

		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>1000038</u></p> <p>Facility Name: <u>DSI Watseka Operator LLC</u></p> <p>Address: <u>577 E. Martin Ave.</u> <u>Watseka</u> <u>60970</u> <small>Number City Zip Code</small></p> <p>County: <u>Iroquois</u></p> <p>Telephone Number: <u>815-432-4560</u> Fax # <u>815-432-4562</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10/25/07</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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 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>01/01/11</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%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>David J. Mitchell</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>CFO, BMA Management, LTD.</u></td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) () _____ 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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	(Firm Name & Address) _____																																						
	(Telephone) () _____ Fax # () _____																																						

Facility Name: DSI Watseka Operator LLC

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	173,175	125,756	1,756	300,687		300,687	1
2	Housekeeping, Laundry and Maintenance	57,675	12,104	20,368	90,147		90,147	2
3	Heat and Other Utilities			113,836	113,836	(13,740)	100,096	3
4	Other (specify):			8,612	8,612		8,612	4
5	TOTAL General Services	230,850	137,860	144,572	513,282	(13,740)	499,542	5
B. Health Care and Programs								
6	Health Care/ Personal Care	276,020	818		276,838		276,838	6
7	Activities and Social Services	25,917	2,910		28,827		28,827	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	301,937	3,728		305,665		305,665	9
C. General Administration								
10	Administrative and Clerical	77,632	9,193	661,839	748,664	(13,670)	734,994	10
11	Marketing Materials, Promotions and Advertising	27,946	2,550	28,393	58,889		58,889	11
12	Employee Benefits and Payroll Taxes			161,978	161,978		161,978	12
13	Insurance-Property, Liability and Malpractice			5,208	5,208		5,208	13
14	Other (specify):			11,312	11,312		11,312	14
15	TOTAL General Administration	105,578	11,743	868,730	986,051	(13,670)	972,381	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	638,365	153,331	1,013,302	1,804,998	(27,410)	1,777,588	16
Capital Expenses								
D. Ownership								
17	Depreciation							17
18	Interest			1,694	1,694		1,694	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			3,302	3,302		3,302	22
23	TOTAL Ownership			4,996	4,996		4,996	23
24	GRAND TOTAL (Sum of lines 16 and 23)	638,365	153,331	1,018,298	1,809,994	(27,410)	1,782,584	24

Facility Name: DSI Watseka Operator LLC

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	\$ 21.68	1
2	Licensed Practical Nurses	1	21.61	2
3	Certified Nurse Assistants	10	9.63	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.41	5
6	Head Cook	2	12.26	6
7	Cook Helpers/Assistants	7	8.93	7
8	Dishwashers			8
9	Maintenance Workers	1	12.12	9
10	Housekeepers	2	8.73	10
11	Laundry			11
12	Managers	1	24.73	12
13	Other Administrative	1	12.99	13
14	Clerical			14
15	Marketing	1	24.09	15
16	Other			16
17	Total (lines 1 thru 16)	27	\$	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	\$ 92,463	1
2			2
Total		\$ 92,463	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
DSI Flora Operator LLC		Flora	
DSI Ottawa Operator LLC		Ottawa	
DSI Manteno Operator LLC		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).

Facility Name: DSI Watseka Operator LLC

Report Period Beginning:

01/01/11

Ending:

12/31/11

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
	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

Facility Name: DSI Watseka Operator LLC

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building	2004	65	10/24/07	\$ 519,084	30		3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		65		\$ 519,084			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 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1					/ /	\$		/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	COUNTRY BANK		X	LINE OF CREDIT	11/1/10	322,000	244,559	10/31/11	VARIABLE	1,694	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 322,000	\$ 244,559			\$ 1,694	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 322,000	\$ 244,559			\$ 1,694	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: DSI Watseka Operator LLC

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	\$ 52,417	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	314,351		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,036		6
7	Other Prepaid Expenses	3,905		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 376,709	\$	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)	\$ 376,709	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,685	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	244,559		29
30	Accrued Salaries Payable	31,562		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	39,918		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 371,724	\$	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)	\$ 371,724	\$	45
46	TOTAL EQUITY	\$ 4,985	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 376,709	\$	47

*(See instructions.)

Facility Name: DSI Watseka Operator LLC

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	\$ 1,978,230	1
2	Discounts and Allowances	(8,503)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,969,727	3
B. Other Operating Revenue			
4	Special Services	81,221	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,252	8
9	Non-Resident Meals	3,378	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 94,851	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	101	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 101	14
D. Other Revenue (specify):			
15	Contract Services	9,926	15
16	Insurance Adjustment	3,023	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 12,949	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,077,628	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	513,282	19
20	Health Care/ Personal Care	305,665	20
21	General Administration	986,051	21
B. Capital Expense			
22	Ownership	4,996	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)	\$ 1,809,994	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 267,634	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 267,634	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	950
Rubbish Removal	3,878
Vehicle Expense	2,902
Transportation Service	-
Water Softener	882
Misc Operating	-
Total	8,612

C. General Administration - Other

Consulting	253
Legal	90
Accounting	50
Audit	3,925
Contract labor	1,200
Bad Debt	5,794
Total	11,312

D. Ownership

Letter of Credit	802
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	2,500
Interest Income	
Total	3,302

Reclassifications and Adjustments

Heat & Other Utilities (13,740) Cable

Administrative and Clerical (13,670) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	12,868
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Incentive Mgmt Fee	
Security Deposits	15,820
Unclaimed Property	3,858
Unearned Revenue	2,172
Accrued MIP	
Reservation Deposit	5,200
Total Other Current Liabilities	39,918