

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.

<p>I. Facility ID Number: <u>1000031</u></p> <p>Facility Name: <u>Cambridge House of O'Fallon</u></p> <p>Address: <u>844 Cambridge Blvd.</u> <u>O'Fallon</u> <u>62269</u> <small>Number City Zip Code</small></p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: (<u>618</u>) <u>624-9900</u> Fax # (<u>618</u>) <u>624-9904</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>4/16/2004</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <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>Grenshinka Osborne</u> Telephone Number: <u>815-935-1992 EXT 257</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 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>01/01/12</u> to <u>12/31/12</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%"> <tr> <td style="width:50%; vertical-align: top;"> <p>Officer or Administrator of Provider</p> <p>(Signed) _____</p> <p>(Type or Print Name) <u>David J. Mitchell</u></p> <p>(Title) <u>CFO, BMA Management, LTD.</u></p> </td> <td style="width:50%; vertical-align: top;"> <p>(Date) <u>4/29/2013</u></p> </td> </tr> <tr> <td style="width:50%; vertical-align: top;"> <p>Paid Preparer</p> <p>(Signed) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</p> </td> <td style="width:50%; vertical-align: top;"> <p>(Date) _____</p> </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>	<p>Officer or Administrator of Provider</p> <p>(Signed) _____</p> <p>(Type or Print Name) <u>David J. Mitchell</u></p> <p>(Title) <u>CFO, BMA Management, LTD.</u></p>	<p>(Date) <u>4/29/2013</u></p>	<p>Paid Preparer</p> <p>(Signed) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____</p>	<p>(Date) _____</p>
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Facility Name Cambridge House of O'Fallon

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	100	Single Unit Apartment	100	36,600	1
2	3	Double Unit Apartment	3	1,098	2
3		Other			3
4	103	TOTALS	103	37,698	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	24,228	12,481		36,709	5
6	Double Unit					6
7	Other					7
8	TOTALS	24,228	12,481		36,709	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.38%

D. Indicate the number of paid bed-hold days the SLF had during this year 381 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 1 (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? 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: Cambridge House of O'Fallon

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	258,082	178,683	2,124	438,889		438,889	1
2	Housekeeping, Laundry and Maintenance	93,841	24,338	51,596	169,775		169,775	2
3	Heat and Other Utilities			157,949	157,949	(23,707)	134,242	3
4	Other (specify):			17,946	17,946		17,946	4
5	TOTAL General Services	351,923	203,021	229,615	784,559	(23,707)	760,852	5
B. Health Care and Programs								
6	Health Care/ Personal Care	413,133	2,775		415,908		415,908	6
7	Activities and Social Services	29,180	4,804		33,984		33,984	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	442,313	7,579		449,892		449,892	9
C. General Administration								
10	Administrative and Clerical	148,013	10,878	344,443	503,334	(17,140)	486,194	10
11	Marketing Materials, Promotions and Advertising	22,528	21,440	21,724	65,692		65,692	11
12	Employee Benefits and Payroll Taxes			223,107	223,107		223,107	12
13	Insurance-Property, Liability and Malpractice			64,128	64,128		64,128	13
14	Other (specify):			16,141	16,141		16,141	14
15	TOTAL General Administration	170,541	32,318	669,543	872,402	(17,140)	855,262	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	964,777	242,918	899,158	2,106,853	(40,847)	2,066,006	16
Capital Expenses								
D. Ownership								
17	Depreciation			327,263	327,263		327,263	17
18	Interest			419,560	419,560		419,560	18
19	Real Estate Taxes			69,120	69,120		69,120	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			525,208	525,208		525,208	22
23	TOTAL Ownership			1,341,151	1,341,151		1,341,151	23
24	GRAND TOTAL (Sum of lines 16 and 23)	964,777	242,918	2,240,309	3,448,004	(40,847)	3,407,157	24

Facility Name: Cambridge House of O'Fallon

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

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 30.61	1
2	Licensed Practical Nurses	1	18.29	2
3	Certified Nurse Assistants	14	10.64	3
4	Activity Director & Assistants	1	13.90	4
5	Social Service Workers			5
6	Head Cook	1	18.02	6
7	Cook Helpers/Assistants	11	9.92	7
8	Dishwashers			8
9	Maintenance Workers	1	16.26	9
10	Housekeepers	3	8.82	10
11	Laundry			11
12	Managers	1	37.47	12
13	Other Administrative			13
14	Clerical	3	14.35	14
15	Marketing	1	29.17	15
16	Other			16
17	Total (lines 1 thru 16)	37	\$	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	\$ 207,127	1
2			2
		Total	3
		\$	207,127

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
Cambridge House of Maryville I LP		Maryville	
Cambridge House of Swansea LP		Swansea	

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: Cambridge House of O'Fallon

Report Period Beginning:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 1,028,000 Year land was acquired 2002

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	103			2003	\$ 8,086,895	\$ 292,598	28	\$ 288,818	\$ (3,780)	\$ 2,683,379	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements				229,973	15,331	15	15,332	1	139,900	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)				\$ 8,316,868	\$ 307,929		\$ 304,149	\$ (3,780)	\$ 2,823,279	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	\$ 638,687	\$ 19,334	\$ 127,737	108,403	5	\$ 617,533	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 638,687	\$ 19,334	\$ 127,737	108,403		\$ 617,533	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: Cambridge House of O'Fallon

Report Period Beginning: 01/01/12

Ending: 12/31/12

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	4/16/04	\$ 7,470,000	\$ 6,976,470	3/1/44	0.0598	\$ 419,560	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 7,470,000	\$ 6,976,470			\$ 419,560	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 7,470,000	\$ 6,976,470			\$ 419,560	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: Cambridge House of O'Fallon

Report Period Beginning: 01/01/12

Ending:

12/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,860,643	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	611,796		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,828		6
7	Other Prepaid Expenses	2,730		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEC DEP UTILITY & PPD MIP	13,074		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,546,071	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,257,973		13
14	Buildings, at Historical Cost	8,086,895		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	638,687		16
17	Accumulated Depreciation (book methods)	(3,440,812)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	408,681		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(264,730)		20
21	Restricted Funds	1,245,346		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,932,040	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,478,111	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,923	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,658		30
31	Accrued Taxes Payable	69,120		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	483,576		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 652,277	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	6,976,470		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)	\$ 6,976,470	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,628,747	\$	45
46	TOTAL EQUITY	\$ 2,849,364	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,478,111	\$	47

*(See instructions.)

Facility Name: Cambridge House of O'Fallon

Report Period Beginning: 01/01/12

Ending:

12/31/12

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	\$ 3,307,252	1
2	Discounts and Allowances	(4,246)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,303,006	3
B. Other Operating Revenue			
4	Special Services	146,738	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	23,331	8
9	Non-Resident Meals	3,270	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 173,339	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	44,817	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 44,817	14
D. Other Revenue (specify):			
15	Postage and Call Pendant Income	833	15
16	Insurance Adjustments Income	5,837	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 6,670	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,527,832	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	784,559	19
20	Health Care/ Personal Care	449,892	20
21	General Administration	872,402	21
B. Capital Expense			
22	Ownership	1,341,151	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)	\$ 3,448,004	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 79,828	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 79,828	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,528
Rubbish Removal	6,668
Vehicle Expense	5,793
Transportation Service	
Water Softener	3,957
Misc Operating	
Total	17,946

C. General Administration - Other

Consulting	779
Legal	650
Accounting	55
Audit	12,560
Contract labor-Serv Prov	
Bad Debt	897
Contract labor	1,200
Total	16,141

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	35,220
Mortgage Service Fee	17,540
Partnership Management Fee	25,000
Asset Management Fee	5,004
Incentive Manangement Fee	432,062
Tax Credit Fee & Incentive Fee	2,150

Amortization Expense	8,232
Remarketing and Trustee Fee	
Property Damage Loss	
Gain on Sale	
Total	525,208

Reclassifications and Adjustments

Heat & Other Utilities (23,707) Cable

Administrative and Clerical (17,140) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	16,806
Accrued Asset Mgmt Fee	5,004
Accrued Partnership Fee	25,000
Accrued Incentive Mgmt Fee	431,910
Unclaimed Property	1,779
Unearned Revenue	3,077
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities:	483,576