

		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>1000136</u></p> <p>Facility Name: <u>Heritage Woods of Plainfield</u></p> <hr/> <p>Address: <u>14731 S Van Dyke Rd</u> <u>Plainfield</u> <u>60544</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Will</u></p> <p>Telephone Number: <u>815-267-3800</u> Fax # <u>815-267-3900</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/21/11</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:</p> <p>Name: <u>Selena Edgington</u> Telephone Number: <u>815-935-1992 EXT 232</u></p> <p>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 align="center">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:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(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> </table> <table style="width:100%; border: none;"> <tr> <td style="width:20%; 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 style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></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 style="border: none;">(Telephone) () _____</td> <td style="border: none;">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 # () _____
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Facility Name Heritage Woods of Plainfield

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	108	Single Unit Apartment	108	39,420	1
2		Double Unit Apartment			2
3		Other			3
4	108	TOTALS	108	39,420	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	32,349	6,543		38,892	5
6	Double Unit					6
7	Other					7
8	TOTALS	32,349	6,543		38,892	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.66%

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

808 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? 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 Plainfield

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		194,194	2,222	196,416		196,416	1
2	Housekeeping, Laundry and Maintenance		19,793	55,170	74,963		74,963	2
3	Heat and Other Utilities			144,464	144,464	(28,806)	115,658	3
4	Other (specify):			7,450	7,450		7,450	4
5	TOTAL General Services		213,987	209,306	423,293	(28,806)	394,487	5
B. Health Care and Programs								
6	Health Care/ Personal Care		5,465		5,465		5,465	6
7	Activities and Social Services		5,285		5,285		5,285	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		10,750		10,750		10,750	9
C. General Administration								
10	Administrative and Clerical		15,549	245,451	261,000	(19,144)	241,856	10
11	Marketing Materials, Promotions and Advertising		6,444	38,067	44,511		44,511	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			18,847	18,847		18,847	13
14	Other (specify):			1,721,122	1,721,122		1,721,122	14
15	TOTAL General Administration		21,993	2,023,487	2,045,480	(19,144)	2,026,336	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		246,730	2,232,793	2,479,523	(47,950)	2,431,573	16
Capital Expenses								
D. Ownership								
17	Depreciation			510,463	510,463		510,463	17
18	Interest			650,714	650,714		650,714	18
19	Real Estate Taxes			86,000	86,000		86,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			95,966	95,966		95,966	22
23	TOTAL Ownership			1,343,143	1,343,143		1,343,143	23
24	GRAND TOTAL (Sum of lines 16 and 23)		246,730	3,575,936	3,822,666	(47,950)	3,774,716	24

Facility Name: Heritage Woods of Plainfield

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	\$ 31.37	1
2	Licensed Practical Nurses	1	14.73	2
3	Certified Nurse Assistants	16	11.70	3
4	Activity Director & Assistants	1	14.54	4
5	Social Service Workers			5
6	Head Cook	1	22.45	6
7	Cook Helpers/Assistants	10	9.55	7
8	Dishwashers			8
9	Maintenance Workers	1	18.3894	9
10	Housekeepers	3	8.91	10
11	Laundry			11
12	Managers	1	45.10	12
13	Other Administrative	3	14.96	13
14	Clerical			14
15	Marketing	1	26.15	15
16	Other			16
17	Total (lines 1 thru 16)	39	\$	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	\$ 193,393	1	
2			2	
		Total	\$ 193,393	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 Plainfield

Report Period Beginning:

01/01/13

Ending:

12/31/13

VIII. OWNERSHIP COSTS

A. Purchase price of land 847,138 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	108			2011	\$ 12,300,480	\$ 307,512	28	\$ 447,290	\$ 139,778	\$ 666,131	1
2											2
3											3
4											4
5											5
Improvement Type											
6	LAND IMPROVEMENTS				301,335	15,067	15	20,089	5,022	33,901	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)				\$ 12,601,815	\$ 322,579		\$ 467,379	\$ 144,800	\$ 700,032	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	\$ 808,763	\$ 187,884	\$ 53917.5	(133,966)	15	\$ 526,936	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 808,763	\$ 187,884	\$ 53,918	(133,966)		\$ 526,936	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 Plainfield

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	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	9/1/10	\$ 12,200,000	\$ 12,003,587	9/1/50	0.0540	\$ 650,714
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 12,200,000	\$ 12,003,587			\$ 650,714
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 12,200,000	\$ 12,003,587			\$ 650,714

* 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 Plainfield

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	\$ 790,333	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	770,299 (69,113)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,425		6
7	Other Prepaid Expenses	490		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,509,434	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	847,138		13
14	Buildings, at Historical Cost	12,300,480		14
15	Leasehold Improvements, at Historical Cost	301,335		15
16	Equipment, at Historical Cost	808,763		16
17	Accumulated Depreciation (book methods)	(1,226,968)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	867,894		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(55,165)		20
21	Restricted Funds	1,368,542		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,212,019	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,721,453	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 500,503	\$	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	86,000		31
32	Accrued Interest Payable	54,016		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	814,624		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,455,143	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	12,003,587		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)	\$ 12,003,587	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 13,458,730	\$	45
46	TOTAL EQUITY	\$ 3,262,723	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 16,721,453	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Plainfield

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.)

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 3,744,679	1
2	Discounts and Allowances	(47,241)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,697,439	3
	B. Other Operating Revenue		
4	Special Services	169,768	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	17,972	8
9	Non-Resident Meals	3,500	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 191,240	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	19,226	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19,226	14
	D. Other Revenue (specify):		
15	Property Tax Adjustments	84,448	15
16	Expense Refunds	11,391	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 95,838	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,003,743	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	423,293	19
20	Health Care/ Personal Care	10,750	20
21	General Administration	2,045,480	21
	B. Capital Expense		
22	Ownership	1,343,143	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)	\$ 3,822,666	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 181,077	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 181,077	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,748
Rubbish Removal	5,702
Vehicle Expense	
Transportation Service	
Water Softener	
Misc Operating	
Total	7,450

C. General Administration - Other

Consulting	20,408
Legal	4,209
Accounting	-
Audit	7,807
Contract labor-Serv Prov	1,638,730
Bad Debt	49,968
Contract labor	
Total	1,721,122

D. Ownership

Letter of Credit	3,660
Mortgage Insurance Premium	54,226
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	13,260
Incentive Manangement Fee	

Tax Credit Fee & Incentive Fee	
Amortization Expense	24,820
Remarketing and Trustee Fee	
Property Damage Loss	
Gain on Sale	
Total	95,966

Reclassifications and Adjustments

Heat & Other Utilities (28,806) Cable

Administrative and Clerical (19,144) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	20,886
Accrued Asset Mgmt Fee	26,135
Accrued Developer Fee	743,116
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Unclaimed Property	
Unearned Revenue	24,487
Accrued MIP	
Reservation Deposit	

Total Other Current Liabilities 814,624