

		FOR BHF USE			

LL2

Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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.</p> <p>Facility Name: <u>Cambridge House of Maryville</u></p> <p>Address: <u>6960 State Road 162</u> <u>Maryville</u> <u>62062</u> <small>Number City Zip Code</small></p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>288-2211</u> Fax # <u>618-288-2299</u></p> <p>Federal Employer ID Number: <u>20-2536384</u></p> <p>Date Current Owners were Certified: <u>11/29/06</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 checked="" 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 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: <u>Selena Edgington</u> Telephone Number: <u>815-935-1992</u> <u>232</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" 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 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>01/01/2007</u> to <u>12/31/2007</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%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>David J. Mitchell</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</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) _____ (Type or Print Name) <u>David J. Mitchell</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name Cambridge House of Maryville

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	100	Single Unit Apartment	100	36,500	1
2	3	Double Unit Apartment	3	2,190	2
3		Other			3
4	103	TOTALS	103	38,690	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	22,818	14,465		37,283	5
6	Double Unit					6
7	Other					7
8	TOTALS	22,818	14,465		37,283	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.36%

D. Indicate the number of paid bed-hold days the SLF had during this year 264 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 0 (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

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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/07 Fiscal Year: 12/31/07

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes

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: Cambridge House of Maryville

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	206,456	164,007	1,525	371,988		371,988	1
2	Housekeeping, Laundry and Maintenance	76,086	25,929	24,790	126,805		126,805	2
3	Heat and Other Utilities			101,298	101,298	(3,610)	97,688	3
4	Other (specify):			5,020	5,020		5,020	4
5	TOTAL General Services	282,542	189,936	132,633	605,111	(3,610)	601,501	5
B. Health Care and Programs								
6	Health Care/ Personal Care	374,537	2,639		377,176		377,176	6
7	Activities and Social Services	20,141	4,341		24,482		24,482	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	394,678	6,980		401,658		401,658	9
C. General Administration								
10	Administrative and Clerical	124,207	11,204	273,914	409,325	(21,699)	387,626	10
11	Marketing Materials, Promotions and Advertising	35,936	4,421	32,465	72,822		72,822	11
12	Employee Benefits and Payroll Taxes			177,090	177,090		177,090	12
13	Insurance-Property, Liability and Malpractice			64,632	64,632		64,632	13
14	Other (specify):			12,649	12,649		12,649	14
15	TOTAL General Administration	160,143	15,625	560,750	736,518	(21,699)	714,819	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	837,363	212,541	693,383	1,743,287	(25,309)	1,717,978	16
Capital Expenses								
D. Ownership								
17	Depreciation			638,300	638,300		638,300	17
18	Interest			448,192	448,192		448,192	18
19	Real Estate Taxes			12,393	12,393		12,393	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			514,201	514,201		514,201	22
23	TOTAL Ownership			1,613,086	1,613,086		1,613,086	23
24	GRAND TOTAL (Sum of lines 16 and 23)	837,363	212,541	2,306,469	3,356,373	(25,309)	3,331,064	24

Facility Name: Cambridge House of Maryville

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 26.04	1
2	Licensed Practical Nurses	1	15.68	2
3	Certified Nurse Assistants	15	9.57	3
4	Activity Director & Assistants	1	10.03	4
5	Social Service Workers			5
6	Head Cook	2	12.04	6
7	Cook Helpers/Assistants	10	8.24	7
8	Dishwashers			8
9	Maintenance Workers	1	16.40	9
10	Housekeepers	3	7.58	10
11	Laundry			11
12	Managers	1	31.87	12
13	Other Administrative	2	12.84	13
14	Clerical			14
15	Marketing	0	28.95	15
16	Other			16
17	Total (lines 1 thru 16)	36	\$	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	BMA Management, LTD.	\$ 169,468 1
2		
Total		\$ 169,468 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 <u>1</u>	City <u>2</u>
Cambridge House of O'Fallon	O'Fallon

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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: _____ If yes, what is the value of those services? \$ _____
 (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: Cambridge House of Maryville

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VIII. OWNERSHIP COSTSA. Purchase price of land 650,127 Year land was acquired 2004

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	103			2006	\$ 9,629,447	\$ 350,004	28	\$ 350,004	\$	\$ 568,773	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			334,649	31,792	15	31,792		48,524	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)				\$ 9,964,096	\$ 381,796		\$ 381,796	\$	\$ 617,297	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	\$ 801,576	\$ 256,504	\$ 256,504	\$	5	\$ 416,819	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 801,576	\$ 256,504	\$ 256,504	\$		\$ 416,819	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: Cambridge House of Maryville

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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	IHDA		X	First Mortgage	12/1/06	\$ 6,950,000	\$ 6,886,723	12/1/41	0.0648	\$ 448,192
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 6,950,000	\$ 6,886,723			\$ 448,192
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 6,950,000	\$ 6,886,723			\$ 448,192

* 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: Cambridge House of Maryville

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

12/31/2007

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,290,999	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	399,500		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,653		6
7	Other Prepaid Expenses	94		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,754,246	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	650,127		13
14	Buildings, at Historical Cost	9,629,447		14
15	Leasehold Improvements, at Historical Cost	334,649		15
16	Equipment, at Historical Cost	801,576		16
17	Accumulated Depreciation (book methods)	(1,034,116)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	116,895		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(10,608)		20
21	Restricted Funds	1,111,084		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,599,054	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,353,300	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 484,049	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	40,000		29
30	Accrued Salaries Payable	31,571		30
31	Accrued Taxes Payable	97,872		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Liabilities & Unearned Rev	14,300		35
36	Accrued Partnership Mgmt Fee	25,000		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 692,792	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,886,722		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)	\$ 6,886,722	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,579,514	\$	45
46	TOTAL EQUITY	\$ 5,773,786	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 13,353,300	\$	47

*(See instructions.)

Facility Name: Cambridge House of Maryville

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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

	1	Amount	
Revenue			
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,856,812	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,856,812	3
B. Other Operating Revenue			
4	Special Services	96,547	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	23,206	8
9	Non-Resident Meals	4,280	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 124,033	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	80,788	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 80,788	14
D. Other Revenue (specify):			
15	Worker's Comp Dividend	1,847	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,847	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,063,480	18

	2	Amount	
Expenses			
A. Operating Expenses			
19	General Services	605,111	19
20	Health Care/ Personal Care	401,658	20
21	General Administration	736,518	21
B. Capital Expense			
22	Ownership	1,613,086	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)	\$ 3,356,373	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (292,893)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (292,893)	31

Cost Center Expenses

A. General Services - Other

Exterminating	1,200
Rubbish Removal	2,898
Vehicle Expense	922
Misc Operating Expenses	
Total	5,020

C. General Administration - Other

Consulting	
Legal	1,111
Accounting	30
Audit	11,500
Bad Debt	8
Total	12,649

D. Ownership

Mortgage Service Fee	18,738
Mortgage Insurance Premium	34,582
Partnership Management Fee	25,000
Asset Management Fee	5,004
Incentive Management Fee	421,412
Tax Credit Fee & Incentive Fee	2,100
Amortization Expense	6,365
Property Damage Loss	1,000
Total	514,201

Reclassifications and Adjustments

Heat & Other Utilities (3,610) Cable Expense

Administrative and Clerical (21,699) Telephone Revenue