

		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>1000129</u></p> <p>Facility Name: <u>Heritage Woods of Belvidere</u></p> <p>Address: <u>4730 Squaw Prairie Road</u> <u>Belvidere</u> <u>61008</u> <small>Number City Zip Code</small></p> <p>County: <u>Boone</u></p> <p>Telephone Number: (<u>815</u>) <u>544-9495</u> Fax # (<u>815</u>) <u>544-9525</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>04/25/2011</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: 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%; border: none;"> <tr> <td style="width:50%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">4/29/2013 (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) _____	4/29/2013 (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) _____	4/29/2013 (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 Belvidere

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	120	Single Unit Apartment	120	43,920	1
2		Double Unit Apartment			2
3		Other			3
4	120	TOTALS	120	43,920	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	22,604	19,255		41,859	5
6	Double Unit					6
7	Other					7
8	TOTALS	22,604	19,255		41,859	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.31%

D. Indicate the number of paid bed-hold days the SLF had during this year 228 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 Belvidere

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	265,766	222,819	1,695	490,280		490,280	1
2	Housekeeping, Laundry and Maintenance	106,644	16,383	44,750	167,777		167,777	2
3	Heat and Other Utilities			151,876	151,876	(30,809)	121,067	3
4	Other (specify):			18,726	18,726		18,726	4
5	TOTAL General Services	372,410	239,202	217,047	828,659	(30,809)	797,850	5
B. Health Care and Programs								
6	Health Care/ Personal Care	509,846	2,775		512,621		512,621	6
7	Activities and Social Services	28,462	10,849		39,311		39,311	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	538,308	13,624		551,932		551,932	9
C. General Administration								
10	Administrative and Clerical	155,136	18,644	306,165	479,945	(22,657)	457,288	10
11	Marketing Materials, Promotions and Advertising	60,227	25,534	40,446	126,207		126,207	11
12	Employee Benefits and Payroll Taxes			255,081	255,081		255,081	12
13	Insurance-Property, Liability and Malpractice			50,120	50,120		50,120	13
14	Other (specify):			64,912	64,912		64,912	14
15	TOTAL General Administration	215,363	44,178	716,724	976,265	(22,657)	953,608	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,126,081	297,004	933,771	2,356,856	(53,466)	2,303,390	16
Capital Expenses								
D. Ownership								
17	Depreciation			814,772	814,772		814,772	17
18	Interest			616,593	616,593		616,593	18
19	Real Estate Taxes			53,051	53,051		53,051	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			83,664	83,664		83,664	22
23	TOTAL Ownership			1,568,080	1,568,080		1,568,080	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,126,081	297,004	2,501,851	3,924,936	(53,466)	3,871,470	24

Facility Name: Heritage Woods of Belvidere

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	\$ 29.50	1
2	Licensed Practical Nurses	1	18.21	2
3	Certified Nurse Assistants	18	10.35	3
4	Activity Director & Assistants	1	12.43	4
5	Social Service Workers			5
6	Head Cook	1	10.21	6
7	Cook Helpers/Assistants	11	9.99	7
8	Dishwashers			8
9	Maintenance Workers	1	17.75	9
10	Housekeepers	3	8.83	10
11	Laundry			11
12	Managers	1	36.59	12
13	Other Administrative	2	13.40	13
14	Clerical	1	15.93	14
15	Marketing	1	23.75	15
16	Other			16
17	Total (lines 1 thru 16)	43	\$	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	\$ 200,903	1
2		2
Total		3
\$ 200,903		

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 Belvidere

Report Period Beginning:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 99 Year land was acquired 2011

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	120			2011	\$ 16,617,308	\$ 604,205	28	\$ 604,266	\$ 61	\$ 1,033,855	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Land Improvements				553,830	36,940	15	36,922	(18)	55,383	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)				\$ 17,171,138	\$ 641,145		\$ 641,188	\$ 43	\$ 1,089,238	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	\$ 868,136	\$ 173,627	\$ 173,627	0	5	\$ 260,441	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 868,136	\$ 173,627	\$ 173,627	0		\$ 260,441	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 Belvidere

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	Centennial Mortgage		X	First Mortgage	12/30/09	\$ 10,875,000	\$ 10,776,811	9/1/51	0.0570	\$ 616,593
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 10,875,000	\$ 10,776,811			\$ 616,593
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 10,875,000	\$ 10,776,811			\$ 616,593

* 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 Belvidere

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	\$ 1,866,945	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,557)	1,485,075		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,253		6
7	Other Prepaid Expenses	7,801		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PREPAID MIP	35,553		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,416,627	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	553,929		13
14	Buildings, at Historical Cost	16,617,308		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	868,136		16
17	Accumulated Depreciation (book methods)	(1,349,679)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	697,235		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(40,625)		20
21	Restricted Funds	1,222,302		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,568,606	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,985,233	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 76,877	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,202		30
31	Accrued Taxes Payable	60,000		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	677,076		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 880,155	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	16,774,634		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)	\$ 16,774,634	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 17,654,789	\$	45
46	TOTAL EQUITY	\$ 4,330,444	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 21,985,233	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Belvidere

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	\$ 4,320,584	1
2	Discounts and Allowances	(541)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,320,044	3
B. Other Operating Revenue			
4	Special Services	66,882	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	26,856	8
9	Non-Resident Meals	7,344	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 101,082	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	836	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 836	14
D. Other Revenue (specify):			
15	Contract Services	250	15
16	Utility Deposit (\$1190); Call Pendant Inc.	2,915	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,165	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,425,126	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	828,659	19
20	Health Care/ Personal Care	551,932	20
21	General Administration	976,265	21
B. Capital Expense			
22	Ownership	1,568,080	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)	\$ 3,924,936	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 500,190	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 500,190	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,280
Rubbish Removal	5,738
Vehicle Expense	3,186
Transportation Service	
Water Softener	8,522
Misc Operating	
Total	18,726

C. General Administration - Other

Consulting	39,411
Legal	2,368
Accounting	90
Audit	19,556
Contract labor-Serv Prov	
Bad Debt	2,287
Contract labor	1,200
Total	64,912

D. Ownership

Organizational Expense	6,675
Mortgage Insurance Premium	51,193
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	2,400

Amortization Expense	23,396
Remarketing and Trustee Fee	
Property Damage Loss	
Gain on Sale	
Total	83,664

Reclassifications and Adjustments

Heat & Other Utilities (30,809) Cable

Administrative and Clerical (22,657) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	19,362
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Accrued Developer Fee	629,641
Unclaimed Property	
Unearned Revenue	28,073
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities:	677,076