\$ 90,216	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 GENESI**

Report Period Beginning: **01/01/2012**

Ending: **2/31/2012**

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	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

	1	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		MB FINANCIAL		X	MORTGAGE	12/28/07	\$ 4,763,400	\$ 4,345,811	6/1/34	5.2500	\$ 223,676	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4		MB FINANCIAL		X	WORKING CAPITAL	11/17/09	125,000	92,808	11/5/14	5.0000	6,442	4
5				X	INSURANCE FINANCING	/ /			/ /		188	5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 4,888,400	\$ 4,438,619			\$ 230,306	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 4,888,400	\$ 4,438,619			\$ 230,306	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 GENESEO**Report Period Beginning: **01/01/2012**

Ending:

12/31/2012**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2012**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 118,105	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	248,963		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,708		6
7	Other Prepaid Expenses	971		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 394,747	\$	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	23,549		15
16	Equipment, at Historical Cost	31,938		16
17	Accumulated Depreciation (book methods)	(31,806)		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): SEC DEPOSIT	3,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,681	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 421,428	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 229,107	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	47,917		29
30	Accrued Salaries Payable	45,740		30
31	Accrued Taxes Payable	49,189		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)	\$ 371,953	\$	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)	\$ 371,953	\$	45
46	TOTAL EQUITY	\$ 49,475	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 421,428	\$	47

*(See instructions.)

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

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	\$ 1,811,115	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,811,115	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	36,017	15
16	OTHER SERVICES-PRIVATE	769	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 36,786	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,847,901	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	435,065	19
20	Health Care/ Personal Care	288,359	20
21	General Administration	363,342	21
B. Capital Expense			
22	Ownership	431,564	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	PRIOR YEAR EXPENSES	(5,081)	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,513,249	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 334,652	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 334,652	31

WOODRIDGE OF GENESEO
12/31/2012

PAGE 3 COLUMN 5 RECLASSIFICATIONSADJUSTMENTS

LINE 3	CABLE TV	2,294
LINE 10	CABLE TV	(2,294)

RELATED PARTY LANDLORD

LINE 17	DEPRECIATION	160,147
LINE 18	MORTGAGE INTEREST	223,676
LINE 19	REAL ESTATE TAX	(60,000)
LINE 19	REAL ESTATE TAX	45,416
LINE 20	RENT	<u>(372,000)</u>
LINE 24	GRAND TOTAL	<u><u>(2,761)</u></u>

PAGE 4 SCHEDULE VII B

DYNAMIC HEALTHCARE CONSULTANTS COST

UTILITIES	197
REPAIRS & MAINT	1,693
EMP BEN-GEN SERV	36
PROFESSIONAL FES	241
DUES & SUBSCRIPTIONS	123
CLERICAL & GENERAL	9,921
SEMINARS & TRAVEL	456
AUTO EXP	12
INSURANCE	-
EMP. BEN.-GEN. ADMIN.	1,914
DEPRECIATION	498

INTEREST	584
REAL ESTATE TAXES	638
AUTO RENTAL	1,575
EQUIPMENT RENTAL	57
	<hr/>
	17,947
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