

		FOR BHF USE			

LL2

Supportive Living Facility

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)**

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 SL RES GALESBURG</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</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></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>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Trust	<input type="checkbox"/> Individual	<input type="checkbox"/> State	IRS Exemption Code _____	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<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>01/01/2018</u> to <u>12/31/2018</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 border="1" 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> </table> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>KATHLEEN MCNAMARA VICE-PRESIDENT</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>KBKB, LTD. 8140 RIVER DRIVE, MORTON GROVE, IL 60053</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u></td> <td>Fax <u>(847) 675-5777</u></td> </tr> </table>	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) <u>KATHLEEN MCNAMARA VICE-PRESIDENT</u>			(Firm Name & Address) <u>KBKB, LTD. 8140 RIVER DRIVE, MORTON GROVE, IL 60053</u>			(Telephone) <u>(847) 675-3585</u>	Fax <u>(847) 675-5777</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>KATHLEEN MCNAMARA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>																																														
<p>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>																																														

Facility Name: WOODRIDGE SL RES GALESBURG

Report Period Beginning:

01/01/2018

Ending: 12/31/2018

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	174,583	149,166	1,686	325,435	(912)	324,523	1
2	Housekeeping, Laundry and Maintenance	78,507	38,273	8,092	124,872		124,872	2
3	Heat and Other Utilities			62,827	62,827	(3,388)	59,439	3
4	Other (specify): Scavenger & Exterminating Services			7,481	7,481		7,481	4
5	TOTAL General Services	253,090	187,439	80,086	520,615	(4,300)	516,315	5
B. Health Care and Programs								
6	Health Care/ Personal Care	410,351	8,258		418,609		418,609	6
7	Activities and Social Services	29,369	8,484		37,853		37,853	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	439,720	16,742		456,462		456,462	9
C. General Administration								
10	Administrative and Clerical	65,083	7,844	171,711	244,638	18,683	263,321	10
11	Marketing Materials, Promotions and Advertising			3,264	3,264		3,264	11
12	Employee Benefits and Payroll Taxes			134,092	134,092		134,092	12
13	Insurance-Property, Liability and Malpractice			15,727	15,727	6,755	22,482	13
14	Other (specify):							14
15	TOTAL General Administration	65,083	7,844	324,794	397,721	25,438	423,159	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	757,893	212,025	404,880	1,374,798	21,138	1,395,936	16
Capital Expenses								
D. Ownership								
17	Depreciation			17,775	17,775	104,246	122,021	17
18	Interest			390	390	174,899	175,289	18
19	Real Estate Taxes					76,407	76,407	19
20	Rent -- Facility and Grounds			419,407	419,407	(419,407)		20
21	Rent -- Equipment			13,384	13,384		13,384	21
22	Other (specify): Mortgage Insurance					28,439	28,439	22
23	TOTAL Ownership			450,956	450,956	(35,416)	415,540	23
24	GRAND TOTAL (Sum of lines 16 and 23)	757,893	212,025	855,836	1,825,754	(14,278)	1,811,476	24

Facility Name: **WOODRIDGE SL RES GALESBURG**

Report Period Beginning: **01/01/2018**

Ending:

12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.54	1
2	Licensed Practical Nurses	4	18.77	2
3	Certified Nurse Assistants	10	10.46	3
4	Activity Director & Assistants	1	12.03	4
5	Social Service Workers			5
6	Head Cook	1	12.81	6
7	Cook Helpers/Assistants	5	9.99	7
8	Dishwashers			8
9	Maintenance Workers	1	15.71	9
10	Housekeepers	2	11.90	10
11	Laundry			11
12	Managers	1	30.09	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	26	\$ 16.37	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	MARSHALL MAUER		1.5	\$ 7,500	1
2	DANIEL AARON		1.08	2,755	2
3					3
4					4
5					5
				Total	\$ 10255 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	GENESEO
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? \$ 44,088
 (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 RES GALESBURG

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 4,270,281	\$ 109,494	27.5	\$ 109,494	\$	\$ 1,443,818	1
2											2
3		RELATED PARTY			13,586			388	388		3
4											4
5											5
Improvement Type											
6		WATERSOFTENER		2009	9,217	335	27.5	335		3,169	6
7		SIDEWALK REPAIR		2010	3,300	120	27.5	120		1,015	7
8		CARPETING		2010	3,268	119	27.5	119		1,006	8
9		FURNACE REPAIRS		2012	706	26	27.5	26		180	9
10		CARPETING		2012	6,195	225	27.5	225		1,359	10
11		REPLACED CAMERAS & DVR		2013	4,982	181	27.5	181		1,010	11
12		OFFSET SUPPLY TRAP		2013	2,126	77	27.5	77		391	12
13		NURSE CALL, PENDANT, WIRELESS CONNECTION		2014	18,640	678	27.5	678		2,893	13
14		REPAIR LEAK, INSTALL RECIRCULATING PUMP		2014	6,505	237	27.5	237		1,137	14
15		ROOF WORK		2014	1,522	55	27.5	55		225	15
16		DOOR		2015	2,025	74	27.5	74		234	16
17		TOTAL (lines 1 thru 16)			\$ 4,342,353	\$ 111,621		\$ 112,009	\$ 388	\$ 1,456,437	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	\$ 284,086	\$ 15,297	\$ 28,408	13,111	10	\$ 225,057	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 284,086	\$ 15,297	\$ 28,408	13,111		\$ 225,057	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 & ID Number **WOODRIDGE SL RES GALESBURG**

#

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 4,342,353	\$ 111,621		\$ 112,009	\$ 388	\$ 1,456,437	1
2	CONCRETE WORK	2016	3,250	118	27.5	118		275	2
3	VENT REPAIR	2016	3,800	138	27.5	138		322	3
4	FLOORING	2017	2,001	73	27.5	73		109	4
5	SIDING	2017	36,685	1,334	27.5	1,334		2,001	5
6	INSTALL NEW SECURITY CAMERAS	2018	3,801	63	27.5	63		63	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	RELATED PARTY: GALESBURG NORTHWEST HOLDINGS LLC								21
22	INSTALL NEW ROOF	2018	145,278	1,863	39	1,863		1,863	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,537,168	\$ 115,210		\$ 115,598	\$ 388	\$ 1,461,070	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: **WOODRIDGE SL RES GALESBURG**

Report Period Beginning: **01/01/2018**

Ending: **2/31/2018**

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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					Date of Note
							Original	Balance					
		A. Directly Facility Related											
		Long-Term											
1		MIDLAND BANK		X	MORTGAGE	4/9/14	\$ 4,743,200	\$ 4,331,414	5/1/44	4.0000	\$ 175,036	1	
2						/ /			/ /			2	
3						/ /			/ /			3	
		Working Capital											
4						/ /			/ /			4	
5						/ /			/ /			5	
6						/ /			/ /			6	
7		TOTAL Facility Related					\$ 4,743,200	\$ 4,331,414			\$ 175,036	7	
		B. Non-Facility Related											
8						/ /			/ /			8	
9						/ /			/ /			9	
10		TOTALS (lines 7, 8 and 9)					\$ 4,743,200	\$ 4,331,414			\$ 175,036	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 RES GALESBURG

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,012	\$ 23,523	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	222,264	222,264	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,106	32,365	6
7	Other Prepaid Expenses	738	738	7
8	Accounts Receivable (owners or related parties)	257,912	257,912	8
9	Other(specify): ESCROWS		137,906	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 515,032	\$ 674,708	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	108,024	253,302	15
16	Equipment, at Historical Cost	77,669	294,770	16
17	Accumulated Depreciation (book methods)	(78,137)	(1,417,038)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		114,308	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,099)	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)	\$ 107,556	\$ 3,586,524	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 622,588	\$ 4,261,232	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,615	\$ 97,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,060	51,060	30
31	Accrued Taxes Payable	4,811	84,041	31
32	Accrued Interest Payable		14,438	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)	\$ 107,486	\$ 247,093	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		4,331,414	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)	\$	\$ 4,331,414	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 107,486	\$ 4,578,507	45
46	TOTAL EQUITY	\$ 515,102	\$ (317,275)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 622,588	\$ 4,261,232	47

*(See instructions.)

Facility Name: WOODRIDGE SL RES GALESBURG

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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	\$ 1,955,707	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,955,707	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	1,755	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)	\$ 1,755	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	137	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 137	14
D. Other Revenue (specify):			
15	FOOD STAMPS	12,865	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 12,865	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,970,464	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	520,615	19
20	Health Care/ Personal Care	456,462	20
21	General Administration	397,721	21
B. Capital Expense			
22	Ownership	450,956	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	PRIOR YEAR ADJUSTMENT	12,638	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,838,392	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 132,072	29
30	Income Taxes	\$ 2,010	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 130,062	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 575,129	32
33	Private Pay - Net Inpatient Revenue	1,380,578	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,955,707	37

WOODBIDGE OF GALESBURG
RELATED HEALTHCARE ENTITIES

NAME	CITY
BRADLEY	BRADLEY
BRIDGEVIEW HEALTHCARE CENTER	BRIDGEVIEW
GROSSE POINT	NILES
OTTAWA PAVILION	OTTAWA
PARK RIDGE	PARK RIDGE
STERLING PAVILION	STERLING
WATERFRONT TERRACE	CHICAGO
WILLOW CREST	SANDWICH
WINDMILL NURSING PAVILION	SOUTH HOLLAND
WOODBIDGE	CHICAGO

OTHER RELATED BUSINESSES

DYNAMIC HEALTHCARE CONSULTANTS	SKOKIE	BOOKKEEPING
SEASONS HOSPICE	PARK RIDGE	HOSPICE
GALESBURG NORTHWEST HOLDINGS		REALTY

WOODBRIIDGE OF GALESBURG
12/31/2018

PAGE 3 COLUMN 5 NOT ALLOWABLE EXPENSES

LINE 1	SALES TAX ON FOOD	(912)
LINE 3	CABLE TV-RESIDENT ROOMS	(3,388)
LINE 10	PENALTIES	(64)
LINE 10	POLITICAL CONTRIBUTIONS	(250)
LINE 17	STRAIGHT LINE DEPRECIATION	(13,111)
LINE 18	INTEREST INCOME	(137)

RELATED PARTY LANDLORD

LINE 20	RENT	(419,407)
LINE 10	PROFESSIONAL FEES	18,997
LINE 13	INSURANCE-PROPERTY	6,755
LINE 17	DEPRECIATION	117,357
LINE 18	MORTGAGE INTEREST	175,036
LINE 19	REAL ESTATE TAXES	76,407
LINE 22	MORTGAGE INSURANCE	28,439
LINE 24	GRAND TOTAL	(14,278)

PAGE 4 SCHEDULE VII B

DYNAMIC HEALTHCARE CONSULTANTS COST

LINE 10	MANAGEMENT FEES	(108,000)
	UTILITIES	263
	REPAIR & MAINT	1,475
	EMP BEN-GEN SVC	179
	PROFESSIONAL FEES	818
	DUES & SUBSCRIPTIONS	495
	CLERICAL & GENERAL	5,030