

		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: 1000026-ii

Facility Name: Eagle Ridge of Decatur LP II

Address: 875 W. McKinley Decatur 62526
Number City Zip Code

County: Macon

Telephone Number: 217-872-1282 Fax # 217-872-1227

Federal Employer ID Number: _____

Date Current Owners were Certified: 08-02-07

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 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 _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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) _____	(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 # () _____	

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

Name: Selena Edgington **Telephone Number:** 815-935-1992
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 Eagle Ridge of Decatur LP II

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	35	Single Unit Apartment	35	12,775	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	37	TOTALS	37	13,505	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	11,298	1,839		13,137	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,298	1,839		13,137	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.28%

D. Indicate the number of paid bed-hold days the SLF had during this year 272 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 26 **(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: 12/31/2010 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? 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: Eagle Ridge of Decatur LP II

Report Period Beginning:

01/01/2010

Ending: 12/31/2010

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			
A. General Services								
1	Dietary and Food Purchase	70,433	61,848	739	133,020		133,020	1
2	Housekeeping, Laundry and Maintenance	36,359	4,927	18,839	60,125		60,125	2
3	Heat and Other Utilities			54,601	54,601	(8,518)	46,083	3
4	Other (specify):			4,729	4,729		4,729	4
5	TOTAL General Services	106,792	66,775	78,908	252,475	(8,518)	243,957	5
B. Health Care and Programs								
6	Health Care/ Personal Care	149,062	1,479		150,541		150,541	6
7	Activities and Social Services	2,085	2,140		4,225		4,225	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	151,147	3,619		154,766		154,766	9
C. General Administration								
10	Administrative and Clerical	19,035	4,337	120,192	143,564	(5,453)	138,111	10
11	Marketing Materials, Promotions and Advertising	5,510	618	9,625	15,753		15,753	11
12	Employee Benefits and Payroll Taxes			53,362	53,362		53,362	12
13	Insurance-Property, Liability and Malpractice			14,557	14,557		14,557	13
14	Other (specify):			17,769	17,769		17,769	14
15	TOTAL General Administration	24,545	4,955	215,505	245,005	(5,454)	239,552	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	282,484	75,349	294,413	652,246	(13,972)	638,275	16
Capital Expenses								
D. Ownership								
17	Depreciation			263,566	263,566		263,566	17
18	Interest			190,624	190,624		190,624	18
19	Real Estate Taxes			45,804	45,804		45,804	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			195,296	195,296		195,296	22
23	TOTAL Ownership			695,290	695,290		695,290	23
24	GRAND TOTAL (Sum of lines 16 and 23)	282,484	75,349	989,703	1,347,536	(13,972)	1,333,565	24

Facility Name: Eagle Ridge of Decatur LP II

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0	\$ 26.72	1
2	Licensed Practical Nurses	0	18.37	2
3	Certified Nurse Assistants	6	10.29	3
4	Activity Director & Assistants	0	14.20	4
5	Social Service Workers			5
6	Head Cook	0	15.97	6
7	Cook Helpers/Assistants	3	8.91	7
8	Dishwashers			8
9	Maintenance Workers	1	16.22	9
10	Housekeepers	1	8.37	10
11	Laundry			11
12	Managers	0	31.41	12
13	Other Administrative	0	14.70	13
14	Clerical			14
15	Marketing	0	20.41	15
16	Other			16
17	Total (lines 1 thru 16)	12	\$	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.	\$ 63,867	1
2			2
Total		\$ 63,867	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 <u>1</u>	City <u>2</u>
Eagle Ridge of Decatur	Decatur

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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 LP II

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

VIII. OWNERSHIP COSTS

A. Purchase price of land 50,000 Year land was acquired 2006

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	37			2007	\$ 3,919,621	\$ 142,726	28	\$ 139,986	\$ (2,740)	\$ 486,880	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			476,265	35,196	15	31,751	(3,445)	141,593	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)				\$ 4,395,886	\$ 177,922		\$ 171,737	\$ (6,185)	\$ 628,473	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	\$ 560,263	\$ 85,644	\$ 112,053	26,409	5	\$ 458,488	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 560,263	\$ 85,644	\$ 112,053	26,409		\$ 458,488	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 LP II

Report Period Beginning: 01/01/2010

Ending: 2/31/2010

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	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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		IHDA		X	First Mortgage	10/1/06	\$ 3,370,000	\$ 3,295,584	2/1/48	0.0544	\$ 180,078	1
2		IHDA		X	Second Mortgage	10/1/06	1,100,000	1,042,257	2/1/48	0.0100	10,546	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 4,470,000	\$ 4,337,841			\$ 190,624	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 4,470,000	\$ 4,337,841			\$ 190,624	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: Eagle Ridge of Decatur LP II

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 157,148	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	309,356		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,768		6
7	Other Prepaid Expenses	407		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 475,679	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	526,265		13
14	Buildings, at Historical Cost	3,919,621		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	560,263		16
17	Accumulated Depreciation (book methods)	(1,086,961)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	192,143		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(17,738)		20
21	Restricted Funds	705,915		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,799,508	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,275,187	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,512	\$	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	43,999		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	116,967		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 163,478	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,337,841		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)	\$ 4,337,841	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,501,319	\$	45
46	TOTAL EQUITY	\$ 773,868	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,275,187	\$	47

Facility Name: Eagle Ridge of Decatur LP II

Report Period Beginning: 01/01/2010

Ending:

12/31/2010

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	\$ 1,222,516	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,222,516	3
B. Other Operating Revenue			
4	Special Services	49,442	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	6,449	8
9	Non-Resident Meals	192	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 56,083	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	4,982	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 4,982	14
D. Other Revenue (specify):			
15	Property Tax Adjustments	65,355	15
16	Insurance Adjustments	850	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 66,205	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,349,786	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	252,475	19
20	Health Care/ Personal Care	154,766	20
21	General Administration	245,005	21
B. Capital Expense			
22	Ownership	695,290	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)	\$ 1,347,536	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 2,250	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 2,250	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,709
Rubbish Removal	1,609
Vehicle Expense	1,398
Transportation Service	10
Misc Operating Expenses	3
Total	4,729

C. General Administration - Other

Consulting	161
Legal	5,918
Accounting	-
Audit	11,360
Contract labor	330
Bad Debt	-
Total	17,769

D. Ownership

Assessment Income	-
Mortgage Service Fee	(16,644)
Mortgage Insurance Premium	16,529
Partnership Management Fee	45,000
Asset Management Fee	10,000
Incentive Manangement Fee	134,253
Tax Credit Fee & Incentive Fee	700
Amortization Expense	5,458
Business Interruption	-
Property Damage Loss	-
Total	195,296

Reclassifications and Adjustments

Heat & Other Utilities (8,518) Cable

Administrative and Clerical (5,454) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	8,660
Accrued Asset Mgmt Fee	10,000
Accrued Partnership Fee	45,000
Accrued Incentive Mgmt Fee	43,000
Accrued Developer Fee	-
Unearned Revenue	10,307
Accrued MIP	-
Reservation Deposit	-
Total Other Current Liabilities	116,967