

		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><b>I.</b></p> <p>Facility Name: <u>Heritage Woods of Aledo</u></p> <p>Address: <u>405 SE 13th Ave.</u> <u>Aledo</u> <u>61231</u>  <small>Number City Zip Code</small></p> <p>County: <u>Mercer</u></p> <p>Telephone Number: ( <u>309</u> ) <u>582-1132</u> Fax # <u>309-582-1134</u></p> <p>Federal Employer ID Number: <u>26-1173738</u></p> <p>Date Current Owners were Certified: <u>10/17/06</u></p> <p>Type of Ownership:</p> <table border="0"> <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 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: <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 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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____</td> <td></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>David J. Mitchell</u>			(Title) <u>CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(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																																								
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> 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 _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) <u>David J. Mitchell</u>																																									
	(Title) <u>CFO</u>																																									
Paid Preparer	(Signed) _____	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) ( <u>   </u> ) _____ Fax # ( <u>   </u> ) _____																																									

Facility Name Heritage Woods of Aledo

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	66	Single Unit Apartment	66	24,090	1
2		Double Unit Apartment			2
3		Other			3
4	66	TOTALS	66	24,090	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	2,610	12,531		15,141	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,610	12,531		15,141	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 62.85%

**D. Indicate the number of paid bed-hold days the SLF had during this year**  
84 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**

ACCURAL  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?** 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: Heritage Woods of Aledo

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	103,584	75,069	1,466	180,119		180,119	1
2	Housekeeping, Laundry and Maintenance	30,933	10,164	14,530	55,627		55,627	2
3	Heat and Other Utilities			83,191	83,191	(9,440)	73,751	3
4	Other (specify):			3,403	3,403		3,403	4
5	<b>TOTAL General Services</b>	134,517	85,233	102,590	322,340	(9,440)	312,900	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	162,829	1,203		164,032		164,032	6
7	Activities and Social Services	11,827	2,214		14,041		14,041	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	174,656	3,417		178,073		178,073	9
<b>C. General Administration</b>								
10	Administrative and Clerical	77,010	7,559	139,316	223,885	(8,916)	214,969	10
11	Marketing Materials, Promotions and Advertising	48,224	3,536	35,461	87,221		87,221	11
12	Employee Benefits and Payroll Taxes			98,074	98,074		98,074	12
13	Insurance-Property, Liability and Malpractice			35,977	35,977		35,977	13
14	Other (specify):			16,429	16,429		16,429	14
15	<b>TOTAL General Administration</b>	125,234	11,095	325,257	461,586	(8,916)	452,670	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	434,407	99,745	427,847	961,999	(18,356)	943,643	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			283,358	283,358		283,358	17
18	Interest			380,285	380,285		380,285	18
19	Real Estate Taxes			136,000	136,000		136,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			74,963	74,963		74,963	22
23	<b>TOTAL Ownership</b>			874,606	874,606		874,606	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	434,407	99,745	1,302,453	1,836,605	(18,356)	1,818,249	24

Facility Name: Heritage Woods of Aledo

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	\$ 23.93	1
2	Licensed Practical Nurses	0	15.57	2
3	Certified Nurse Assistants	6	9.17	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	12.09	6
7	Cook Helpers/Assistants	4	8.27	7
8	Dishwashers			8
9	Maintenance Workers	1	12.42	9
10	Housekeepers	1	7.53	10
11	Laundry			11
12	Managers	1	26.74	12
13	Other Administrative	1	11.24	13
14	Clerical			14
15	Marketing	1	15.47	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	BMA Management, LTD.	\$ 73,897	1
2			2
<b>Total</b>		<b>\$ 73,897</b>	<b>3</b>

**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>
_____	_____
_____	_____
_____	_____

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: Heritage Woods of Aledo

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## VIII. OWNERSHIP COSTS

A. Purchase price of land 234,500 Year land was acquired 2005

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	66			2006	\$ 5,735,413	\$ 147,192	28	\$ 147,192	\$	\$ 165,591	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Land Improvements			8,788	659	15	659		741	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)				\$ 5,744,201	\$ 147,851		\$ 147,851	\$	\$ 166,332	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	\$ 474,273	\$ 135,507	\$ 135,507	\$	5	\$ 152,439	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 474,273	\$ 135,507	\$ 135,507	\$		\$ 152,439	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: Heritage Woods of Aledo

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	<b>TOTAL</b>				\$			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				
	<b>A. Directly Facility Related</b>										
	<b>Long-Term</b>										
1	TheCountry Bank	X		First Mortgage	11/15/06	\$ 4,594,335	\$ 4,531,699	11/15/11	0.0639	\$ 320,381	1
2	TheCountry Bank	X		Second Mortgage	11/15/06	1,305,665	1,287,864	11/15/11	0.0639	58,813	2
3	TheCountry Bank	X		Line of Credit	NA	50,000	44,224	NA	Variable	1,091	3
	<b>Working Capital</b>										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 5,950,000	\$ 5,863,787			\$ 380,285	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 5,950,000	\$ 5,863,787			\$ 380,285	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: Heritage Woods of Aledo

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 31,402	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	83,371		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,667		6
7	Other Prepaid Expenses	460		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Utility Deposit</u>	240		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 125,140	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	234,500		13
14	Buildings, at Historical Cost	5,735,413		14
15	Leasehold Improvements, at Historical Cost	8,788		15
16	Equipment, at Historical Cost	474,273		16
17	Accumulated Depreciation (book methods)	(318,771)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	754,325		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,429)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,813,099	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,938,239	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 162,479	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	490,916		29
30	Accrued Salaries Payable	17,716		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	16,693		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
<b>Other Current Liabilities(specify):</b>				
35	<u>Accrued Liabilities &amp; Unearned Rev</u>	7,880		35
36	<u>Accrued Prop Taxes</u>	136,000		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 831,684	\$	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,819,563		39
40	Bonds Payable			40
41	Deferred Compensation			41
<b>Other Long-Term Liabilities(specify):</b>				
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 5,819,563	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 6,651,247	\$	45
46	<b>TOTAL EQUITY</b>	\$ 286,992	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,938,239	\$	47

\*(See instructions.)

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,169,134	1
2	Discounts and Allowances	(9,949)	2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 1,159,185	3
<b>B. Other Operating Revenue</b>			
4	Special Services	27,421	4
5	Other Health Care Services	2,548	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	5,866	8
9	Non-Resident Meals	5,877	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 41,712	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,632	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 1,632	14
<b>D. Other Revenue (specify):</b>			
15	2006 Property Taxes	1,253	15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 1,253	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 1,203,782	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	322,340	19
20	Health Care/ Personal Care	178,073	20
21	General Administration	461,586	21
<b>B. Capital Expense</b>			
22	Ownership	874,606	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 1,836,605	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (632,823)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (632,823)	31

Cost Center Expenses

A. General Services - Other

Exterminating	1,165
Rubbish Removal	1,076
Vehicle Expense	1,145
Misc Operating Expenses	17

Total **3,403**

C. General Administration - Other

Consulting	16,125
Legal	256
Bad Debt	48

Total **16,429**

D. Ownership

Mortgage Service Fee	
Mortgage Insurance Premium	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	
Amortization Expense	67,048
Business Interruption	1,458
Property Damage Loss	6,457

Total **74,963**

Reclassifications and Adjustments

Heat & Other Utilities (9,440) Cable

Administrative and Clerical (8,916) Telephone Revenue