

		FOR BHF USE			

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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 SL RESIDNCE GENSEO</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>847 679-7377</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: _____ Telephone Number: (_____) _____ 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>01/01/2015</u> to <u>12/31/2015</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>MARSHALL MAUER</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>TREASURER</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (_____) _____</td> <td>Fax # (_____) _____</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) _____	(Date) _____		(Type or Print Name) <u>MARSHALL MAUER</u>			(Title) <u>TREASURER</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) (_____) _____	Fax # (_____) _____
<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 _____																																													
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																												
	(Type or Print Name) <u>MARSHALL MAUER</u>																																													
	(Title) <u>TREASURER</u>																																													
Paid Preparer	(Signed) _____	(Date) _____																																												
	(Print Name and Title) _____																																													
	(Firm Name & Address) _____																																													
	(Telephone) (_____) _____	Fax # (_____) _____																																												

Facility Name: WOODRIDGE SL RESIDNCE GENSEO

Report Period Beginning:

01/01/2015

Ending: 12/31/2015

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	118,801	138,011	1,685	258,497		258,497	1
2	Housekeeping, Laundry and Maintenance	59,340	35,084	10,324	104,748		104,748	2
3	Heat and Other Utilities			83,554	83,554	2,242	85,796	3
4	Other (specify):							4
5	TOTAL General Services	178,141	173,095	95,563	446,799	2,242	449,041	5
B. Health Care and Programs								
6	Health Care/ Personal Care	298,482	1,314	1,000	300,796		300,796	6
7	Activities and Social Services	36,147	7,873		44,020		44,020	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	334,629	9,187	1,000	344,816		344,816	9
C. General Administration								
10	Administrative and Clerical	105,311	8,230	106,283	219,824	20,748	240,572	10
11	Marketing Materials, Promotions and Advertising			16,944	16,944		16,944	11
12	Employee Benefits and Payroll Taxes			104,475	104,475		104,475	12
13	Insurance-Property, Liability and Malpractice			16,064	16,064	5,005	21,069	13
14	Other (specify):							14
15	TOTAL General Administration	105,311	8,230	243,766	357,307	25,753	383,060	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	618,081	190,512	340,329	1,148,922	27,995	1,176,917	16
Capital Expenses								
D. Ownership								
17	Depreciation			5,870	5,870	148,701	154,571	17
18	Interest			618	618	160,326	160,944	18
19	Real Estate Taxes					46,919	46,919	19
20	Rent -- Facility and Grounds			360,000	360,000	(360,000)		20
21	Rent -- Equipment			8,856	8,856		8,856	21
22	Other (specify):							22
23	TOTAL Ownership			375,344	375,344	(4,054)	371,290	23
24	GRAND TOTAL (Sum of lines 16 and 23)	618,081	190,512	715,673	1,524,266	23,941	1,548,207	24

Facility Name: WOODRIDGE SL RESIDNCE GENSEO

Report Period Beginning 01/01/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.85	1
2	Licensed Practical Nurses	1	15.00	2
3	Certified Nurse Assistants	12	9.83	3
4	Activity Director & Assistants	2	12.10	4
5	Social Service Workers			5
6	Head Cook	2	11.75	6
7	Cook Helpers/Assistants	5	9.20	7
8	Dishwashers			8
9	Maintenance Workers	1	15.95	9
10	Housekeepers	3	8.90	10
11	Laundry			11
12	Managers	1	26.25	12
13	Other Administrative			13
14	Clerical	1	17.75	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	29	\$	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				\$	1
2					2
3					3
4					4
5					5
				Total	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	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		GALESBURG	
WOODRIDGE OF PONTIAC		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? \$ 55,315

(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 RESIDNCE GENSEO

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	27.5	\$ 148,701	\$	\$ 1,111,867	1
2											2
3											3
4											4
5											5
Improvement Type											
6		PLUMBING WORK		2010	2,938	107	27.5	107		548	6
7		DOOR		2011	1,925	70	27.5	70		324	7
8		CARPENTRY AND LABOR		2011	6,219	226	27.5	226		951	8
9		REPAIR WALLPAPER		2012	1,122	41	27.5	41		53	9
10		SIDEWALK		2012	11,344	756	15.0	756		7,373	10
11		LANDSCAPING		2013	4,553	304	15.0	304		633	11
12		WINDOW TREATMENTS/DECORATING		2013	5,463	199	27.5	199		463	12
13		DATA WIRING/DVR'S		2013	3,507	128	27.5	128		313	13
14		SPRINKLER REPAIRS, OFFSET TRAP SUPPLY		2013	3,620	132	27.5	132		288	14
15		NURSE CALL PAGERS,PENDANT,WIRELESS CONNE		2014	19,320	703	27.5	703		1,711	15
16		ALARM, WATER HEATER, SOFTENER, GRAVEL PAI		2015	23,371	546		546		546	16
17		TOTAL (lines 1 thru 16)			\$ 4,148,012	\$ 151,913		\$ 151,913	\$	\$ 1,125,070	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	\$ 252,826	\$ 4,557	\$ 25,283	20,726	10 YRS	\$ 160,533	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 252,826	\$ 4,557	\$ 25,283	20,726		\$ 160,533	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 RESIDNCE GENSEO

Report Period Beginning: 01/01/2015

Ending: 2/31/2015

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	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			
	A. Directly Facility Related									
	Long-Term									
1	HEARTLAND BANK		X	MORTGAGE	4/9/14	\$ 4,089,500	\$ 3,974,125	5/1/44	4.0000	\$ 160,326
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4			X	INSURANCE FINANCING	/ /			/ /		618
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,089,500	\$ 3,974,125			\$ 160,944
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 4,089,500	\$ 3,974,125			\$ 160,944

* 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 RESIDNCE GENSEO

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,537	\$ 148,541	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	61,852	61,852	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,523	31,439	6
7	Other Prepaid Expenses	4,071	4,071	7
8	Accounts Receivable (owners or related parties)	36,312	151,312	8
9	Other(specify): ESCROWS		156,150	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 209,295	\$ 553,365	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,148	13
14	Buildings, at Historical Cost		4,064,630	14
15	Leasehold Improvements, at Historical Cost	83,381	83,381	15
16	Equipment, at Historical Cost	51,174	252,826	16
17	Accumulated Depreciation (book methods)	(44,737)	(1,358,257)	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): DEFERRED LOAN COSTS NET		109,410	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 89,818	\$ 3,403,138	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 299,113	\$ 3,956,503	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,481	\$ 68,146	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,382	34,382	30
31	Accrued Taxes Payable	1,116	48,116	31
32	Accrued Interest Payable		13,247	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	INTERCOMPANY		480,418	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 98,979	\$ 644,309	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		3,974,125	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)	\$	\$ 3,974,125	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 98,979	\$ 4,618,434	45
46	TOTAL EQUITY	\$ 200,134	\$ (661,931)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 299,113	\$ 3,956,503	47

*(See instructions.)

Facility Name: WOODRIDGE SL RESIDNCE GENSEO

Report Period Beginning: 01/01/2015

Ending:

12/31/2015

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	\$ 1,967,213	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,967,213	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	270	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)	\$ 270	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 STAMPS	16,807	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 16,807	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,984,290	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	446,799	19
20	Health Care/ Personal Care	344,816	20
21	General Administration	357,307	21
B. Capital Expense			
22	Ownership	375,344	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	PRIOR ADJ	15,035	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,539,301	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 444,989	29
30	Income Taxes	\$ 6,874	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 438,115	31

12/31/2015

PAGE 3 COLUMN 5 RECLASSIFICATIONSADJUSTMENTS

LINE 3	CABLE TV	2,242
LINE 10	CABLE TV	(2,242)
LINE 14	CONTRIBUTION	(395)

RELATED PARTY LANDLORD

LINE 17	DEPRECIATION	148,701
LINE 18	MORTGAGE INTEREST	160,326
LINE 19	REAL ESTATE TAXES	46,919
LINE 10	PROFESSIONAL FEES	23,385
LINE 13	PROPERTY INSURANCE	5,005
LINE 20	RENT	<u>(360,000)</u>
LINE 24	GRAND TOTAL	<u><u>23,941</u></u>

PAGE 4 SCHEDULE VII B

DYNAMIC HEALTHCARE CONSULTANTS COST

LINE 10	MANAGEMENT FEES		62,750
	UTILITIES	177	
	REPAIRS & MAINT	1,311	
	EMP BEN-GEN SERV	38	
	PROFESSIONAL FES	508	
	DUES & SUBSCRIPTIONS	467	
	CLERICAL & GENERAL	15,243	
	SEMINARS & TRAVEL	449	
	AUTO EXP	371	
	INSURANCE	523	
	EMP. BEN.-GEN. ADMIN.	2,315	
	DEPRECIATION	430	

INTEREST	358
REAL ESTATE TAXES	671
REAL ESTATE TAXES PROTEST FEES	-
AUTO RENTAL	1,822

WOODRIDGE OF GENESEO
RELATED HEALTHCARE ENTITIES

BRADLEY
BRIDGEVIEW HEALTHCARE CENTER
GROSSE POINT
OTTAWA PAVILION
PARK RIDGE
STERLING PAVILION
WATERFRONT TERRACE
WILLOW CREST
WINDMILL NURSING PAVILION
WOODBIDGE

BRADLEY
BRIDGEVIEW
NILES
OTTAWA
PARK RIDGE
STERLING
CHICAGO
SANDWICH
SOUTH HOLLAND
CHICAGO

OTHER RELATED BUSINESSES

DYNAMIC HEALTHCARE CONSULTANTS
SEASONS HOSPICE
NORTHWEST ILLINOIS HOLDINGS LLC

SKOKIE
PARK RIDGE

BOOKKEEPING COMPANY
HOSPICE
BUILDING CO.