

		FOR BHF USE			

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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>1000121</u></p> <p>Facility Name: <u>Heritage Woods of Dwight</u></p> <p>Address: <u>701 East Mazon Avenue</u> <u>Dwight</u> <u>60420</u> <small>Number City Zip Code</small></p> <p>County: <u>Livingston</u></p> <p>Telephone Number: (<u>815</u>) <u>584-9280</u> Fax # (<u>815</u>) <u>584-9283</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/24/2009</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 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>Grenshinka Osborne</u> Telephone Number: <u>815-935-1992 EXT 257</u> 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>01/01/12</u> to <u>12/31/12</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:30%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td align="right"><u>4/29/2013</u> (Date)</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, BMA Management, LTD.</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td align="right">(Date)</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td align="right">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) _____	<u>4/29/2013</u> (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 # () _____
<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) _____	<u>4/29/2013</u> (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 # () _____																																												

Facility Name Heritage Woods of Dwight

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

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	68	Single Unit Apartment	68	24,888	1
2		Double Unit Apartment			2
3		Other			3
4	68	TOTALS	68	24,888	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	12,059	7,710		19,769	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,059	7,710		19,769	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 79.43%

D. Indicate the number of paid bed-hold days the SLF had during this year 237 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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2012 Fiscal Year: 2012

* 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 Dwight

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	146,104	93,798	1,772	241,674		241,674	1
2	Housekeeping, Laundry and Maintenance	66,440	12,417	35,579	114,436		114,436	2
3	Heat and Other Utilities			89,806	89,806	(12,552)	77,254	3
4	Other (specify):			13,179	13,179		13,179	4
5	TOTAL General Services	212,544	106,215	140,336	459,095	(12,552)	446,543	5
B. Health Care and Programs								
6	Health Care/ Personal Care	227,315	2,221		229,536		229,536	6
7	Activities and Social Services	22,517	3,257		25,774		25,774	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	249,832	5,478		255,310		255,310	9
C. General Administration								
10	Administrative and Clerical	76,419	13,813	194,536	284,768	(14,088)	270,680	10
11	Marketing Materials, Promotions and Advertising	37,430	3,501	32,510	73,441		73,441	11
12	Employee Benefits and Payroll Taxes			141,288	141,288		141,288	12
13	Insurance-Property, Liability and Malpractice			27,495	27,495		27,495	13
14	Other (specify):			17,172	17,172		17,172	14
15	TOTAL General Administration	113,849	17,314	413,001	544,164	(14,088)	530,076	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	576,225	129,007	553,337	1,258,569	(26,640)	1,231,929	16
Capital Expenses								
D. Ownership								
17	Depreciation			359,475	359,475		359,475	17
18	Interest			469,649	469,649		469,649	18
19	Real Estate Taxes			66,638	66,638		66,638	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			3,281	3,281		3,281	22
23	TOTAL Ownership			899,043	899,043		899,043	23
24	GRAND TOTAL (Sum of lines 16 and 23)	576,225	129,007	1,452,380	2,157,612	(26,640)	2,130,972	24

Facility Name: Heritage Woods of Dwight

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

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.33	1
2	Licensed Practical Nurses	0	18.16	2
3	Certified Nurse Assistants	8	9.23	3
4	Activity Director & Assistants	1	10.75	4
5	Social Service Workers			5
6	Head Cook	1	14.19	6
7	Cook Helpers/Assistants	6	9.05	7
8	Dishwashers			8
9	Maintenance Workers	1	0.19	9
10	Housekeepers	2	8.71	10
11	Laundry			11
12	Managers	1	25.75	12
13	Other Administrative			13
14	Clerical	1	11.48	14
15	Marketing	1	16.69	15
16	Other			16
17	Total (lines 1 thru 16)	23	\$	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	\$ 1
2		2
		Total
		\$ 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 Dwight

Report Period Beginning:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 295,541 Year land was acquired 2008

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	68			2009	\$ 6,307,787	\$ 229,351	28	\$ 225,278	\$ (4,073)	\$ 811,428	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			454,341	17,492	15	30,289	12,797	297,026	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)				\$ 6,762,128	\$ 246,843		\$ 255,568	\$ 8,725	\$ 1,108,454	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	\$ 1,854,868	\$ 112,632	\$ 370,974	258,342	5	\$ 1,687,271	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,854,868	\$ 112,632	\$ 370,974	258,342		\$ 1,687,271	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 Dwight

Report Period Beginning: 01/01/12

Ending: 12/31/12

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	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	Midland States Bank		X	First Mortgage	12/31/11	\$ 7,288,000	\$ 7,036,989	2/1/15	0.0690	\$ 459,357	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Midland States Bank		X	Line of Credit	6/20/11	300,000		6/20/12	0.0650	8,532	4
5	Midland States Bank		X	Line of Credit	4/25/12	300,000	29,798	4/25/13	0.0525	1,761	5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 7,888,000	\$ 7,066,787			\$ 469,649	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 7,888,000	\$ 7,066,787			\$ 469,649	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 Dwight

Report Period Beginning: 01/01/12

Ending:

12/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,338	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,854)	257,231		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,747		6
7	Other Prepaid Expenses	1,569		7
8	Accounts Receivable (owners or related parties)	573		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 270,457	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	749,882		13
14	Buildings, at Historical Cost	6,307,787		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,854,868		16
17	Accumulated Depreciation (book methods)	(2,795,725)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	133,650		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(133,650)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): cip	1		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,116,813	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,387,270	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 25,649	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,368		30
31	Accrued Taxes Payable	70,000		31
32	Accrued Interest Payable	42,055		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	SEE PAGE 7 ATTACHMENT	16,394		35
36	Line of Credit	29,798		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 218,264	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	7,036,989		38
39	Mortgage Payable			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)	\$ 7,036,989	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,255,253	\$	45
46	TOTAL EQUITY	\$ (867,983)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,387,270	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Dwight

Report Period Beginning: 01/01/12

Ending:

12/31/12

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	\$ 1,967,485	1
2	Discounts and Allowances	(42,694)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,924,791	3
B. Other Operating Revenue			
4	Special Services	55,050	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	20,475	8
9	Non-Resident Meals	5,484	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 81,009	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	3,434	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,434	14
D. Other Revenue (specify):			
15	Resident Reimb for Damaged Property	1,000	15
16	Call Pendant Income	1,159	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,159	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,011,393	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	459,095	19
20	Health Care/ Personal Care	255,310	20
21	General Administration	544,164	21
B. Capital Expense			
22	Ownership	899,043	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)	\$ 2,157,612	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (146,219)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (146,219)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,405
Rubbish Removal	5,685
Vehicle Expense	1,062
Transportation Service	
Water Softener	5,028
Misc Operating	
Total	13,180

C. General Administration - Other

Consulting	514
Legal	7,463
Accounting	90
Audit	12,172
Contract labor-Serv Prov	
Bad Debt	(4,267)
Contract labor	1,200
Total	17,172

D. Ownership

Financing Fees	781
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	

Amortization Expense	
Remarketing and Trustee Fee	
Property Damage Loss	2,500
Gain on Sale	
Total	3,281

Reclassifications and Adjustments

Heat & Other Utilities (12,552) Cable

Administrative and Clerical (14,088) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	14,076
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Unclaimed Property	
Unearned Revenue	1,818
Accrued MIP	
Reservation Deposit	500
Total Other Current Liabilities:	16,394