

		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>1000115</u></p> <p>Facility Name: <u>Heritage Woods of Bolingbrook</u></p> <p>Address: <u>550 Kildeer</u> <u>Bolingbrook</u> <u>60440</u> <small>Number City Zip Code</small></p> <p>County: <u>Will</u></p> <p>Telephone Number: <u>630-783-9640</u> Fax # <u>630-783-9648</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>02/27/09</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>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 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>01/01/13</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 style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>David J. Mitchell</u> (Title) <u>CFO, BMA Management, LTD</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (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) _____ (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																											
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Facility Name Heritage Woods of Bolingbrook

Report 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	105	Single Unit Apartment	105	38,325	1
2		Double Unit Apartment			2
3		Other			3
4	105	TOTALS	105	38,325	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	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	33,045	5,140		38,185	5
6	Double Unit					6
7	Other					7
8	TOTALS	33,045	5,140		38,185	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.63%

D. Indicate the number of paid bed-hold days the SLF had during this year 515 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 58 (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: 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 Bolingbrook

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		184,426	1,777	186,203		186,203	1
2	Housekeeping, Laundry and Maintenance		27,421	63,267	90,688		90,688	2
3	Heat and Other Utilities			184,066	184,066	(28,335)	155,731	3
4	Other (specify):			9,731	9,731		9,731	4
5	TOTAL General Services		211,847	258,841	470,688	(28,335)	442,353	5
B. Health Care and Programs								
6	Health Care/ Personal Care		2,973		2,973		2,973	6
7	Activities and Social Services		6,325		6,325		6,325	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		9,298		9,298		9,298	9
C. General Administration								
10	Administrative and Clerical		14,097	259,253	273,350	(19,453)	253,897	10
11	Marketing Materials, Promotions and Advertising		8,315	44,645	52,960		52,960	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			16,635	16,635		16,635	13
14	Other (specify):			1,497,626	1,497,626		1,497,626	14
15	TOTAL General Administration		22,412	1,818,159	1,840,571	(19,453)	1,821,118	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		243,557	2,077,000	2,320,557	(47,788)	2,272,769	16
Capital Expenses								
D. Ownership								
17	Depreciation			554,074	554,074		554,074	17
18	Interest			816,554	816,554		816,554	18
19	Real Estate Taxes			94,217	94,217		94,217	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			500,889	500,889		500,889	22
23	TOTAL Ownership			1,965,734	1,965,734		1,965,734	23
24	GRAND TOTAL (Sum of lines 16 and 23)		243,557	4,042,734	4,286,291	(47,788)	4,238,503	24

Facility Name: Heritage Woods of Bolingbrook

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	\$ 32.83	1
2	Licensed Practical Nurses	1	21.57	2
3	Certified Nurse Assistants	15	10.83	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	15.40	5
6	Head Cook	1	24.39	6
7	Cook Helpers/Assistants	10	9.69	7
8	Dishwashers			8
9	Maintenance Workers	1	21.67	9
10	Housekeepers	3	9.30	10
11	Laundry			11
12	Managers	1	45.06	12
13	Other Administrative	3	15.36	13
14	Clerical			14
15	Marketing	1	23.34	15
16	Other			16
17	Total (lines 1 thru 16)	38	\$	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	\$ 191,688 1
2		
		Total
		\$ 191,688 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 Bolingbrook

Report Period Beginning:

01/01/13

Ending:

12/31/13

VIII. OWNERSHIP COSTS

A. Purchase price of land 815,542 Year land was acquired 2007

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	105			2009	\$ 12,529,068	\$ 455,604	28	\$ 455,602	\$ (2)	\$ 2,235,900	1
2											2
3											3
4											4
5											5
Improvement Type											
6	LAND IMPROVEMENTS				242,571	16,171	15	16,171		79,510	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)				\$ 12,771,639	\$ 471,775		\$ 471,774	\$ (2)	\$ 2,315,410	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	\$ 680,758	\$ 82,299	\$ 136,152	53,853	5	\$ 617,859	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 680,758	\$ 82,299	\$ 136,152	53,853		\$ 617,859	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 Bolingbrook

Report Period Beginning: 01/01/13

Ending: 12/31/13

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		AMALGAMATED BANK		X	FIRST MORTGAGE / BOND	12/1/07	\$ 11,900,000	\$ 11,550,000	12/1/42	0.0700	\$ 816,519	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 11,900,000	\$ 11,550,000			\$ 816,519	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 11,900,000	\$ 11,550,000			\$ 816,519	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 Bolingbrook

Report Period Beginning: 01/01/13

Ending:

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	\$ 222,850	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	458,432 (80,933)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	782		6
7	Other Prepaid Expenses	2,576		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 603,707	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	815,542		13
14	Buildings, at Historical Cost	12,529,069		14
15	Leasehold Improvements, at Historical Cost	242,571		15
16	Equipment, at Historical Cost	680,758		16
17	Accumulated Depreciation (book methods)	(2,933,269)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	544,440		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(84,726)		20
21	Restricted Funds	2,197,776		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,992,161	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,595,868	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,027	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	93,970		31
32	Accrued Interest Payable	67,374		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	601,918		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 814,289	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,550,000		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)	\$ 11,550,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 12,364,289	\$	45
46	TOTAL EQUITY	\$ 2,231,579	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 14,595,868	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Bolingbrook

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	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,627,551	1
2	Discounts and Allowances	3,268	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,630,819	3
B. Other Operating Revenue			
4	Special Services	192,468	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,416	8
9	Non-Resident Meals	4,149	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 205,033	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	20,453	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 20,453	14
D. Other Revenue (specify):			
15	Property Lease Income	3,600	15
16	Ins Adj/Bank Fees/Late Fees	5,541	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 9,141	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,865,445	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	470,688	19
20	Health Care/ Personal Care	9,298	20
21	General Administration	1,840,571	21
B. Capital Expense			
22	Ownership	1,965,734	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)	\$ 4,286,291	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (420,846)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (420,846)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	2,992
Rubbish Removal	1,885
Vehicle Expense	
Transportation Service	
Water Softener	
Misc Operating	4,854
Total	9,731

C. General Administration - Other

Consulting	27,830
Legal	1,339
Accounting	210
Audit	11,140
Contract labor-Serv Prov	1,390,072
Bad Debt	67,035
Contract labor	
Total	1,497,626

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	16,884
Incentive Manangement Fee	457,026
Tax Credit Fee & Incentive Fee	2,075

Amortization Expense	17,193
Remarketing and Trustee Fee	7,711
Property Damage Loss	
Gain on Sale	
Total	500,889

Reclassifications and Adjustments

Heat & Other Utilities (28,335) Cable

Administrative and Clerical (19,453) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	17,315
Accrued Asset Mgmt Fee	16,884
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	551,768
Unclaimed Property	699
Unearned Revenue	15,252
Accrued MIP	
Reservation Deposit	

Total Other Current Liabilities 601,918