	FOR BHF USE	

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)

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: 1000098

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO

Address: 620 OLIVIA COURT (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

Federal Employer ID Number:

Date Current Owners were Certified: 07/02/2008

Type of Ownership:

	VOLUNTARY, NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
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 01/01/20010 to 12/31/2010 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.

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name) MARSHALL MAUER
	(Title) TREASURER
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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 SUPPORTIVE LIVING RESIDENCE OF GENESEO
Report Period Beginning: 01/01/20010 Ending: 12/31/2010

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	50	Single Unit Apartment	50	18,250	1
2	10	Double Unit Apartment	10	3,650	2
3		Other		730	3
4	60	TOTALS	60	22,630	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	6,061	12,533		18,594	5
6	Double Unit	277	589		866	6
7	Other					7
8	TOTALS	6,338	13,122		19,460	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 85.99%

D. Indicate the number of paid bed-hold days the SLF had during this year ______ 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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/10 Fiscal Year: 12/31/10
* 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 SUPPORTIVE LIVING RESIDENCE OF GI   Report Period Beginning: 01/01/20010   Ending: 12/31/2010

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	59,360	119,898	63,414	242,672		242,672	1
2	Housekeeping, Laundry and Maintenance	26,225	32,529	25,944	84,698		84,698	2
3	Heat and Other Utilities			84,956	84,956		84,956	3
4	Other (specify):			3,118	3,118		3,118	4
5	**TOTAL General Services**	85,585	152,427	177,432	415,444		415,444	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	155,354	2,353	166,052	323,759		323,759	6
7	Activities and Social Services	10,463	1,862	13,176	25,501		25,501	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	165,817	4,215	179,228	349,260		349,260	9
	C. General Administration							
10	Administrative and Clerical	33,071	8,040	49,601	90,712		90,712	10
11	Marketing Materials, Promotions and Advertising			35,463	35,463		35,463	11
12	Employee Benefits and Payroll Taxes			50,763	50,763		50,763	12
13	Insurance-Property, Liability and Malpractice			20,997	20,997		20,997	13
14	Other (specify):							14
15	**TOTAL General Administration**	33,071	8,040	156,824	197,935		197,935	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	284,473	164,682	513,484	962,639		962,639	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			8,374	8,374		8,374	17
18	Interest			6,505	6,505		6,505	18
19	Real Estate Taxes			30,000	30,000		30,000	19
20	Rent -- Facility and Grounds			336,000	336,000		336,000	20
21	Rent -- Equipment			11,389	11,389		11,389	21
22	Other (specify):							22
23	**TOTAL Ownership**			392,268	392,268		392,268	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	284,473	164,682	905,752	1,354,907		1,354,907	24

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO   Report Period Beginning 01/01/20010   Ending: 12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	$ 19.24	1
2	Licensed Practical Nurses	2	16.32	2
3	Certified Nurse Assistants	10	10.37	3
4	Activity Director & Assistants	1	12.50	4
5	Social Service Workers			5
6	Head Cook	3	10.34	6
7	Cook Helpers/Assistants	4	8.51	7
8	Dishwashers			8
9	Maintenance Workers	1	14.47	9
10	Housekeepers	1	9.17	10
11	Laundry			11
12	Managers	1	28.15	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	24	$ 5.49	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	N/A			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	$	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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	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 [X] NO [ ]

Name of related entity: DYNAMIC HEALTHCARE CONSULTANTS   If yes, what is the value of those services? $ 18,000

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES [X] 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 GE Report Period Beginning: 01/01/20010 Ending: 12/31/2010

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	$ 4,064,630	$ 148,701	28	$ 148,701	$	$ 368,362	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	PLUMBING WORK			2010	2,938	13	28	13		13	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 4,067,568	$ 148,714		$ 148,714	$	$ 368,375	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	$ 227,573	$ 26,841	$ 22,757	(4,084)	10 YRS	$ 43,668	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 227,573	$ 26,841	$ 22,757	(4,084)		$ 43,668	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: 01/01/2001(Ending: 2/31/2010

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NA-RELATED PARTY

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	MB FINANCIAL		X	MORTGAGE	12/28/07	$ 4,763,400	$ 4,625,441	6/1/34	5.2500	$ 269,960	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB FINANCIAL		X	WORKING CAPITAL	11/17/09	125,000	97,917	11/5/14	5.0000	6,224	4
5				INSURANCE FINANCING	/ /			/ /		281	5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 4,888,400	$ 4,723,358			$ 276,465	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 4,888,400	$ 4,723,358			$ 276,465	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: 01/01/20010   Ending: 12/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 238,724	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	125,653		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,129		6
7	Other Prepaid Expenses	528		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 384,034	$	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	2,938		15
16	Equipment, at Historical Cost	25,920		16
17	Accumulated Depreciation (book methods)	(13,293)		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): SECURITY DEPOSIT	3,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,565	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 402,599	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,154	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	97,917		29
30	Accrued Salaries Payable	29,727		30
31	Accrued Taxes Payable	6,781		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)**	$ 244,579	$	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)**	$ 244,579	$	45
46	**TOTAL EQUITY**	$ 158,020	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 402,599	$	47

*(See instructions.)

Facility Name: WOODRIDGE SUPPORTIVE LIVING RESIDENCE OI Report Period Beginning: 01/01/20010 Ending: 12/31/2010

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,649,044	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,649,044	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	239	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)**	$ 239	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 INCOME**	21,193	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 21,193	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,670,476	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	415,444	19
20	Health Care/ Personal Care	349,260	20
21	General Administration	197,935	21
	B. Capital Expense		
22	Ownership	392,268	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 1,354,907	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 315,569	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 315,569	31