

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2013  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2013)**

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 SL RESID GALESBURG

**Address:** 261 NORTH LINWOOD RD 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
<b>IRS Exemption Code</b> _____	<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:** \_\_\_\_\_ **Telephone Number:** ( )  
**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 01/01/2013 to 12/31/2013 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> _____	<b>Fax #</b> <u>( )</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 SL RESID GALESBURG

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**III. STATISTICAL DATA**

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

Date of change in certified units       /      /      

	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	51	Single Unit Apartment	51	18,615	1
2	9	Double Unit Apartment	9	3,285	2
3		Other			3
4	60	TOTALS	60	21,900	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	5,457	14,391		19,848	5
6	Double Unit		757		757	6
7	Other					7
8	TOTALS	5,457	15,148		20,605	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)       94.09%      

**D. Indicate the number of paid bed-hold days the SLF had during this year**       47       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

**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:                      Fiscal Year:                     

\* 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 SL RESID GALESBURG

Report Period Beginning:

01/01/2013

Ending: 12/31/2013

## 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	119,184	127,740	1,668	248,592		248,592	1
2	Housekeeping, Laundry and Maintenance	75,344	25,883	9,854	111,081		111,081	2
3	Heat and Other Utilities			55,700	55,700	2,183	57,883	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>194,528</b>	<b>153,623</b>	<b>67,222</b>	<b>415,373</b>	<b>2,183</b>	<b>417,556</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	295,605	3,195		298,800		298,800	6
7	Activities and Social Services	27,626	2,540		30,166		30,166	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>323,231</b>	<b>5,735</b>		<b>328,966</b>		<b>328,966</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	57,985	5,292	39,122	102,399	(2,183)	100,216	10
11	Marketing Materials, Promotions and Advertising			14,321	14,321		14,321	11
12	Employee Benefits and Payroll Taxes			126,703	126,703		126,703	12
13	Insurance-Property, Liability and Malpractice			21,592	21,592		21,592	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>57,985</b>	<b>5,292</b>	<b>201,738</b>	<b>265,015</b>	<b>(2,183)</b>	<b>262,832</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>575,744</b>	<b>164,650</b>	<b>268,960</b>	<b>1,009,354</b>		<b>1,009,354</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			4,169	4,169	166,093	170,262	17
18	Interest			2,430	2,430	105,876	108,306	18
19	Real Estate Taxes			63,659	63,659		63,659	19
20	Rent -- Facility and Grounds			313,023	313,023	(313,023)		20
21	Rent -- Equipment			14,704	14,704		14,704	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>397,985</b>	<b>397,985</b>	<b>(41,054)</b>	<b>356,931</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>575,744</b>	<b>164,650</b>	<b>666,945</b>	<b>1,407,339</b>	<b>(41,054)</b>	<b>1,366,285</b>	<b>24</b>

Facility Name: WOODRIDGE SL RESID GALESBURG

Report Period Beginning 01/01/2013 Ending: 12/31/2013

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	3	17.25	2
3	Certified Nurse Assistants	14	9.25	3
4	Activity Director & Assistants	1	13.00	4
5	Social Service Workers			5
6	Head Cook	2	10.15	6
7	Cook Helpers/Assistants	6	9.50	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	3	9.75	10
11	Laundry			11
12	Managers	1	23.00	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>31</b>	<b>\$</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	E MARYLES - CLERICAL	8.3	8.4	\$ 15,162	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$ 15162</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	NA	\$ 1
2		2
<b>Total</b>		<b>\$ 3</b>

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 GENESEO			
WOODRIDGE OF PONTIAC			
SCHEDULE ATTACHED			

OTHER RELATED BUSINESS ENTITIES

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  NO

Name of related entity: DYNAMIC HEALTHCARE CONSULTANTS If yes, what is the value of those services? \$ 19,739

(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 SL RESID GALESBURG

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VIII. OWNERSHIP COSTS

A. Purchase price of land 89,000 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	60		2008	2008	\$ 4,270,281	\$ 155,283	28	\$ 155,283	\$	\$ 804,770	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		WATERSOFTENER		2009	9,217	335	28	335		1,494	6
7		SIDEWALK REPAIR		2010	3,300	120	28	120		415	7
8		CARPETING		2010	3,268	119	28	119		411	8
9		FURNACE REPAIRS		2012	706	26	28	26		50	9
10		CARPETING		2012	6,195	225	28	225		234	10
11		REPLACED CAMERAS & DVR		2013	4,982	105	28	105		105	11
12		OFFSET SUPPLY TRAP		2013	2,126	6	28	6		6	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,300,075	\$ 156,219		\$ 156,219	\$	\$ 807,485	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	\$ 255,109	\$ 14,042	\$ 25,511	11,469	10 YRS	\$ 103,474	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 255,109	\$ 14,042	\$ 25,511	11,469		\$ 103,474	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 SL RESID GALESBURG**

Report Period Beginning: **01/01/2013**

Ending: **2/31/2013**

**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	<b>TOTAL</b>				\$			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	2	3	4	6	7	8	9			
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	MB FINANCIAL		X	MORTGAGE	12/28/07	\$ 4,576,600	\$ 4,175,497	6/1/34	5.2500	\$ 105,876	1
2					/ /			/ /			2
3					/ /			/ /			3
	<b>Working Capital</b>										
4	MB FINANCIAL		X	WORKING CAPITAL	11/17/09	125,000	22,917	11/5/14	5.5000	2,034	4
5			X	INSURANCE FINANCING	/ /			/ /		396	5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 4,701,600	\$ 4,198,414			\$ 108,306	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 4,701,600	\$ 4,198,414			\$ 108,306	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 SL RESID GALESBURG

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 197,040	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	47,824		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,796		6
7	Other Prepaid Expenses	3,196		7
8	Accounts Receivable (owners or related parties)	717,251		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 993,107	\$	10
	<b>B. Long-Term Assets</b>			
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	29,795		15
16	Equipment, at Historical Cost	41,676		16
17	Accumulated Depreciation (book methods)	(32,056)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 39,415	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,032,522	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 70,131	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	22,917		29
30	Accrued Salaries Payable	47,808		30
31	Accrued Taxes Payable	68,698		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				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 209,554	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 209,554	\$	45
46	<b>TOTAL EQUITY</b>	\$ 822,968	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,032,522	\$	47

\*(See instructions.)

Facility Name: WOODRIDGE SL RESID GALESBURG

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

## 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	\$ 1,888,516	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,888,516</b>	<b>3</b>
<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
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 1</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	FOOD STAMP	20,786	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 20,786</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,909,303</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	415,373	19
20	Health Care/ Personal Care	328,966	20
21	General Administration	265,015	21
<b>B. Capital Expense</b>			
22	Ownership	397,985	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	<b>PRIOR YEAR EXPENSES</b>	<b>(8,243)</b>	<b>26</b>
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,399,096</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 510,207</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 510,207</b>	<b>31</b>

12/31/2013

PAGE 3 COLUMN 5 RECLASSIFICATIONSADJUSTMENTS

LINE 3	CABLE TV	2,183
LINE 10	CABLE TV	(2,183)

RELATED PARTY LANDLORD

LINE 17	DEPRECIATION	166,093
LINE 18	MORTGAGE INTEREST	105,876
LINE 20	RENT	<u>(313,023)</u>
LINE 24	GRAND TOTAL	<u><u>(41,054)</u></u>

PAGE 4 SCHEDULE VII B

DYNAMIC HEALTHCARE CONSULTANTS COST

UTILITIES	183
REPAIRS & MAINT	1,522
EMP BEN-GEN SERV	37
PROFESSIONAL FES	393
DUES & SUBSCRIPTIONS	191
CLERICAL & GENERAL	11,349
SEMINARS & TRAVEL	146
AUTO EXP	380
INSURANCE	158
EMP. BEN.-GEN. ADMIN.	2,120
DEPRECIATION	356
INTEREST	563
REAL ESTATE TAXES	708
AUTO RENTAL	1,619
EQUIPMENT RENTAL	<u>13</u>
	<u><u>19,739</u></u>



