

		FOR BHF USE			

LL2

Supportive Living Facility

**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)**

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>1000106</u></p> <p>Facility Name: <u>WOODRIDGE SUP LVG RES GLSBRG</u></p> <p>Address: <u>261 NORTH LINWOOD RD</u> <u>GALESBURG</u> <u>61401</u> <small>Number City Zip Code</small></p> <p>County: <u>KNOX</u></p> <p>Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/15/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td><input checked="" type="checkbox"/> PROPRIETARY Individual</td> <td><input type="checkbox"/> GOVERNMENTAL 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 Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL 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>01/01/2017</u> to <u>12/31/2017</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 Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State																																									
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	(Firm Name & Address) _____																																										
	(Telephone) (____) _____	Fax # (____) _____																																									

Facility Name: WOODRIDGE SUP LVG RES GLSBRG

Report Period Beginning:

01/01/2017

Ending: 12/31/2017

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	170,231	149,030	1,612	320,873		320,873	1
2	Housekeeping, Laundry and Maintenance	76,960	37,141	9,612	123,713		123,713	2
3	Heat and Other Utilities			56,444	56,444		56,444	3
4	Other (specify):			6,970	6,970		6,970	4
5	TOTAL General Services	247,191	186,171	74,638	508,000		508,000	5
B. Health Care and Programs								
6	Health Care/ Personal Care	386,288	2,943		389,231		389,231	6
7	Activities and Social Services	18,712	5,641		24,353		24,353	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	405,000	8,584		413,584		413,584	9
C. General Administration								
10	Administrative and Clerical	62,027	8,813	139,679	210,519	16,121	226,640	10
11	Marketing Materials, Promotions and Advertising			6,057	6,057		6,057	11
12	Employee Benefits and Payroll Taxes			141,742	141,742		141,742	12
13	Insurance-Property, Liability and Malpractice			17,077	17,077	6,486	23,563	13
14	Other (specify):							14
15	TOTAL General Administration	62,027	8,813	304,555	375,395	22,607	398,002	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	714,218	203,568	379,193	1,296,979	22,607	1,319,586	16
Capital Expenses								
D. Ownership								
17	Depreciation			7,872	7,872	109,494	117,366	17
18	Interest			409	409	178,822	179,231	18
19	Real Estate Taxes					81,308	81,308	19
20	Rent -- Facility and Grounds			441,000	441,000	(441,000)		20
21	Rent -- Equipment			9,652	9,652		9,652	21
22	Other (specify):							22
23	TOTAL Ownership			458,933	458,933	(71,376)	387,557	23
24	GRAND TOTAL (Sum of lines 16 and 23)	714,218	203,568	838,126	1,755,912	(48,769)	1,707,143	24

Facility Name: WOODRIDGE SUP LVG RES GLSBRG

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 21.89	1
2	Licensed Practical Nurses	5	17.83	2
3	Certified Nurse Assistants	19	10.11	3
4	Activity Director & Assistants	1	11.92	4
5	Social Service Workers			5
6	Head Cook	2	12.34	6
7	Cook Helpers/Assistants	10	9.98	7
8	Dishwashers			8
9	Maintenance Workers	1	15.38	9
10	Housekeepers	2	11.37	10
11	Laundry			11
12	Managers	1	28.90	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	43	\$ 12.63	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	ESTHER MARYLES	0.0833	25	\$ 4,500	1
2	DANIEL AARON	0.0389	2.16	4,133	2
3					3
4					4
5					5
				Total	\$ 8633 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 GENESEO		GENESE0	
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? \$ 40,519

(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 SUP LVG RES GLSBRG

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$	28	\$ 109,494	\$ 109,494	\$ 1,334,324	1
2											2
3	RELATED PARTY				11,090			317	317	7,710	3
4											4
5											5
Improvement Type											
6		WATERSOFTENER		2009		335	27.5	335		2,834	6
7		SIDEWALK REPAIR		2010		120	27.5	120		895	7
8		CARPETING		2010		119	27.5	119		887	8
9		FURNACE REPAIRS		2012		26	27.5	26		154	9
10		CARPETING		2012		225	27.5	225		1,134	10
11		REPLACED CAMERAS & DVR		2013		181	27.5	181		829	11
12		OFFSET SUPPLY TRAP		2013		77	27.5	77		314	12
13		NURSE CALL, PENDANT, WIRELESS CONNECTION		2014		678	27.5	678		2,215	13
14		REPAIR LEAK, INSTALL RECIRCULATING PUMP		2014		237	27.5	237		900	14
15		ROOF WORK		2014		55	27.5	55		170	15
16		DOOR		2015		74	27.5	74		160	16
17	TOTAL (lines 1 thru 16)				\$ 4,281,371	\$ 2,127		\$ 111,938	\$ 109,811	\$ 1,352,526	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	\$ 271,909	\$	\$ 27,191	27,191	10 YRS	\$ 196,649	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 271,909	\$	\$ 27,191	27,191		\$ 196,649	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

									8	9	
									Adjustments	Accumulated	
									\$	\$	
									0		1
									0		2
									0		3
									0		4
5									0		5
	Improvement Type										
6	CONCRETE WORK		2016	3,250			28	118	118	157	6
7	VENT REPAIR		2016	3,800			28	138	138	184	7
8	FLOORING		2017	2,001			28	36	36	36	8
9	SIDING		2017	36,685			28	667	667	667	9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17	TOTAL (lines 1 thru 16)			\$ 45,736		\$ 0		\$ 959	\$ 959	\$ 1,044	17

Facility Name: WOODRIDGE SUP LVG RES GLSBRG

Report Period Beginning: 01/01/2017

Ending: 2/31/2017

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	\$ 4,743,200	\$ 4,427,795	5/1/44	4.0000	\$ 178,822
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		409
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,743,200	\$ 4,427,795			\$ 179,231
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 4,743,200	\$ 4,427,795			\$ 179,231

* 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 SUP LVG RES GLSBRG

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 132,231	\$ 156,175	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	170,096	170,096	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,288	32,814	6
7	Other Prepaid Expenses	1,128	1,128	7
8	Accounts Receivable (owners or related parties)	415,549	415,549	8
9	Other(specify): ESCROWS		200,231	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 738,292	\$ 975,993	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		89,000	13
14	Buildings, at Historical Cost		4,270,281	14
15	Leasehold Improvements, at Historical Cost	104,223	104,223	15
16	Equipment, at Historical Cost	72,556	289,657	16
17	Accumulated Depreciation (book methods)	(60,362)	(1,282,906)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		114,308	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,289)	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)	\$ 116,417	\$ 3,570,274	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 854,709	\$ 4,546,267	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 59,268	\$ 59,268	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,373	44,373	30
31	Accrued Taxes Payable	5,537	86,037	31
32	Accrued Interest Payable		14,759	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)	\$ 109,178	\$ 204,437	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		4,427,795	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)	\$	\$ 4,427,795	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 109,178	\$ 4,632,232	45
46	TOTAL EQUITY	\$ 745,531	\$ (85,965)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 854,709	\$ 4,546,267	47

*(See instructions.)

Facility Name: WOODRIDGE SUP LVG RES GLSBRG

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,964,578	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,964,578	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	1,350	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,350	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	128	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 128	14
D. Other Revenue (specify):			
15	INSURANCE SETTLEMENT	18,100	15
16	FOOD STAMPS	24,765	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 42,865	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,008,921	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	508,000	19
20	Health Care/ Personal Care	413,584	20
21	General Administration	375,395	21
B. Capital Expense			
22	Ownership	458,933	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	PRIOR PERIOD	104	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,756,016	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 252,905	29
30	Income Taxes	\$ 4,879	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 248,026	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 597,076	32
33	Private Pay - Net Inpatient Revenue	1,367,502	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,964,578	37

WOODRIDGE OF GALESBURG
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
GALESBURG NORTHWEST HOLDINGS

SKOKIE
PARK RIDGE

BOOKKEEPING COMPANY
HOSPICE
BUILDING CO.