

		FOR BHF USE			

LL2

Supportive Living Facility

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)

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>100038</u></p> <p>Facility Name: <u>Heritage Woods of Watseka</u></p> <hr/> <p>Address: <u>577 East Martin Ave</u> <u>Watseska</u> <u>60970</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Iroquois</u></p> <p>Telephone Number: <u>815-432-4560</u> Fax # <u>815-432-4562</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/25/07</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>Selena Edgington</u> Telephone Number: <u>815-935-1992 EXT 232</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>01/01/13</u> to <u>12/31/13</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%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(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> </table> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(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) <u>()</u> _____</td> <td>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) <u>()</u> _____	Fax # () _____
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	(Telephone) <u>()</u> _____	Fax # () _____																																												

Facility Name Heritage Woods of WatsekaReport Period Beginning: 01/01/13 Ending: 12/31/13

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	65	Single Unit Apartment	65	23,725	1
2		Double Unit Apartment			2
3		Other			3
4	65	TOTALS	65	23,725	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 Total	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	10,331	11,861		22,192	5
6	Double Unit					6
7	Other					7
8	TOTALS	10,331	11,861		22,192	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.54%

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

185 Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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

ACCUAL MODIFIED CASH* CASH* I. Is your fiscal year identical to your tax year? YES NOTax Year: 2013 Fiscal Year: 2013

* 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 Watseka

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	165,487	121,479	2,052	289,018		289,018	1
2	Housekeeping, Laundry and Maintenance	59,093	13,140	31,194	103,427		103,427	2
3	Heat and Other Utilities			84,844	84,844	(14,215)	70,629	3
4	Other (specify):			7,766	7,766		7,766	4
5	TOTAL General Services	224,580	134,619	125,856	485,055	(14,215)	470,840	5
B. Health Care and Programs								
6	Health Care/ Personal Care	289,129	1,354		290,483		290,483	6
7	Activities and Social Services	26,576	2,683		29,259		29,259	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	315,705	4,037		319,742		319,742	9
C. General Administration								
10	Administrative and Clerical	72,978	11,087	149,630	233,695	(11,133)	222,562	10
11	Marketing Materials, Promotions and Advertising	25,426	5,321	26,121	56,868		56,868	11
12	Employee Benefits and Payroll Taxes			199,331	199,331		199,331	12
13	Insurance-Property, Liability and Malpractice			23,306	23,306		23,306	13
14	Other (specify):			20,342	20,342		20,342	14
15	TOTAL General Administration	98,404	16,408	418,730	533,542	(11,133)	522,409	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	638,689	155,064	544,586	1,338,339	(25,348)	1,312,991	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest			1,685	1,685		1,685	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			492,360	492,360		492,360	20
21	Rent -- Equipment							21
22	Other (specify):			3,020	3,020		3,020	22
23	TOTAL Ownership			497,065	497,065		497,065	23
24	GRAND TOTAL (Sum of lines 16 and 23)	638,689	155,064	1,041,651	1,835,404	(25,348)	1,810,056	24

Facility Name: Heritage Woods of Watseka

Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.16	1
2	Licensed Practical Nurses	1	17.77	2
3	Certified Nurse Assistants	10	9.78	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.77	5
6	Head Cook	1	13.25	6
7	Cook Helpers/Assistants	7	9.03	7
8	Dishwashers			8
9	Maintenance Workers	1	12.46	9
10	Housekeepers	2	9.02	10
11	Laundry			11
12	Managers	1	24.01	12
13	Other Administrative	1	13.29	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	26	\$	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	\$ 91,387	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
DSI Flora Operator & Owner		Flora	
DSI Ottawa Operator & Owner		Ottawa	
DSI Manteno Operator & Owner		Manteno	

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).

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VIII. OWNERSHIP COSTS

A. Purchase price of land Donated Year land was acquired 1999

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					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				\$	\$		\$	\$	\$	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		\$	\$			\$	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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

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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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1						/ /	\$		/ /		\$	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4		PEOPLES BANK		X	LINE OF CREDIT	11/26/13	400,000	54,098	11/24/14	VARIABLE	1,684	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 400,000	\$ 54,098			\$ 1,684	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 400,000	\$ 54,098			\$ 1,684	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.

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12/31/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 780	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	202,316 (6,935)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,561		6
7	Other Prepaid Expenses	24,879		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 229,601	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 229,601	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,402	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,685		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,698		30
31	Accrued Taxes Payable			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	85,255		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 192,040	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 192,040	\$	45
46	TOTAL EQUITY	\$ 37,561	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 229,601	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Watseka

Report Period Beginning: 01/01/13

Ending:

12/31/13

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	\$ 1,974,181	1
2	Discounts and Allowances	(8,579)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,965,602	3
	B. Other Operating Revenue		
4	Special Services	62,786	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	9,415	8
9	Non-Resident Meals	7,787	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 79,988	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	11,564	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 11,564	14
	D. Other Revenue (specify):		
15	Insurance Adjustments	3,728	15
16		.	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,728	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,060,882	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	485,055	19
20	Health Care/ Personal Care	319,742	20
21	General Administration	533,542	21
	B. Capital Expense		
22	Ownership	497,065	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)	\$ 1,835,404	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 225,478	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 225,478	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	910
Rubbish Removal	4,302
Vehicle Expense	1,895
Transportation Service	
Water Softener	659
Misc Operating	
Total	7,766

C. General Administration - Other

Consulting	574
Legal	185
Accounting	210
Audit	8,284
Contract labor-Serv Prov	1,200
Bad Debt	9,889
Contract labor	
Total	20,342

D. Ownership

Letter of Credit	520
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	3,020

Reclassifications and Adjustments

Heat & Other Utilities (14,215) Cable

Administrative and Clerical (11,133) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	11,946
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Unclaimed Property	3,859
Unearned Revenue	11,052
Line of Credit	54,098
Accrued MIP	
Reservation Deposit	4,300
Total Other Current Liabilities	85,255