

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>1000134</u></p> <p>Facility Name: <u>Heritage Woods of Charleston</u></p> <p>Address: <u>480 West Polk Avenue</u> <u>Charleston</u> <u>61920</u> <small>Number City Zip Code</small></p> <p>County: <u>Coles</u></p> <p>Telephone Number: <u>217-345-4900</u> Fax # <u>217-345-4904</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/27/11</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%;">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> <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) _____	(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																																												
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	(Telephone) () _____	Fax # () _____																																												

Facility Name Heritage Woods of Charleston

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	68	Single Unit Apartment	68	24,820	1
2		Double Unit Apartment			2
3		Other			3
4	68	TOTALS	68	24,820	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	14,068	8,792		22,860	5
6	Double Unit					6
7	Other					7
8	TOTALS	14,068	8,792		22,860	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.10%

D. Indicate the number of paid bed-hold days the SLF had during this year 107 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

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? 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 Charleston

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	184,793	127,286	1,652	313,731		313,731	1
2	Housekeeping, Laundry and Maintenance	65,016	19,191	30,592	114,799		114,799	2
3	Heat and Other Utilities			76,690	76,690	(14,409)	62,281	3
4	Other (specify):			10,968	10,968		10,968	4
5	TOTAL General Services	249,809	146,477	119,902	516,188	(14,409)	501,779	5
B. Health Care and Programs								
6	Health Care/ Personal Care	263,129	2,394		265,523		265,523	6
7	Activities and Social Services	25,110	3,529		28,639		28,639	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	288,239	5,923		294,162		294,162	9
C. General Administration								
10	Administrative and Clerical	102,661	8,659	226,518	337,838	(9,326)	328,512	10
11	Marketing Materials, Promotions and Advertising	35,493	6,222	35,994	77,709		77,709	11
12	Employee Benefits and Payroll Taxes			123,314	123,314		123,314	12
13	Insurance-Property, Liability and Malpractice			27,902	27,902		27,902	13
14	Other (specify):			45,028	45,028		45,028	14
15	TOTAL General Administration	138,154	14,881	458,756	611,791	(9,326)	602,465	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	676,202	167,281	578,658	1,422,141	(23,735)	1,398,406	16
Capital Expenses								
D. Ownership								
17	Depreciation			469,987	469,987		469,987	17
18	Interest			287,077	287,077		287,077	18
19	Real Estate Taxes			76,383	76,383		76,383	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			34,582	34,582		34,582	22
23	TOTAL Ownership			868,029	868,029		868,029	23
24	GRAND TOTAL (Sum of lines 16 and 23)	676,202	167,281	1,446,687	2,290,170	(23,735)	2,266,435	24

Facility Name: Heritage Woods of Charleston

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	\$ 25.37	1
2	Licensed Practical Nurses	1	17.41	2
3	Certified Nurse Assistants	9	9.62	3
4	Activity Director & Assistants	1	12.02	4
5	Social Service Workers			5
6	Head Cook	1	16.95	6
7	Cook Helpers/Assistants	8	9.26	7
8	Dishwashers			8
9	Maintenance Workers	1	16.48	9
10	Housekeepers	2	8.85	10
11	Laundry			11
12	Managers	1	27.55	12
13	Other Administrative	2	13.51	13
14	Clerical			14
15	Marketing	1	16.50	15
16	Other			16
17	Total (lines 1 thru 16)	27	\$	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	\$ 108,514	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 Charleston

Report Period Beginning:

01/01/13

Ending:

12/31/13

VIII. OWNERSHIP COSTS

A. Purchase price of land 35,000 Year land was acquired 2010

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			2011	\$ 8,926,302	\$ 324,560	28	\$ 324,593	\$ 33	\$ 716,781	1
2											2
3											3
4											4
5											5
Improvement Type											
6		LAND IMPROVEMENTS			73,127	4,875	15	4,875	0	10,563	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)				\$ 8,999,429	\$ 329,435		\$ 329,468	\$ 33	\$ 727,344	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	\$ 702,762	\$ 140,552	\$ 140,552	0	5	\$ 302,826	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 702,762	\$ 140,552	\$ 140,552	0		\$ 302,826	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 Charleston

Report Period Beginning: 01/01/13

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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

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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
A. Directly Facility Related											
Long-Term											
1	PEOPLES NATIONAL BANK		X	FIRST MORTGAGE	9/15/10	\$ 4,400,000	4,339,412	9/15/35	0.0650	287,077	1
2	IHDA		X	SECOND MORTGAGE	8/1/10	865,708	865,708	2/1/37	NONE		2
3											3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,265,708	\$ 5,205,120			\$ 287,077	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,265,708	\$ 5,205,120			\$ 287,077	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 Charleston

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	\$ 618,081	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	350,272 (37,557)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,336		6
7	Other Prepaid Expenses	9,101		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 963,233	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	8,926,302		14
15	Leasehold Improvements, at Historical Cost	73,127		15
16	Equipment, at Historical Cost	702,762		16
17	Accumulated Depreciation (book methods)	(1,030,170)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	519,743		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(58,026)		20
21	Restricted Funds	1,372,411		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,541,149	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,504,382	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 22,375	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,116		30
31	Accrued Taxes Payable	77,537		31
32	Accrued Interest Payable	12,531		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	358,468		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 513,027	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,205,120		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)	\$ 5,205,120	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,718,147	\$	45
46	TOTAL EQUITY	\$ 5,786,235	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,504,382	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Charleston

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	\$ 2,117,681	1
2	Discounts and Allowances	(15,926)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,101,756	3
B. Other Operating Revenue			
4	Special Services	91,193	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	9,248	8
9	Non-Resident Meals	6,580	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 107,021	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	6,507	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 6,507	14
D. Other Revenue (specify):			
15	Bank Fees/Ins Refund/Employee fund	395	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 395	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,215,678	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	516,188	19
20	Health Care/ Personal Care	294,162	20
21	General Administration	611,791	21
B. Capital Expense			
22	Ownership	868,029	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)	\$ 2,290,170	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (74,492)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (74,492)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,200
Rubbish Removal	3,193
Vehicle Expense	3,894
Transportation Service	
Water Softener	2,681
Misc Operating	
Total	10,968

C. General Administration - Other

Consulting	24,056
Legal	548
Accounting	
Audit	2,950
Contract labor-Serv Prov	1,200
Bad Debt	16,274
Contract labor	
Total	45,028

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	2,400

Amortization Expense	29,682
Remarketing and Trustee Fee	
Property Damage Loss	2,500
Gain on Sale	
Total	34,582

Reclassifications and Adjustments

Heat & Other Utilities (14,409) Cable

Administrative and Clerical (9,326) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	13,832
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Unclaimed Property	
Unearned Revenue	6,709
Accrued MIP	
Accrued Developer Fee	337,927
Reservation Deposit	
Total Other Current Liabilities	358,468