

		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>1000085</u></p> <p>Facility Name: <u>Heritage Woods of Rockford</u></p> <p>Address: <u>202 N. Showplace</u> <u>Rockford</u> <u>61107</u> <small>Number City Zip Code</small></p> <p>County: <u>Winnabago</u></p> <p>Telephone Number: <u>815-332-5777</u> Fax # <u>815-332-3407</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>09/03/08</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 # () _____
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	(Telephone) () _____	Fax # () _____																																												

Facility Name Heritage Woods of Rockford

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	99	Single Unit Apartment	99	36,135	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,135	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	25,760	9,527		35,287	5
6	Double Unit					6
7	Other					7
8	TOTALS	25,760	9,527		35,287	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.65%

D. Indicate the number of paid bed-hold days the SLF had during this year 408 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 82 (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 Rockford

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		178,724	1,714	180,438		180,438	1
2	Housekeeping, Laundry and Maintenance			62,565	62,565		62,565	2
3	Heat and Other Utilities			151,194	151,194	(26,091)	125,103	3
4	Other (specify):			17,615	17,615		17,615	4
5	TOTAL General Services		178,724	233,088	411,812	(26,091)	385,721	5
B. Health Care and Programs								
6	Health Care/ Personal Care		2,495		2,495		2,495	6
7	Activities and Social Services		9,370		9,370		9,370	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		11,865		11,865		11,865	9
C. General Administration								
10	Administrative and Clerical		12,507	222,929	235,436	(21,794)	213,642	10
11	Marketing Materials, Promotions and Advertising		8,984	24,331	33,315		33,315	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			18,640	18,640		18,640	13
14	Other (specify):			1,699,911	1,699,911		1,699,911	14
15	TOTAL General Administration		21,491	1,965,811	1,987,302	(21,794)	1,965,508	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		212,080	2,198,899	2,410,979	(47,885)	2,363,094	16
Capital Expenses								
D. Ownership								
17	Depreciation			527,410	527,410		527,410	17
18	Interest			422,640	422,640		422,640	18
19	Real Estate Taxes			97,756	97,756		97,756	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			73,308	73,308		73,308	22
23	TOTAL Ownership			1,121,114	1,121,114		1,121,114	23
24	GRAND TOTAL (Sum of lines 16 and 23)		212,080	3,320,013	3,532,093	(47,885)	3,484,208	24

Facility Name: Heritage Woods of Rockford

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	\$ 30.04	1
2	Licensed Practical Nurses	1	20.55	2
3	Certified Nurse Assistants	16	9.57	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.14	5
6	Head Cook	1	17.00	6
7	Cook Helpers/Assistants	10	8.93	7
8	Dishwashers			8
9	Maintenance Workers	1	18.70	9
10	Housekeepers	3	8.52	10
11	Laundry			11
12	Managers	1	38.03	12
13	Other Administrative	3	15.42	13
14	Clerical			14
15	Marketing	1	29.77	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	\$ 137,119	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 Rockford

Report Period Beginning:

01/01/11

Ending:

12/31/11

VIII. OWNERSHIP COSTS

A. Purchase price of land 416,192 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	99			2007	\$ 9,896,859	\$ 359,952	28	\$ 353,459	\$ (6,493)	\$ 1,511,891	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			662,486	47,699	15	44,166	(3,533)	233,328	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)				\$ 10,559,345	\$ 407,651		\$ 397,625	\$ (10,026)	\$ 1,745,219	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	\$ 620,675	\$ 119,759	\$ 23,952	(95,807)	5	\$ 521,553	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 620,675	\$ 119,759	\$ 23,952	(95,807)		\$ 521,553	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 Rockford

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	\$ 308,168	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	907,953		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,788		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Utility Security Deposit</u>	157		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,231,066	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,078,678		13
14	Buildings, at Historical Cost	9,896,859		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	620,675		16
17	Accumulated Depreciation (book methods)	(2,266,700)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	367,185		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(58,455)		20
21	Restricted Funds	1,677,240		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,315,482	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,546,548	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 748,877	\$	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	97,804		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>See Page 7 Attachment</u>	102,836		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 949,517	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,317,941		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)	\$ 9,317,941	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 10,267,458	\$	45
46	TOTAL EQUITY	\$ 2,279,090	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 12,546,548	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Rockford

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	\$ 3,394,208	1
2	Discounts and Allowances	(91,348)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,302,860	3
B. Other Operating Revenue			
4	Special Services	123,602	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	39,367	8
9	Non-Resident Meals	8,950	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 171,919	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	4,719	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,719	14
D. Other Revenue (specify):			
15	Insurance Adjustments	5,297	15
16	Deposit Revenue/AP Credits	543	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 5,840	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,485,338	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	411,812	19
20	Health Care/ Personal Care	11,865	20
21	General Administration	1,987,302	21
B. Capital Expense			
22	Ownership	1,121,114	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)	\$ 3,532,093	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (46,755)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (46,755)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	2,286
Rubbish Removal	6,962
Vehicle Expense	-
Transportation Service	-
Water Softener	8,367
Misc Operating	-
Total	17,615

C. General Administration - Other

Consulting	82,348
Legal	2,823
Accounting	50
Audit	12,335
Contract labor	1,553,152
Bad Debt	49,203
Total	1,699,911

D. Ownership

Assessment Income	-
Letter of Credit	
Mortgage Insurance Premium	37,581
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	20,000
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	1,975
Amortization Expense	13,752
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	73,308

Reclassifications and Adjustments

Heat & Other Utilities (26,091) Cable

Administrative and Clerical (21,794) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	19,523
Accrued Asset Mgmt Fee	20,000
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Unclaimed Property	24,066
Unearned Revenue	39,247
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities	102,836