

		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.

<p>I. Facility ID Number: <u>1000078</u></p> <p>Facility Name: <u>Heritage Woods of Mt. Vernon</u></p> <hr/> <p>Address: <u>1033 S. 42nd Street</u> <u>Mt. Vernon</u> <u>62864</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Jefferson</u></p> <p>Telephone Number: <u>618-241-9518</u> Fax # <u>618-241-9516</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10-09-07</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 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 checked="" 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:</p> <p>Name: <u>Selena Edgington</u> Telephone Number: <u>815-935-1992</u></p> <p>Email Address: _____</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>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>01/01/2010</u> to <u>12/31/2010</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>David J. Mitchell</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>CFO, BMA Management, LTD.</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) () _____ Fax # () _____</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, BMA Management, LTD.</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____ Fax # () _____	
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Facility Name Heritage Woods of Mt. Vernon

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 / /

	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	16,432	6,390		22,822	5
6	Double Unit					6
7	Other					7
8	TOTALS	16,432	6,390		22,822	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.74%

D. Indicate the number of paid bed-hold days the SLF had during this year 422 Also, indicate the number of unpaid bed-hold days the SLF had during this year. zero **(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: 12/31/2010 Fiscal Year: 12/31/2010

* 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 Mt. Vernon

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 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	152,865	117,566	2,027	272,458		272,458	1
2	Housekeeping, Laundry and Maintenance	53,858	10,681	27,580	92,119		92,119	2
3	Heat and Other Utilities			101,626	101,626	(16,398)	85,228	3
4	Other (specify):			5,819	5,819		5,819	4
5	TOTAL General Services	206,723	128,247	137,052	472,022	(16,398)	455,624	5
B. Health Care and Programs								
6	Health Care/ Personal Care	246,440	1,919		248,359		248,359	6
7	Activities and Social Services	24,931	3,536		28,467		28,467	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	271,371	5,455		276,826		276,826	9
C. General Administration								
10	Administrative and Clerical	81,805	8,651	153,102	243,558	(16,004)	227,554	10
11	Marketing Materials, Promotions and Advertising	20,411	3,847	25,215	49,473		49,473	11
12	Employee Benefits and Payroll Taxes			130,536	130,536		130,536	12
13	Insurance-Property, Liability and Malpractice			27,472	27,472		27,472	13
14	Other (specify):			31,368	31,368		31,368	14
15	TOTAL General Administration	102,216	12,498	367,693	482,407	(16,004)	466,403	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	580,310	146,200	504,745	1,231,255	(32,402)	1,198,853	16
Capital Expenses								
D. Ownership								
17	Depreciation			323,108	323,108		323,108	17
18	Interest			320,980	320,980		320,980	18
19	Real Estate Taxes			4,375	4,375		4,375	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			15,309	15,309		15,309	22
23	TOTAL Ownership			663,772	663,772		663,772	23
24	GRAND TOTAL (Sum of lines 16 and 23)	580,310	146,200	1,168,517	1,895,027	(32,402)	1,862,625	24

Facility Name: Heritage Woods of Mt. Vernon

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	1	\$ 20.02	1
2	Licensed Practical Nurses	1	15.59	2
3	Certified Nurse Assistants	10	8.84	3
4	Activity Director & Assistants	1	11.94	4
5	Social Service Workers			5
6	Head Cook	1	12.07	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	1	15.19	9
10	Housekeepers	2	8.61	10
11	Laundry			11
12	Managers	1	29.15	12
13	Other Administrative			13
14	Clerical			14
15	Marketing	1	17.91	15
16	Other			16
17	Total (lines 1 thru 16)	18	\$	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.	\$ 96,174	1
2			2
Total		\$ 96,174	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
_____		_____	
_____		_____	
_____		_____	

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 Woods of Mt. Vernon

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land 189,832 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	66			2007	\$ 5,394,411	\$ 196,160	28	\$ 192,658	\$ (3,502)	\$ 678,387	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land improvements			611,707	46,861	15	40,780	(6,081)	189,971	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)				\$ 6,006,118	\$ 243,021		\$ 233,438	\$ (9,583)	\$ 868,358	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	\$ 619,320	\$ 74,309	\$ 123,864	49,555	5	\$ 455,356	18
19	Vehicles	50,160	5,778	10,032	4,254	5	41,492	19
20	TOTAL (lines 18 and 19)	\$ 669,480	\$ 80,087	\$ 133,896	53,809		\$ 496,848	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 Mt. Vernon

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	
		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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		MIDLAND STATES BANK		X	FIRST MORTGAGE	12/31/08	\$ 6,450,000	\$ 6,175,030	1/1/14	VARIABLE	\$ 320,980	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4		COUNTRY BANK		X	LINE OF CREDIT	8/7/09	500,000	zero	7/31/11	VARIABLE	zero	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 6,950,000	\$ 6,175,030			\$ 320,980	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 6,950,000	\$ 6,175,030			\$ 320,980	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 Mt. Vernon

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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 193,114	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	22,137		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,151		6
7	Other Prepaid Expenses	2,790		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 228,192	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	801,539		13
14	Buildings, at Historical Cost	5,394,411		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	669,480		16
17	Accumulated Depreciation (book methods)	(1,365,206)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	185,933		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(41,011)		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)	\$ 5,645,146	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,873,338	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,099	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,313		30
31	Accrued Taxes Payable	5,238		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	16,120		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 69,770	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,175,031		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)	\$ 6,175,031	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,244,801	\$	45
46	TOTAL EQUITY	\$ (371,463)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,873,338	\$	47

Facility Name: Heritage Woods of Mt. Vernon

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	\$ 1,855,257	1
2	Discounts and Allowances	(19,209)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,836,048	3
B. Other Operating Revenue			
4	Special Services	86,708	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,327	8
9	Non-Resident Meals	2,126	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 99,161	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	Insurance Adjustments	390	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 390	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,935,599	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	472,022	19
20	Health Care/ Personal Care	276,826	20
21	General Administration	482,407	21
B. Capital Expense			
22	Ownership	663,772	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)	\$ 1,895,027	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 40,572	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 40,572	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,020
Rubbish Removal	2,982
Vehicle Expense	1,817
Transportation Service	
Water Softener	
Total	5,819

C. General Administration - Other

Consulting	15,838
Legal	613
Accounting	-
Audit	3,325
Contract labor	1,000
Bad Debt	10,592
Total	31,368

D. Ownership

Assessment Income	-
Bond and Draw Fee	-
Mortgage Insurance Premium	-
Partnership Management Fee	-
Asset Management Fee	-
Incentive Manangement Fee	-
Tax Credit Fee & Incentive Fee	-
Amortization Expense	12,809
Dividend Income	-
Property Damage Loss	2,500
Total	15,309

Reclassifications and Adjustments

Heat & Other Utilities (16,398) Cable

Administrative and Clerical (16,004) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	8,302
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Accrued Developer Fee	
Unearned Revenue	6,218
Accrued MIP	
Reservation Deposit	1,600
Total Other Current Liabilities	16,120