

		FOR BHF USE			

LL2

Supportive Living Facility
2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)

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>Heritage Place</u></p> <p>Address: <u>400 North Bluff St.</u> <u>Joliet</u> <u>60435</u> <small>Number City Zip Code</small></p> <p>County: <u>Will</u></p> <p>Telephone Number: (<u>815</u>) <u>823-8905</u> Fax # <u>815 726-8978</u></p> <p>Federal Employer ID Number: <u>36 6001314</u></p> <p>Date Current Owners were Certified: <u>12/6/2007</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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 checked="" 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>Veronica Rosas</u> Telephone Number: <u>815-727-0611</u> Email Address: <u>vrosas@hajoliet.org</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 checked="" 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>12/09/07</u> to <u>6/30/08</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) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</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 & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (_____) _____ Fax # (_____) _____</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) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (_____) _____ Fax # (_____) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 checked="" 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 _____																																									
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) _____																																									
	(Title) _____																																									
Paid Preparer	(Signed) _____	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) _____																																									
	(Telephone) (_____) _____ Fax # (_____) _____																																									

Facility Name Heritage Place

Report Period Beginning: 12/09/07 Ending: 6/30/08

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	45	Single Unit Apartment	45	9,180	1
2		Double Unit Apartment			2
3		Other			3
4	45	TOTALS	45	9,180	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	1,230	260		1,490	5
6	Double Unit					6
7	Other					7
8	TOTALS	1,230	260		1,490	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 16.23%

D. Indicate the number of paid bed-hold days the SLF had during this year
59 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

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: _____ Fiscal Year: _____

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

*The Housing Authority of Joliet does not pay any State or Federal Taxes

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 Place

Report Period Beginning:

12/09/07

Ending:

6/30/08

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							1
2	Housekeeping, Laundry and Maintenance	63,283	74,785	66,352	204,420		204,420	2
3	Heat and Other Utilities			48,453	48,453		48,453	3
4	Other (specify): Protective Services	3,924		305	4,229		4,229	4
5	TOTAL General Services	67,207	74,785	115,110	257,102		257,102	5
B. Health Care and Programs								
6	Health Care/ Personal Care	21,123		13,536	34,659		34,659	6
7	Activities and Social Services			12,408	12,408		12,408	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	21,123		25,944	47,067		47,067	9
C. General Administration								
10	Administrative and Clerical	232,379			232,379		232,379	10
11	Marketing Materials, Promotions and Advertising			5,186	5,186		5,186	11
12	Employee Benefits and Payroll Taxes				116,476		116,476	12
13	Insurance-Property, Liability and Malpractice			44,652	44,652		44,652	13
14	Other (specify): see attachment 1			199,964	199,964		199,964	14
15	TOTAL General Administration	232,379		249,802	598,657		598,657	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	320,709	74,785	390,856	902,826		902,826	16
Capital Expenses								
D. Ownership								
17	Depreciation			122,656	122,656		122,656	17
18	Interest			77,833	77,833		77,833	18
19	Real Estate Taxes			1,488	1,488		1,488	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): bank fees			2,048	2,048		2,048	22
23	TOTAL Ownership			204,025	204,025		204,025	23
24	GRAND TOTAL (Sum of lines 16 and 23)	320,709	74,785	594,881	1,106,851		1,106,851	24

Facility Name: Heritage Place

Report Period Beginning 12/09/07 Ending: 6/30/08

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.35	\$ 28.00	1
2	Licensed Practical Nurses	0.35	21.00	2
3	Certified Nurse Assistants	6.00	9.17	3
4	Activity Director & Assistants	0.38	10.80	4
5	Social Service Workers			5
6	Head Cook	1.00	13.46	6
7	Cook Helpers/Assistants	2.00	8.00	7
8	Dishwashers			8
9	Maintenance Workers	0.60	21.08	9
10	Housekeepers	0.57	9.00	10
11	Laundry			11
12	Managers	1.00	21.56	12
13	Other Administrative	1.00	23.07	13
14	Clerical	1.00	10.00	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14	\$ 16	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	None			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	MIA Consulting Group	\$ 91,925 1
2		
Total		\$ 91,925 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
None			

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: _____ 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 Place

Report Period Beginning: 12/09/07

Ending: 6/30/08

VIII. OWNERSHIP COSTS

A. Purchase price of land 248,411 Year land was acquired 1967

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	45		1973	1973	\$ 660,509	\$	20	\$	\$	\$ 660,509	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Various		1977-2008		4,606,716	120,964	20	120,963	(1)	680,839	6
7	Land		2005		23,982	1,599	15	1,599		5,596	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)				\$ 5,291,207	\$ 122,563		\$ 122,562	\$ (1)	\$ 1,346,944	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	\$ 1,941	\$ 93	\$ 93	\$	5	\$ 1,103	18
19	Vehicles	17,916				5	17,916	19
20	TOTAL (lines 18 and 19)		\$ 19,857	\$ 93	\$ 93		\$ 19,019	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 Place

Report Period Beginning: 12/09/07

Ending: 6/30/08

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Amount of Note	Balance				
			YES	NO		Date of Note	Original		Maturity Date			
		A. Directly Facility Related Long-Term										
1						/ /	\$		/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$	\$			\$	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$	\$			\$	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.

STATE OF ILLINOIS

Page 7

Facility Name: Heritage Place

Report Period Beginning: 12/09/07

Ending:

6/30/08

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 19,349	\$	1
2	Cash-Patient Deposits	2,655		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	96,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,285		5
6	Prepaid Insurance	4,300		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 125,329	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,359		12
13	Land	248,411		13
14	Buildings, at Historical Cost	5,267,225		14
15	Leasehold Improvements, at Historical Cost	23,982		15
16	Equipment, at Historical Cost	19,857		16
17	Accumulated Depreciation (book methods)	(1,365,963)		17
18	Deferred Charges	63,719		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,259,590	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,384,919	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,676	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,655		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,536		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	24,901		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Pension payable & deferred revenue	11,829		35
36	Compensated absences	8,936		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 79,533	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	80,025		38
39	Mortgage Payable			39
40	Bonds Payable	1,696,611		40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Compensated absences	15,768		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,792,404	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,871,937	\$	45
46	TOTAL EQUITY	\$ 2,512,982	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,384,919	\$	47

*(See instructions.)

Facility Name: Heritage Place

Report Period Beginning: 12/09/07

Ending:

6/30/08

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	\$ 134,499	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 134,499	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	58	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 58	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	8,401	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8,401	14
D. Other Revenue (specify):			
15	HUD Operating & Capital grants	965,044	15
16	Tenant charges & MISC	7,436	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 972,480	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,115,438	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	257,102	19
20	Health Care/ Personal Care	47,067	20
21	General Administration	598,657	21
B. Capital Expense			
22	Ownership	204,025	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)	\$ 1,106,851	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 8,587	29
30	Income Taxes		30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 8,587	31

Other General services

Outside management fee	91,925
Legal expense	1,657
Staff training	7,934
Travel	3,010
Telephone	13,710
Sundry (office supplies, background checks, postage, misc exper	54,255
Office equipment & furnishes for facility (not capitalized)	<u>27,473</u>
	199,964