

		FOR BHF USE			

LL2

Supportive Living Facility

2012

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2012)

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.

I. Facility ID Number: 1000038

Facility Name: Heritage Woods of Watseka

Address: 577 East Martin Avenue Watsaka 60970

Number City Zip Code

County: Iroquois

Telephone Number: 815-432-4560 Fax # 815-432-4562

Federal Employer ID Number: _____

Date Current Owners were Certified: 10/25/07

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☐ Charitable Corp.

☐ Trust

IRS Exemption Code _____

☐ PROPRIETARY

☐ Individual

☐ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☒ Limited Liability Co.

☐ Trust

☐ Other _____

☐ GOVERNMENTAL

☐ State

☐ County

☐ Other _____

In the event there are further questions about this report, please contact:

Name: Selena Edgington Telephone Number: 815-935-1992 EXT 232

Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ 4/29/2013
(Date)

(Type or Print Name) David J. Mitchell

(Title) CFO, BMA Management, LTD.

Paid
Preparer

(Signed) _____
(Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () Fax # ()

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

Facility Name Heritage Woods of Watseka Report Period Beginning: 01/01/12 Ending: 12/31/12

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	65	Single Unit Apartment	65	23,790	1
2		Double Unit Apartment			2
3		Other			3
4	65	TOTALS	65	23,790	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	7,758	15,752		23,510	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,758	15,752		23,510	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.82%

D. Indicate the number of paid bed-hold days the SLF had during this year 230 Also, indicate the number of unpaid bed-hold days the SLF had during this year. (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: 2012 Fiscal Year: 2012

* 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.

STATE OF ILLINOIS

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Facility Name: Heritage Woods of Watseka

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	175,544	120,584	2,021	298,149		298,149	1
2	Housekeeping, Laundry and Maintenance	58,856	12,165	28,419	99,440		99,440	2
3	Heat and Other Utilities			98,257	98,257	(15,549)	82,708	3
4	Other (specify):			8,121	8,121		8,121	4
5	TOTAL General Services	234,400	132,749	136,818	503,967	(15,549)	488,418	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	275,417	1,525		276,942		276,942	6
7	Activities and Social Services	26,169	4,159		30,328		30,328	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	301,586	5,684		307,270		307,270	9
	C. General Administration							
10	Administrative and Clerical	75,409	9,710	659,747	744,866	(13,758)	731,108	10
11	Marketing Materials, Promotions and Advertising	28,735	2,090	23,008	53,833		53,833	11
12	Employee Benefits and Payroll Taxes			178,649	178,649		178,649	12
13	Insurance-Property, Liability and Malpractice			12,578	12,578		12,578	13
14	Other (specify):			8,066	8,066		8,066	14
15	TOTAL General Administration	104,144	11,800	882,048	997,992	(13,758)	984,234	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	640,130	150,233	1,018,866	1,809,229	(29,307)	1,779,922	16
	Capital Expenses							
	D. Ownership							
17	Depreciation							17
18	Interest			6,947	6,947		6,947	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			560	560		560	22
23	TOTAL Ownership			7,507	7,507		7,507	23
24	GRAND TOTAL (Sum of lines 16 and 23)	640,130	150,233	1,026,373	1,816,736	(29,307)	1,787,429	24

Facility Name: Heritage Woods of Watseka

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$ 21.30	1
2	Licensed Practical Nurses	1	20.40	2
3	Certified Nurse Assistants	10	9.85	3
4	Activity Director & Assistants	1	12.56	4
5	Social Service Workers			5
6	Head Cook	1	13.02	6
7	Cook Helpers/Assistants	8	9.28	7
8	Dishwashers			8
9	Maintenance Workers	1	12.32	9
10	Housekeepers	2	8.95	10
11	Laundry			11
12	Managers	1	24.08	12
13	Other Administrative			13
14	Clerical	1	13.39	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	26	\$	17

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
DSI FLORA OPERATOR		FLORA	
DSI OTTAWA OPERATOR		OTTAWA	
DSI MANTENO OPERATOR		MANTENO	

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).

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	\$ 96,311	1
2			2
Total		\$ 96,311	3

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VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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					\$	\$		\$	\$	\$	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)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: DSI Watseka Owner LLC

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	2004	65	10/24/07	\$ 503,548	30		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		65		\$ 503,548			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					/ /	\$		/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	PEOPLES BANK		X	LINE OF CREDIT	11/28/12	400,000	22,901	11/26/13	VARIABLE	6,947	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 400,000	\$ 22,901			\$ 6,947	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 400,000	\$ 22,901			\$ 6,947	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,665	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	219,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,835		6
7	Other Prepaid Expenses	7,489		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 252,600	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 252,600	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,219	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,328		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See Page 7 Attachment	64,308		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 181,855	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 181,855	\$	45
46	TOTAL EQUITY	\$ 70,745	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 252,600	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Watseka

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12/31/12

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	\$ 2,031,875	1
2	Discounts and Allowances	(1,710)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,030,165	3
	B. Other Operating Revenue		
4	Special Services	84,393	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,655	8
9	Non-Resident Meals	5,241	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 100,289	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	8,275	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8,275	14
	D. Other Revenue (specify):		
15	Contract Services	15,023	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 15,023	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,153,752	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	503,967	19
20	Health Care/ Personal Care	307,270	20
21	General Administration	997,992	21
	B. Capital Expense		
22	Ownership	7,507	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)	\$ 1,816,736	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 337,016	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 337,016	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	855
Rubbish Removal	3,849
Vehicle Expense	2,628
Transportation Service	
Water Softener	789
Misc Operating	
Total	8,121

C. General Administration - Other

Consulting	752
Legal	327
Accounting	90
Audit	5,020
Contract labor	1,200
Bad Debt	677
Total	8,066

D. Ownership

Letter of Credit	560
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	
Amortization Expense	

Remarketing and Trustee Fee
Property Damage Loss
Interest Income

Total	560
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Reclassifications and Adjustments

Heat & Other Utilities	(15,549) Cable
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Administrative and Clerical	(13,758) Telephone Revenue
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BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	11,093
Line of Credit	22,901
Security Deposits	12,685
Accrued Incentive Mgmt Fee	
Unclaimed Property	3,858
Unearned Revenue	9,571
Accrued Developer Fee	
Reservation Deposit	4,200

Total Other Current Liabilities 64,308