

FOR BHF USE					

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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>1000015</u></p> <p>Facility Name: <u>Heritage Woods of Chicago</u></p> <p>Address: <u>2800 West Fulton</u> <u>Chicago</u> <u>60612</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>773-722-2900</u> Fax # <u>773-772-7662</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>08/14/02</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>01/01/11</u> to <u>12/31/11</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 Chicago

Report Period Beginning: 01/01/11 Ending: 12/31/11

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	110	Single Unit Apartment	110	40,150	1
2		Double Unit Apartment			2
3		Other			3
4	110	TOTALS	110	40,150	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	30,247	306		30,553	5
6	Double Unit					6
7	Other					7
8	TOTALS	30,247	306		30,553	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.10%

D. Indicate the number of paid bed-hold days the SLF had during this year 1,213 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 489 (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: 12/31/11 Fiscal Year: 12/31/11

* 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 Chicago

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	224,300	175,971	2,030	402,301		402,301	1
2	Housekeeping, Laundry and Maintenance	92,216	36,857	132,636	261,709		261,709	2
3	Heat and Other Utilities			165,033	165,033		165,033	3
4	Other (specify):			24,889	24,889		24,889	4
5	TOTAL General Services	316,516	212,828	324,588	853,932		853,932	5
B. Health Care and Programs								
6	Health Care/ Personal Care	354,909	2,685		357,594		357,594	6
7	Activities and Social Services	37,314	7,121		44,435		44,435	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	392,223	9,806		402,029		402,029	9
C. General Administration								
10	Administrative and Clerical	285,655	13,409	287,902	586,966		586,966	10
11	Marketing Materials, Promotions and Advertising	42,494	5,529	32,733	80,756		80,756	11
12	Employee Benefits and Payroll Taxes			189,537	189,537		189,537	12
13	Insurance-Property, Liability and Malpractice			45,703	45,703		45,703	13
14	Other (specify):			73,327	73,327		73,327	14
15	TOTAL General Administration	328,149	18,938	629,202	976,289		976,289	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,036,888	241,572	953,790	2,232,250		2,232,250	16
Capital Expenses								
D. Ownership								
17	Depreciation			306,906	306,906		306,906	17
18	Interest			17,283	17,283		17,283	18
19	Real Estate Taxes			55,230	55,230		55,230	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			68,906	68,906		68,906	22
23	TOTAL Ownership			448,325	448,325		448,325	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,036,888	241,572	1,402,115	2,680,575		2,680,575	24

Facility Name: Heritage Woods of Chicago

Report Period Beginning 01/01/11 Ending: 12/31/11

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	15.89	2
3	Certified Nurse Assistants	12	9.79	3
4	Activity Director & Assistants	1	16.81	4
5	Social Service Workers			5
6	Head Cook	1	25.84	6
7	Cook Helpers/Assistants	9	10.03	7
8	Dishwashers			8
9	Maintenance Workers	1	20.22	9
10	Housekeepers	2	8.90	10
11	Laundry			11
12	Managers	1	40.08	12
13	Other Administrative			13
14	Clerical	5	19.48	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	34	\$	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	\$ 184,675	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 Chicago

Report Period Beginning:

01/01/11

Ending:

12/31/11

VIII. OWNERSHIP COSTS

A. Purchase price of land 108,947 Year land was acquired 1999

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	110			2000	\$ 1,094,183	\$ 272,781	40	\$ 27,355	\$ (245,426)	\$ 2,525,801	1
2											2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 1,094,183	\$ 272,781		\$ 27,355	\$ (245,426)	\$ 2,525,801	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	\$ 458,086	\$ 33,468	\$ 91,617	58,149	5	\$ 408,760	18
19	Vehicles	4,800	657	960	303	5	3,815	19
20	TOTAL (lines 18 and 19)		\$ 462,886	\$ 34,125	\$ 92,577		\$ 412,575	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 Chicago

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	Harris Trust & Savings Bank		X	FIRST MORTGAGE	12/1/99	\$ 3,050,000	\$ 2,450,000	10/01/31/	VARIABLE	\$ 8,158	1
2	City of Chicago		X	SECOND MORTGAGE	12/1/99	2,011,977	2,011,977	12/1/34	NONE		2
3	City of Chicago		X	THIRD MORTGAGE	12/1/99	1,300,000	1,300,000	1/1/34	NONE		
4	Renaissance Social Services		X	FOURTH MORTGAGE	12/1/99	300,000	300,000	12/31/29	NONE		
5	IDHA		X	FIFTH MORTGAGE	11/1/01	875,000	772,403	10/1/31	0.0100	9,125	
6					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 7,536,977	\$ 6,834,380			\$ 17,283	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 7,536,977	\$ 6,834,380			\$ 17,283	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 Chicago

Report Period Beginning: 01/01/11

Ending:

12/31/11

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 445,933	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	640,022		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,236		6
7	Other Prepaid Expenses	37,631		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,135,822	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	108,947		13
14	Buildings, at Historical Cost	10,941,830		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	462,886		16
17	Accumulated Depreciation (book methods)	(2,938,376)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	361,248		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(138,849)		20
21	Restricted Funds	477,207		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,274,893	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,410,715	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,320	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,240,251		29
30	Accrued Salaries Payable	54,463		30
31	Accrued Taxes Payable	70,322		31
32	Accrued Interest Payable	5,821		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	297,303		35
36	Accrued Vacation & Sick Time	49,328		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,953,808	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,834,380		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)	\$ 6,834,380	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,788,188	\$	45
46	TOTAL EQUITY	\$ 622,527	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,410,715	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Chicago

Report Period Beginning: 01/01/11

Ending:

12/31/11

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	\$ 3,102,740	1
2	Discounts and Allowances	(179,661)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,923,079	3
B. Other Operating Revenue			
4	Special Services	130,222	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,035	8
9	Non-Resident Meals	1,121	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 132,378	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	980	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 980	14
D. Other Revenue (specify):			
15	Election Payment/Lease Income	13,750	15
16	Insurance Dividend	767	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 14,517	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,070,954	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	853,932	19
20	Health Care/ Personal Care	402,029	20
21	General Administration	976,289	21
B. Capital Expense			
22	Ownership	448,325	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)	\$ 2,680,575	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 390,379	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 390,379	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	4,120
Rubbish Removal	11,811
Vehicle Expense	4,516
Transportation Service	4,442
Water Softener	-
Misc Operating	-
Total	24,889

C. General Administration - Other

Consulting	3,149
Legal	16,604
Accounting	60
Audit	12,400
Contract labor	1,200
Bad Debt	39,914
Total	73,327

D. Ownership

Letter of Credit	35,799
Bond & Draw Fee	2,700
Mortgage Service Fee	-
Partnership Management Fee	10,000
Asset Management Fee	-
Incentive Manangement Fee	-
Tax Credit Fee & Incentive Fee	2,750
Amortization Expense	12,084
Remarketing and Trustee Fee	2,573
Property Damage Loss	3,000
Interest Income	
Total	68,906

Reclassifications and Adjustments

Heat & Other Utilities - Cable

Administrative and Clerical - Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	132,208
Accrued Asset Mgmt Fee	-
Accrued Partnership Fee	100,000
Accrued Incentive Mgmt Fee	
Accrued Developer Fee	55,815
Unclaimed Property	1,453
Unearned Revenue	7,827
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities	297,303