

		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 Woods of Benton</u></p> <p>Address: <u>1305 Bailey Lane</u> <u>Benton</u> <u>62812</u> <small>Number City Zip Code</small></p> <p>County: <u>Franklin</u></p> <p>Telephone Number: (<u>618</u>) <u>439-9431</u> Fax # <u>618-439-9432</u></p> <p>Federal Employer ID Number: <u>36-4230987</u></p> <p>Date Current Owners were Certified: <u>01-13-05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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 EXT 232</u> Email Address: <u>selena.edgington@bma-mgmt.com</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>01/01/2008</u> to <u>12/31/2008</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>David J. Mitchell</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(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) _____ (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																																					
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	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																																						

Facility Name Heritage Woods of Benton

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	92	Single Unit Apartment	92	33,672	1
2	8	Double Unit Apartment	8	2,928	2
3		Other		58	3
4	100	TOTALS	100	36,658	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	27,591	7,334		34,925	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,591	7,334		34,925	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.27%

D. Indicate the number of paid bed-hold days the SLF had during this year 642 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 107 (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: 2008 Fiscal Year: 2008

* 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: Heritage Woods of Benton

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	197,991	161,122	1,754	360,867		360,867	1
2	Housekeeping, Laundry and Maintenance	77,331	14,196	36,065	127,592		127,592	2
3	Heat and Other Utilities			137,315	137,315	(13,388)	123,927	3
4	Other (specify):			5,443	5,443		5,443	4
5	TOTAL General Services	275,322	175,318	180,577	631,217	(13,388)	617,829	5
B. Health Care and Programs								
6	Health Care/ Personal Care	359,142	2,208		361,350		361,350	6
7	Activities and Social Services	27,403	9,366		36,769		36,769	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	386,545	11,574		398,119		398,119	9
C. General Administration								
10	Administrative and Clerical	96,832	11,878	181,221	289,931	(18,737)	271,194	10
11	Marketing Materials, Promotions and Advertising	39,718	1,332	40,795	81,845		81,845	11
12	Employee Benefits and Payroll Taxes			160,655	160,655		160,655	12
13	Insurance-Property, Liability and Malpractice			63,407	63,407		63,407	13
14	Other (specify):			21,687	21,687		21,687	14
15	TOTAL General Administration	136,550	13,210	467,765	617,525	(18,737)	598,788	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	798,417	200,102	648,342	1,646,861	(32,125)	1,614,736	16
Capital Expenses								
D. Ownership								
17	Depreciation			417,737	417,737		417,737	17
18	Interest			396,215	396,215		396,215	18
19	Real Estate Taxes			22,595	22,595		22,595	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			84,962	84,962		84,962	22
23	TOTAL Ownership			921,509	921,509		921,509	23
24	GRAND TOTAL (Sum of lines 16 and 23)	798,417	200,102	1,569,851	2,568,370	(32,125)	2,536,245	24

Facility Name: Heritage Woods of Benton

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.69	1
2	Licensed Practical Nurses	1	15.15	2
3	Certified Nurse Assistants	15	9.07	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	13.11	5
6	Head Cook	1	13.38	6
7	Cook Helpers/Assistants	10	8.48	7
8	Dishwashers			8
9	Maintenance Workers	1	14.05	9
10	Housekeepers	3	7.89	10
11	Laundry			11
12	Managers	1	25.26	12
13	Other Administrative	2	11.99	13
14	Clerical			14
15	Marketing	1	16.84	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.	\$ 110,135	1
2			2
Total		\$ 110,135	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>
_____	_____
_____	_____
_____	_____

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 Benton

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

VIII. OWNERSHIP COSTS

A. Purchase price of land 81,711 Year land was acquired 2002

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	100			2004	\$ 8,084,083	\$ 293,754	28	\$ 288,360	\$ (5,394)	\$ 1,258,771	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			422,429	29,274	15	28,162	(1,112)	128,820	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)				\$ 8,506,512	\$ 323,028		\$ 316,522	\$ (6,506)	\$ 1,387,591	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	\$ 822,129	\$ 94,709	\$ 164,426	69,717	5	\$ 631,988	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 822,129	\$ 94,709	\$ 164,426	69,717		\$ 631,988	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 Benton

Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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
			YES	NO			Original	Balance				
	A. Directly Facility Related Long-Term											
1	IHDA			X	First Mortgage	12/20/02	\$ 7,730,000	\$ 7,269,236	2/1/35	0.0540	\$ 396,215	1
2						/ /			/ /			2
3						/ /			/ /			3
	Working Capital											
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7	TOTAL Facility Related						\$ 7,730,000	\$ 7,269,236			\$ 396,215	7
	B. Non-Facility Related											
8						/ /			/ /			8
9						/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)						\$ 7,730,000	\$ 7,269,236			\$ 396,215	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 Benton

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 381,748	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	486,330		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,975		6
7	Other Prepaid Expenses	5,254		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 909,307	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,140		13
14	Buildings, at Historical Cost	8,084,883		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	822,129		16
17	Accumulated Depreciation (book methods)	(2,019,579)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	484,841		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(96,973)		20
21	Restricted Funds	802,266		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,581,707	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,491,014	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,029	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,190		30
31	Accrued Taxes Payable	12,442		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	562,969		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 658,630	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,269,236		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)	\$ 7,269,236	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,927,866	\$	45
46	TOTAL EQUITY	\$ 1,563,148	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,491,014	\$	47

*(See instructions.)

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	\$ 2,634,809	1
2	Discounts and Allowances	(2,466)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,632,343	3
B. Other Operating Revenue			
4	Special Services	116,208	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	17,700	8
9	Non-Resident Meals	5,315	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 139,223	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	30,961	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 30,961	14
D. Other Revenue (specify):			
15	See Page 8 Attachment	10,486	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 10,486	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,813,013	18

	2	Amount	
Expenses			
A. Operating Expenses			
19	General Services	631,217	19
20	Health Care/ Personal Care	398,119	20
21	General Administration	617,525	21
B. Capital Expense			
22	Ownership	921,509	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)	\$ 2,568,370	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 244,643	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 244,643	31

Cost Center Expenses

A. General Services - Other

Exterminating	2,064
Rubbish Removal	2,388
Vehicle Expense	981
Misc Operating Expenses	
Total	5,433

C. General Administration - Other

Consulting	
Legal	7,884
Accounting	60
Audit	12,600
Bad Debt	1,143
Total	21,687

D. Ownership

Mortgage Service Fee	18,343
Mortgage Insurance Premium	33,697
Partnership Management Fee	-
Asset Management Fee	14,508
Incentive Management Fee	
Tax Credit Fee & Incentive Fee	2,250
Amortization Expense	16,164
Business Interruption	
Property Damage Loss	
Total	84,962

Reclassifications and Adjustments

Heat & Other Utilities (13,388) Cable Revenue

Administrative and Clerical (18,737) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	12,577
Payroll Benefits	
Reservation Deposits	
Unearned Revenue	3,995
Accrued Developer Fee	546,397

Total Other Current Liabilities **562,969**

INCOME STATEMENT

D. Other Revenue

Insurance adjustments	4,664
Vending	40
Medicaid interest	4,589
Donations	1,193

Total Other Revenue **10,486**