

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2010  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2010)**

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:** 1000007

**Facility Name:** Heritage Woods of Ottawa

**Address:** 801 East Etna Road Ottawa 61350  
Number City Zip Code

**County:** LaSalle

**Telephone Number:** 815-431-1400 Fax # 815-431-9147

**Federal Employer ID Number:** \_\_\_\_\_

**Date Current Owners were Certified:** 10-25-07

**Type of Ownership:**

<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 _____	

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>David J. Mitchell</u>	
	(Title) <u>CFO, BMA Management, LTD.</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> _____ Fax # <u>( )</u> _____	

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

**Name:** Selena Edgington **Telephone Number:** 815-935-1992 EXT 232  
**Email Address:** \_\_\_\_\_

**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 Ottawa

Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	76	Single Unit Apartment	76	27,740	1
2	8	Double Unit Apartment	8	2,920	2
3		Other			3
4	84	TOTALS	84	30,660	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	13,614	16,639		30,253	5
6	Double Unit					6
7	Other					7
8	TOTALS	13,614	16,639		30,253	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.67%

**D. Indicate the number of paid bed-hold days the SLF had during this year**  
134 Also, indicate the number of unpaid bed-hold days the SLF had during this year. zero **(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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

\* 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 Ottawa

Report Period Beginning:

01/01/10

Ending:

12/31/10

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	197,846	148,928	1,772	348,546		348,546	1
2	Housekeeping, Laundry and Maintenance	84,268	17,484	63,156	164,908		164,908	2
3	Heat and Other Utilities			151,397	151,397	(15,776)	135,621	3
4	Other (specify):			7,186	7,186		7,186	4
5	<b>TOTAL General Services</b>	<b>282,114</b>	<b>166,412</b>	<b>223,511</b>	<b>672,037</b>	<b>(15,776)</b>	<b>656,261</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	368,665	2,797		371,462		371,462	6
7	Activities and Social Services	22,402	2,903		25,305		25,305	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>391,067</b>	<b>5,700</b>		<b>396,767</b>		<b>396,767</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	98,751	11,683	895,487	1,005,921	(23,676)	982,245	10
11	Marketing Materials, Promotions and Advertising	37,829	2,692	30,058	70,579		70,579	11
12	Employee Benefits and Payroll Taxes			195,586	195,586		195,586	12
13	Insurance-Property, Liability and Malpractice			10,446	10,446		10,446	13
14	Other (specify):			6,588	6,588		6,588	14
15	<b>TOTAL General Administration</b>	<b>136,580</b>	<b>14,375</b>	<b>1,138,165</b>	<b>1,289,120</b>	<b>(23,676)</b>	<b>1,265,444</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>809,761</b>	<b>186,487</b>	<b>1,361,676</b>	<b>2,357,924</b>	<b>(39,452)</b>	<b>2,318,472</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation							17
18	Interest			2,512	2,512		2,512	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			2,860	2,860		2,860	22
23	<b>TOTAL Ownership</b>			<b>5,372</b>	<b>5,372</b>		<b>5,372</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>809,761</b>	<b>186,487</b>	<b>1,367,048</b>	<b>2,363,296</b>	<b>(39,452)</b>	<b>2,323,844</b>	<b>24</b>

Facility Name: Heritage Woods of Ottawa

Report Period Beginning: 01/01/10

Ending:

12/31/10

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.84	1
2	Licensed Practical Nurses	1	17.73	2
3	Certified Nurse Assistants	14	9.97	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	17.88	6
7	Cook Helpers/Assistants	8	9.09	7
8	Dishwashers			8
9	Maintenance Workers	1	15.93	9
10	Housekeepers	3	8.59	10
11	Laundry			11
12	Managers	1	27.24	12
13	Other Administrative			13
14	Clerical			14
15	Marketing	1	18.27	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>32</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

Amount of Fee

		Amount of Fee	
1	BMA Management, LTD	\$ 134,115	1
2			2
<b>Total</b>		<b>\$ 134,115</b>	<b>3</b>

**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 LLC		Flora	
DSI Manteno Operator LLC		Manteno	
DSI Watseka Operator LLC		Witseka	

**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).

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VIII. OWNERSHIP COSTS

N/A - Leased

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
<b>Improvement Type</b>											
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 Ottawa 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	1999	84	10/24/07	\$ 677,675	30		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>		84		\$ 677,675			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	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
<b>Working Capital</b>											
4	COUNTRY BANK		X	LINE OF CREDIT	11/1/10	372,000	114,693	10/31/11	VARIABLE	2,512	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 372,000	\$ 114,693			\$ 2,512	7
<b>B. Non-Facility Related</b>											
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 372,000	\$ 114,693			\$ 2,512	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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Report Period Beginning: 01/01/10

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 26,903	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	186,651		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,799		6
7	Other Prepaid Expenses	7,150		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 234,503	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 234,503	\$	25

\*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 34,101	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	114,693		29
30	Accrued Salaries Payable	38,356		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Page 7 Attachment	43,217		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 230,367	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 230,367	\$	45
46	<b>TOTAL EQUITY</b>	\$ 4,136	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 234,503	\$	47

Facility Name: Heritage Woods of Ottawa

Report Period Beginning: 01/01/10

Ending:

12/31/10

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,885,487	1
2	Discounts and Allowances	(2,029)	2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 2,883,458	3
<b>B. Other Operating Revenue</b>			
4	Special Services	89,389	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	28,107	8
9	Non-Resident Meals	1,899	9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 119,395	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	198	13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$ 198	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 3,003,051	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	672,037	19
20	Health Care/ Personal Care	396,767	20
21	General Administration	1,289,120	21
<b>B. Capital Expense</b>			
22	Ownership	5,372	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 2,363,296	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ 639,755	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ 639,755	31

**COST CENTER EXPENSES**

A. General Services - Other

Exterminating	1,080
Rubbish Removal	5,070
Vehicle Expense	68
Transportation Service	62
Water Softener	906
Misc Operating	-
Total	<b>7,186</b>

C. General Administration - Other

Consulting	408
Legal	-
Accounting	-
Audit	3,349
Contract labor	1,000
Bad Debt	1,831
Total	<b>6,588</b>

D. Ownership

Assessment Income	-
Letter of Credit	1,860
Mortgage Insurance Premium	-
Partnership Management Fee	-
Asset Management Fee	-
Incentive Manangement Fee	-
Tax Credit Fee & Incentive Fee	-
Amortization Expense	-
Remarketing and Trustee Fee	-
Property Damage Loss	1,000
Interest Income	-
Total	<b>2,860</b>

Reclassifications and Adjustments

Heat & Other Utilities (15,776) Cable

Administrative and Clerical (23,676) Telephone Revenue

**BALANCE SHEET**

C. Current Liabilities

Accrued Liabilities	20,464
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Security Deposits	20,805
Unearned Revenue	148
Accrued MIP	
Reservation Deposit	1,800
<b>Total Other Current Liabilities</b>	<b>43,217</b>