

		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>1000111</u></p> <p>Facility Name: <u>Heritage Woods of McLeansboro</u></p> <p>Address: <u>605 South Marshall</u> <u>McLeansboro</u> <u>62859</u> <small>Number City Zip Code</small></p> <p>County: <u>Hamilton</u></p> <p>Telephone Number: (<u>618</u>) <u>643-2908</u> Fax # (<u>618</u>) <u>643-2941</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>12/22/2008</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 checked="" 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 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 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>01/01/12</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><u>4/29/2013</u></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td>(Date)</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>(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>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>		(Type or Print Name) <u>David J. Mitchell</u>	(Date)		(Title) <u>CFO, BMA Management, LTD.</u>		Paid Preparer	(Signed) _____	(Date)		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
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	(Telephone) () _____	Fax # () _____																																												

Facility Name Heritage Woods of McLeansboro

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	41	Single Unit Apartment	41	15,006	1
2		Double Unit Apartment			2
3		Other			3
4	41	TOTALS	41	15,006	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	6,536	7,371		13,907	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,536	7,371		13,907	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.68%

D. Indicate the number of paid bed-hold days the SLF had during this year 179 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 1 (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? 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 McLeansboro

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	117,119	75,389	1,457	193,965		193,965	1
2	Housekeeping, Laundry and Maintenance	32,225	6,194	18,594	57,013		57,013	2
3	Heat and Other Utilities			74,589	74,589	(8,430)	66,159	3
4	Other (specify):			5,481	5,481		5,481	4
5	TOTAL General Services	149,344	81,583	100,121	331,048	(8,430)	322,618	5
B. Health Care and Programs								
6	Health Care/ Personal Care	139,580	931		140,511		140,511	6
7	Activities and Social Services	5,347	1,080		6,427		6,427	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	144,927	2,011		146,938		146,938	9
C. General Administration								
10	Administrative and Clerical	75,252	6,740	100,701	182,693	(9,100)	173,593	10
11	Marketing Materials, Promotions and Advertising	18,548	3,509	15,055	37,112		37,112	11
12	Employee Benefits and Payroll Taxes			107,397	107,397		107,397	12
13	Insurance-Property, Liability and Malpractice			16,587	16,587		16,587	13
14	Other (specify):			34,184	34,184		34,184	14
15	TOTAL General Administration	93,800	10,249	273,924	377,973	(9,100)	368,873	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	388,071	93,843	374,045	855,959	(17,530)	838,429	16
Capital Expenses								
D. Ownership								
17	Depreciation			256,809	256,809		256,809	17
18	Interest			181,396	181,396		181,396	18
19	Real Estate Taxes			4,606	4,606		4,606	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			72,570	72,570		72,570	22
23	TOTAL Ownership			515,381	515,381		515,381	23
24	GRAND TOTAL (Sum of lines 16 and 23)	388,071	93,843	889,426	1,371,340	(17,530)	1,353,810	24

Facility Name: Heritage Woods of McLeansboro

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	0	\$ 18.43	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	10.17	3
4	Activity Director & Assistants	0	9.58	4
5	Social Service Workers			5
6	Head Cook	1	11.64	6
7	Cook Helpers/Assistants	6	9.08	7
8	Dishwashers			8
9	Maintenance Workers	1	11.64	9
10	Housekeepers			10
11	Laundry			11
12	Managers	1	22.96	12
13	Other Administrative			13
14	Clerical	1	14.28	14
15	Marketing	1	12.36	15
16	Other			16
17	Total (lines 1 thru 16)	17	\$	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 McLeansboro

Report Period Beginning:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 145,000 Year land was acquired 2005

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	41			2008	\$ 4,948,747	\$	28	\$ 176,741	\$ 176,741	\$ 727,316	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			352,520	23,502	15	23,501	(1)	94,985	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)				\$ 5,301,267	\$ 23,502		\$ 200,242	\$ 176,740	\$ 822,301	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	\$ 480,761	\$ 53,312	\$ 96,152	42,840	5	\$ 433,036	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 480,761	\$ 53,312	\$ 96,152	42,840		\$ 433,036	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 McLeansboro

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	\$ 440,815	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,675)	240,733		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,255		6
7	Other Prepaid Expenses	2,227		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 689,029	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	497,520		13
14	Buildings, at Historical Cost	4,948,747		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	480,761		16
17	Accumulated Depreciation (book methods)	(1,255,337)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	162,892		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(35,084)		20
21	Restricted Funds	741,988		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,541,488	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,230,516	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 17,359	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,327		30
31	Accrued Taxes Payable	3,896		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	425,408		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 467,989	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,625,139		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)	\$ 4,625,139	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,093,128	\$	45
46	TOTAL EQUITY	\$ 1,137,388	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,230,516	\$	47

*(See instructions.)

Facility Name: Heritage Woods of McLeansboro

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	\$ 1,153,652	1
2	Discounts and Allowances	(4,851)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,148,800	3
B. Other Operating Revenue			
4	Special Services	57,015	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,340	8
9	Non-Resident Meals	4,927	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 70,282	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	6,440	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 6,440	14
D. Other Revenue (specify):			
15	Workers' Comp. Insurance Dividend	1,891	15
16	Call Pendant & Late Fee Income	548	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,439	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,227,960	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	331,048	19
20	Health Care/ Personal Care	146,938	20
21	General Administration	377,973	21
B. Capital Expense			
22	Ownership	515,381	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)	\$ 1,371,340	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (143,380)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (143,380)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,020
Rubbish Removal	2,471
Vehicle Expense	1,984
Transportation Service	
Water Softener	6
Misc Operating	
Total	5,481

C. General Administration - Other

Consulting	6,258
Legal	260
Accounting	90
Audit	10,950
Contract labor-Serv Prov	
Bad Debt	15,426
Contract labor	1,200
Total	34,184

D. Ownership

Financing Fees	42
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	3,000
Incentive Manangement Fee	59,432
Tax Credit Fee & Incentive Fee	825

Amortization Expense	8,771
Remarketing and Trustee Fee	
Property Damage Loss	500
Gain on Sale	
Total	72,570

Reclassifications and Adjustments

Heat & Other Utilities (8,430) Cable

Administrative and Clerical (9,100) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	14,355
Accrued Asset Mgmt Fee	12,000
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	131,143
Accrued Developer Fee	267,614
Unclaimed Property	
Unearned Revenue	295
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities:	425,408