

		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: 1000060

Facility Name: Shabbona Supportive Living Facility

Address: 407 West Comanche Ave. Shabbona 60550
Number City Zip Code

County: DeKalb

Telephone Number: (815) 824-4800 Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: 3/30/06

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☒	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:

Name: Michael W. Martin Telephone Number: (217) 258-8888
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 01/01/2010 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)			
	(Title)			
Paid Preparer	(Signed)			
	(Print Name and Title)	See Accountants' Compilation Report		
	(Firm Name & Address)	McGladrey & Pullen, LLP 20 N. Martingale, Suite 500, Schaumburg, IL 60173		
	(Telephone)	(847) 517-7070 Fax (847) 517-7067		
	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 Shabbona Supportive Living Facility

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

Date of change in certified units N/A

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	29	Single Unit Apartment	29	10,585
2	7	Double Unit Apartment	7	2,555
3		Other		
4	36	TOTALS	36	13,140

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	4,263	5,045		9,308	5
6 Double Unit	695	2,601		3,296	6
7 Other					7
8 TOTALS	4,958	7,646		12,604	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.92%

D. Indicate the number of paid bed-hold days the SLF had during this year N/A Also, indicate the number of unpaid bed-hold days the SLF had during this year. N/A (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 ☐ Non-allowable costs have been eliminated in Schedule IV, Column 5.

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)
None

H. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ 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? N/A
If no, explain. N/A

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? N/A
If no, explain. N/A

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? N/A
If no, explain. N/A

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning:

01/01/2010

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	131,939	123,703	1,840	257,482	(6)	257,476	1
2	Housekeeping, Laundry and Maintenance	79,221	29,617	3,352	112,190		112,190	2
3	Heat and Other Utilities			43,188	43,188		43,188	3
4	Other (specify):							4
5	TOTAL General Services	211,160	153,320	48,380	412,860	(6)	412,854	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	249,564	253	1,000	250,817		250,817	6
7	Activities and Social Services	58,800	3,740		62,540		62,540	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	308,364	3,993	1,000	313,357		313,357	9
	C. General Administration							
10	Administrative and Clerical	20,082		35,966	56,048	1,248	57,296	10
11	Marketing Materials, Promotions and Advertising			15,102	15,102	(15,102)		11
12	Employee Benefits and Payroll Taxes			78,558	78,558		78,558	12
13	Insurance-Property, Liability and Malpractice			23,222	23,222		23,222	13
14	Other (specify):							14
15	TOTAL General Administration	20,082		152,848	172,930	(13,854)	159,076	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	539,606	157,313	202,228	899,147	(13,860)	885,287	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			8,069	8,069	104,763	112,832	17
18	Interest			42,424	42,424	143,179	185,603	18
19	Real Estate Taxes			27,171	27,171		27,171	19
20	Rent -- Facility and Grounds			168,000	168,000	(168,000)		20
21	Rent -- Equipment			8	8		8	21
22	Other (specify):							22
23	TOTAL Ownership			245,672	245,672	79,942	325,614	23
24	GRAND TOTAL (Sum of lines 16 and 23)	539,606	157,313	447,900	1,144,819	66,082	1,210,901	24

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.47	\$ 24.58	1
2	Licensed Practical Nurses	0.69	25.77	2
3	Certified Nurse Assistants	8.61	10.53	3
4	Activity Director & Assistants	0.65	10.13	4
5	Social Service Workers	1.00	21.69	5
6	Head Cook	1.01	12.45	6
7	Cook Helpers/Assistants	5.92	8.58	7
8	Dishwashers			8
9	Maintenance Workers	1.05	13.78	9
10	Housekeepers	1.91	8.22	10
11	Laundry	0.95	8.34	11
12	Managers			12
13	Other Administrative	0.95	10.18	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	23	\$ 14.02	17

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
See attached schedule 4A	

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5

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: N/A If yes, what is the value of those services? \$ N/A
(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).

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	Albert Milstein	45%		\$ N/A	1
2	Sheldon Wolfe	43%	1.5	N/A	2
3	Mo Herman	10%	1.5	N/A	3
4	Jeremy Amster	2%		N/A	4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	N/A	\$	1
2			2
Total		\$	3

VIII. OWNERSHIP COSTS

A. Purchase price of land 33,632 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	36		2006	2006	\$ 2,605,419	\$	27.5	\$ 95,359	\$ 95,359	\$ 447,315	1
2											2
3											3
4											4
5											5
6	Improvement Type										
6	Laundry Room			2007	12,716	462	27.50	462		1,714	6
7	Carpet			2007	4,998	182	27.50	182		569	7
8	Check Valve			2008	5,435	198	27.50	198		421	8
9	Fence			2008	2,434	108	15	108		243	9
10	Elevator Motor			2009	8,133	296	27.50	296		432	10
11	Carpet			2009	2,799	102	27.50	102		191	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,641,934	\$ 1,348		\$ 96,707	\$ 95,359	\$ 450,885	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	\$ 100,912	\$ 1,921	\$ 11,325	9,404	5	\$ 92,412	18
19	Vehicles	4,800	4,800	4,800		5	4,800	19
20	TOTAL (lines 18 and 19)	\$ 105,712	\$ 6,721	\$ 16,125	9,404		\$ 97,212	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☐ NO
3	Original Building			/ /	\$ N/A			3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	
									9. Rental amount for movable equipment \$ N/A
									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 Bank		X	Mortgage	12/24/07	\$ 2,320,000	\$ 2,220,443	1/15/08	8.2500	\$ 161,547	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank		X	Working Capital	6/30/06	500,000	231,600	Demand	8.2500	42,424	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,820,000	\$ 2,452,043			\$ 203,971	7
	B. Non-Facility Related										
8					/ /	Amortization of mortgage cost		/ /		3,654	8
9					/ /	Interest Income offset		/ /		-22,022	9
10	TOTALS (lines 7, 8 and 9)					\$ 2,820,000	\$ 2,452,043			\$ 185,603	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: **Shabbona Supportive Living Facility**Report Period Beginning: **01/01/2010**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	\$ 25,274	\$ 27,814	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	40,224	40,224	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,264	6,264	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	530,869	530,869	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 602,631	\$ 605,171	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		2,605,419	14
15	Leasehold Improvements, at Historical Cost	36,515	36,515	15
16	Equipment, at Historical Cost	21,684	105,712	16
17	Accumulated Depreciation (book methods)	(24,626)	(548,097)	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): <u>Mortgage Costs</u>		18,272	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 33,573	\$ 2,217,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 636,204	\$ 2,822,992	25

*(See instructions.)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 14,558	\$ 14,558	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,198	11,198	30
31	Accrued Taxes Payable	85,714	85,714	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>See Schedule 7A</u>	919,936	1,460,805	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,031,406	\$ 1,572,275	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	231,600	231,600	38
39	Mortgage Payable		2,220,443	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)	\$ 231,600	\$ 2,452,043	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,263,006	\$ 4,024,318	45
46	TOTAL EQUITY	\$ (626,802)	\$ (1,201,326)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 636,204	\$ 2,822,992	47

Facility Name: Shabbona Supportive Living Facility

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

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	\$ 1,137,809	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,137,809	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		8
9	Non-Resident Meals	6	9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 6	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	22,022	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 22,022	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 1,159,837	18

2			
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	412,860	19
20	Health Care/ Personal Care	313,357	20
21	General Administration	172,930	21
	B. Capital Expense		
22	Ownership	245,672	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,144,819	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 15,018	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 15,018	31

<u>Related Nursing Homes</u>
<u>In State</u>
Cahokia Nursing and Rehab,Inc.
Caseyville Nursing and Rehab,Inc.
Franklin Grove Nursing Center,Inc.
Kenwood Healthcare Center,Inc.
Oregon Healthcare Center,Inc.
Shabbona Healthcare Center,Inc.
Towerhill Healthcare Center,LLC
Virgil Calvert Nursing and Rehab,Inc.

<u>City</u>
Cahokia
Caseyville
Franklin Grove
Chicago
Oregon
Shabbona
South Elgin
East St. Louis

<u>Out of State</u>
Hillside Manor Healthcare and Rehab,LLC
Rancho Manor Healthcare and Rehab,LLC
Beauvais Manor Healthcare and Rehabilitation,LLC

St. Louis, MO
Florissant, MO
St. Louis, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S & E Medical Supply Co.	Skokie	Medical Supplies
*SFO Associates	Skokie	Finance Company
**Unity Hospice	Skokie	Hospice Services

*This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center and Oregon Healthcare Center.

XI. Line 35

<u>Description</u>	<u>Amount</u>	<u>Consolidated</u>
Reimbursement Due	101	101
Due to Shabbona Healthcare	664,083	664,083
FICA Withholding	735	735
Short Term Loan Exchange		10,000
Due to Public Aid	17	17
N/P Auto		530,869
Due to/From Partners	255,000	255,000
	<u>919,936</u>	<u>1,460,805</u>