

		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>1000121</u></p> <p>Facility Name: <u>Heritage Woods of Dwight LLC</u></p> <p>Address: <u>701 East Mazon Avenue</u> <u>Dwight</u> <u>60420</u> <small>Number City Zip Code</small></p> <p>County: <u>Livingston</u></p> <p>Telephone Number: (<u>815</u>) <u>584-9280</u> Fax # (<u>815</u>) <u>584-9283</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/24/2009</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 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 checked="" 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</u>) <u>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 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>01/01/2011</u> to <u>12/31/2011</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 Dwight LLC

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	9,834	10,653		20,487	5
6	Double Unit					6
7	Other					7
8	TOTALS	9,834	10,653		20,487	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.54%

D. Indicate the number of paid bed-hold days the SLF had during this year 188 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 52 (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: 12/31/2011 Fiscal Year: 12/31/2011

* 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 Dwight LLC

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

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	141,699	92,920	1,756	236,375		236,375	1
2	Housekeeping, Laundry and Maintenance	60,398	10,039	32,432	102,869		102,869	2
3	Heat and Other Utilities			88,049	88,049	(13,352)	74,697	3
4	Other (specify):			12,661	12,661		12,661	4
5	TOTAL General Services	202,097	102,959	134,898	439,954	(13,352)	426,602	5
B. Health Care and Programs								
6	Health Care/ Personal Care	199,542	2,150		201,692		201,692	6
7	Activities and Social Services	21,932	3,149		25,081		25,081	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	221,474	5,299		226,773		226,773	9
C. General Administration								
10	Administrative and Clerical	71,732	9,955	189,360	271,047	(14,697)	256,350	10
11	Marketing Materials, Promotions and Advertising	30,634	4,270	29,274	64,178		64,178	11
12	Employee Benefits and Payroll Taxes			110,508	110,508		110,508	12
13	Insurance-Property, Liability and Malpractice			27,388	27,388		27,388	13
14	Other (specify):			78,080	78,080		78,080	14
15	TOTAL General Administration	102,366	14,225	434,610	551,201	(14,697)	536,504	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	525,937	122,483	569,508	1,217,928	(28,049)	1,189,879	16
Capital Expenses								
D. Ownership								
17	Depreciation			433,794	433,794		433,794	17
18	Interest			515,451	515,451		515,451	18
19	Real Estate Taxes			152,671	152,671		152,671	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			78,166	78,166		78,166	22
23	TOTAL Ownership			1,180,082	1,180,082		1,180,082	23
24	GRAND TOTAL (Sum of lines 16 and 23)	525,937	122,483	1,749,590	2,398,010	(28,049)	2,369,961	24

Facility Name: Heritage Woods of Dwight LLC

Report Period Beginning 01/01/2011 Ending: 12/31/2011

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.80	1
2	Licensed Practical Nurses		17.00	2
3	Certified Nurse Assistants	7	9.33	3
4	Activity Director & Assistants	1	10.49	4
5	Social Service Workers			5
6	Head Cook	1	13.76	6
7	Cook Helpers/Assistants	6	8.92	7
8	Dishwashers			8
9	Maintenance Workers	1	17.34	9
10	Housekeepers	1	8.82	10
11	Laundry			11
12	Managers	1	25.74	12
13	Other Administrative			13
14	Clerical	1	11.14	14
15	Marketing	1	15.18	15
16	Other			16
17	Total (lines 1 thru 16)	21	\$	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	\$ 100,333	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 Dwight LLC

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land 25,000 Year land was acquired 06/30/2008

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			2009	\$ 6,307,787	\$ 229,351	28	\$ 225,278	\$ (4,073)	\$ 582,077	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvement			454,341	19,423	15	30,289	10,866	279,534	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)				\$ 6,762,128	\$ 248,774		\$ 255,568	\$ 6,794	\$ 861,611	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	\$ 1,852,168	\$ 185,020	\$ 370,434	185,414	5	\$ 1,574,639	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,852,168	\$ 185,020	\$ 370,434	185,414		\$ 1,574,639	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 Dwight LLC

Report Period Beginning: 01/01/2011

Ending: 2/31/2011

IX. RENTAL COSTS**A. Building and Fixed Equipment**1. Name of Party Holding Lease: N/A2. 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		
	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	Midland States Bank		X	First Mortgage	12/31/11	\$ 7,288,000	\$ 7,186,312	2/1/15	0.0690	\$ 509,637
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	Country Bank		X	Line of Credit	6/11/10	300,000	300,000	6/11/11	0.0575	5,814
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 7,588,000	\$ 7,486,312			\$ 515,451
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 7,588,000	\$ 7,486,312			\$ 515,451

* 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 Dwight LLC

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 191,155	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 88,097)	267,251		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,340		6
7	Other Prepaid Expenses	1,948		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 470,693	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	749,882		13
14	Buildings, at Historical Cost	6,307,787		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,852,168		16
17	Accumulated Depreciation (book methods)	(2,436,250)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	133,650		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(133,650)		20
21	Restricted Funds	9,540		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	1		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,483,128	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,953,821	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 25,373	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,785		30
31	Accrued Taxes Payable	88,764		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	SEE ATTACHMENT PG 7	310,351		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 454,273	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,186,312		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)	\$ 7,186,312	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,640,585	\$	45
46	TOTAL EQUITY	\$ (686,763)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,953,821	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Dwight LLC

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	\$ 2,059,915	1
2	Discounts and Allowances	(77,147)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,982,768	3
B. Other Operating Revenue			
4	Special Services	52,099	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	19,230	8
9	Non-Resident Meals	6,869	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 78,198	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	Deposit Fee	100	15
16	Vending	225	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 325	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,061,291	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	439,954	19
20	Health Care/ Personal Care	226,773	20
21	General Administration	551,201	21
B. Capital Expense			
22	Ownership	1,180,082	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)	\$ 2,398,010	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (336,719)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (336,719)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,425
Rubbish Removal	4,940
Vehicle Expense	1,645
Transportation Service	25
Water Softener	4,626
Misc Operating	
Total	12,661

C. General Administration - Other

Consulting	
Legal	822
Accounting	60
Audit	4,930
Contract labor	1,200
Bad Debt	71,068
Total	78,080

D. Ownership

Financing Fees	72,880
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	
Amortization Expense	5,286
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	78,166

Reclassifications and Adjustments

Heat & Other Utilities (13,352) Cable

Administrative and Clerical (14,697) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	7,230
Reservation Deposit	600
Unearned Revenue	2,521
Line of Credit	<u>300,000</u>

Total Other Current Liabilities 310,351