

		FOR BHF USE			

LL2

Supportive Living Facility
2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)

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.</p> <p>Facility Name: <u>Eagle Ridge of Decatur</u></p> <p>Address: <u>875 W. McKinley</u> <u>Decatur</u> <u>62523</u> Number City Zip Code</p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>217-872-1282</u> Fax # <u>217-872-1227</u></p> <p>Federal Employer ID Number: <u>37-1407002</u></p> <p>Date Current Owners were Certified: <u>06/23/03</u></p> <p>Type of Ownership:</p> <table border="0"> <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>David Mitchell</u> Telephone Number: <u>815-935-1992</u></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>01/01/05</u> to <u>12/31/05</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 border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <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 rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table> <p align="center">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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Facility Name Eagle Ridge of Decatur

Report Period Beginning: 01/01/05 Ending: 12/31/05

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		Double Unit Apartment			2
3		Other			3
4	76	TOTALS	76	27,740	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	18,721	8,810		27,531	5
6	Double Unit					6
7	Other					7
8	TOTALS	18,721	8,810		27,531	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.25%

D. Indicate the number of paid bed-hold days the SLF had during this year 457 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)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* 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. _____

STATE OF ILLINOIS

Page 3

Facility Name: Eagle Ridge of Decatur

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	179,188	143,635	1,271	324,094		324,094	1
2	Housekeeping, Laundry and Maintenance	59,071	36,465		95,536		95,536	2
3	Heat and Other Utilities			93,769	93,769	(13,824)	79,945	3
4	Other (specify):			15,907	15,907		15,907	4
5	TOTAL General Services	238,259	180,100	110,947	529,306	(13,824)	515,482	5
B. Health Care and Programs								
6	Health Care/ Personal Care	312,449	3,795		316,244		316,244	6
7	Activities and Social Services	24,913	4,661		29,574		29,574	7
8	Other (specify):			8,829	8,829	(8,829)		8
9	TOTAL Health Care and Programs	337,362	8,456	8,829	354,647	(8,829)	345,818	9
C. General Administration								
10	Administrative and Clerical	88,280	11,771	148,755	248,806	(12,493)	236,313	10
11	Marketing Materials, Promotions and Advertising	38,627	8,565	16,936	64,128		64,128	11
12	Employee Benefits and Payroll Taxes			137,141	137,141		137,141	12
13	Insurance-Property, Liability and Malpractice			35,577	35,577		35,577	13
14	Other (specify):							14
15	TOTAL General Administration	126,907	20,336	338,409	485,652	(12,493)	473,159	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	702,528	208,892	458,185	1,369,605	(35,146)	1,334,459	16
Capital Expenses								
D. Ownership								
17	Depreciation			348,054	348,054		348,054	17
18	Interest			302,610	302,610		302,610	18
19	Real Estate Taxes			18,092	18,092		18,092	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			434,103	434,103		434,103	22
23	TOTAL Ownership			1,102,859	1,102,859		1,102,859	23
24	GRAND TOTAL (Sum of lines 16 and 23)	702,528	208,892	1,561,044	2,472,464	(35,146)	2,437,318	24

Facility Name: Eagle Ridge of Decatur

Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 19.31	1
2	Licensed Practical Nurses	1	14.51	2
3	Certified Nurse Assistants	12	9.02	3
4	Activity Director & Assistants	1	11.95	4
5	Social Service Workers			5
6	Head Cook	1	14.90	6
7	Cook Helpers/Assistants	9	8.16	7
8	Dishwashers			8
9	Maintenance Workers	1	13.90	9
10	Housekeepers	2	7.48	10
11	Laundry			11
12	Managers	1	26.13	12
13	Other Administrative	2	11.29	13
14	Clerical			14
15	Marketing	1	17.08	15
16	Other			16
17	Total (lines 1 thru 16)	32	\$	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	None			\$	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	\$ 102,411 1
2		
Total		\$ 102,411 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: Eagle Ridge of Decatur

Report Period Beginning:

01/01/05

Ending:

12/31/05

VIII. OWNERSHIP COSTS

A. Purchase price of land 231,886 Year land was acquired 2001

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	76			2003	\$ 5,980,619	\$ 217,455	28	\$ 217,455	\$	\$ 552,728	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			351,206	23,425	15	23,425		58,545	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)				\$ 6,331,825	\$ 240,880		\$ 240,880	\$	\$ 611,273	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	\$ 484,846	\$ 80,897	\$ 80,897	\$	5	\$ 345,210	18
19	Vehicles	40,644	20,322	20,322		5	20,322	19
20	TOTAL (lines 18 and 19)		\$ 525,490	\$ 101,219	\$ 101,219		\$ 365,532	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: Eagle Ridge of Decatur

Report Period Beginning: 1/1/2005

Ending: 12/31/ 12/31/2005

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: NO LEASE - PARTNERSHIP OWNS BUILDING & FIXED EQUIPMENT

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		/ /	\$			3
4	Additions		/ /				4
5			/ /				5
6			/ /				6
7	TOTAL			\$			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					
		YES	NO			Original	Balance				
A. Directly Facility Related											
Long-Term											
1	IHDA		X	MORTGAGE - LOAN	11/2/02	\$ 5,041,000	\$ 4,985,668	2/1/44	0.0605	\$ 302,546	1
2					/ /			/ /			2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,041,000	\$ 4,985,668			\$ 302,546	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,041,000	\$ 4,985,668			\$ 302,546	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.

STATE OF ILLINOIS

Page 7

Facility Name: Eagle Ridge of Decatur

Report Period Beginning: 01/01/05

Ending:

12/31/05

12/31/05

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 405,129	\$ 1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	333,433	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	24,846	6
7	Other Prepaid Expenses	5,775	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):	743,304	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,512,487	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	583,092	13
14	Buildings, at Historical Cost	5,980,619	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	525,490	16
17	Accumulated Depreciation (book methods)	(976,805)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs	271,910	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(131,877)	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)	\$ 6,252,429	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,764,916	\$ 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 25,662	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	19,907	30
31	Accrued Taxes Payable	142,550	31
32	Accrued Interest Payable		32
33	Deferred Compensation		33
34	Federal and State Income Taxes		34
	Other Current Liabilities(specify):		
35	Accrued liabilities	9,705	35
36	Accrued Mortgage Interest Prem.	22,895	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 220,719	\$ 37
D. Long-Term Liabilities			
38	Long-Term Notes Payable		38
39	Mortgage Payable	4,985,668	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)	\$ 4,985,668	\$ 44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,206,387	\$ 45
46	TOTAL EQUITY	\$ 2,558,529	\$ 46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,764,916	\$ 47

*(See instructions.)

Facility Name: Eagle Ridge of Decatur

Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 1,964,038	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,964,038	3
B. Other Operating Revenue			
4	Special Services	39,585	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	10	7
8	Barber and Beauty Care	11,185	8
9	Non-Resident Meals	2,408	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 53,188	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	27,961	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 27,961	14
D. Other Revenue (specify):			
15	Misc Revenue	3,241	15
16	Cable and Telephone	28,033	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 31,274	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 2,076,461	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	529,306	19
20	Health Care/ Personal Care	354,647	20
21	General Administration	485,652	21
B. Capital Expense			
22	Ownership	1,102,859	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,472,464	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (396,003)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (396,003)	31

Operating Expenses PG 3

A. General Services - Other	\$	15,907
Exterminating	\$	3,825
Security and Monitoring	\$	8,557
Rubbish Removal	\$	2,444
Vehicle Expense	\$	1,081
	\$	15,907
B. Healthcare and Programs - Other	\$	8,829
Beauty Shop	\$	8,829
D. Ownership - Other	\$	259,187
Mortgage Insurance Premium	\$	34,148
Partnership Management Fee	\$	10,000
Asset Management Fee	\$	10,000
Incentive Management	\$	203,514
Tax Credit Fees	\$	1,525
	\$	259,187

A. Current Assets - Other	\$ 743,304
Construction Interest	\$ 187
Debt Service	\$ 29,241
Medicaid Delayed Payment	\$ 125,586
Medicaid Budget Delay	\$ 301,936
Mortgage Insurance Premium	\$ 28,487
Property Tax and Insurance	\$ 202,973
Replacement	\$ 54,894
	\$ 743,304