

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>1000026</u></p> <p>Facility Name: <u>Eagle Ridge I SLF</u></p> <p>Address: <u>875 McKinley Avenue</u> <u>Decatur</u> <u>62526</u> <small>Number City Zip Code</small></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: _____</p> <p>Date Current Owners were Certified: <u>06/23/03</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>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 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>4/29/2013 (Date)</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) () _____ Fax # () _____</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>4/29/2013 (Date)</p>	<p>Paid Preparer</p> <p>(Signed) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) () _____ Fax # () _____</p>	<p>(Date)</p>
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Facility Name Eagle Ridge I SLF

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	76	Single Unit Apartment	76	27,816	1
2		Double Unit Apartment			2
3		Other			3
4	76	TOTALS	76	27,816	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	20,888	6,596		27,484	5
6	Double Unit					6
7	Other					7
8	TOTALS	20,888	6,596		27,484	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.81%

D. Indicate the number of paid bed-hold days the SLF had during this year 409 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 22 (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: Eagle Ridge I SLF

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		137,424	1,375	138,799		138,799	1
2	Housekeeping, Laundry and Maintenance		13,215	33,350	46,565		46,565	2
3	Heat and Other Utilities			90,297	90,297	(19,126)	71,171	3
4	Other (specify):			4,864	4,864		4,864	4
5	TOTAL General Services		150,639	129,886	280,525	(19,126)	261,399	5
B. Health Care and Programs								
6	Health Care/ Personal Care		3,161		3,161		3,161	6
7	Activities and Social Services		6,050		6,050		6,050	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		9,211		9,211		9,211	9
C. General Administration								
10	Administrative and Clerical		5,815	205,249	211,064	(10,832)	200,232	10
11	Marketing Materials, Promotions and Advertising		4,227	40,336	44,563		44,563	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			11,213	11,213		11,213	13
14	Other (specify):			1,306,614	1,306,614		1,306,614	14
15	TOTAL General Administration		10,042	1,563,412	1,573,454	(10,832)	1,562,622	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		169,892	1,693,298	1,863,190	(29,958)	1,833,232	16
Capital Expenses								
D. Ownership								
17	Depreciation			263,283	263,283		263,283	17
18	Interest			285,515	285,515		285,515	18
19	Real Estate Taxes			69,129	69,129		69,129	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			769,029	769,029		769,029	22
23	TOTAL Ownership			1,386,956	1,386,956		1,386,956	23
24	GRAND TOTAL (Sum of lines 16 and 23)		169,892	3,080,254	3,250,146	(29,958)	3,220,188	24

CONTRACT LABOR

Facility Name: Eagle Ridge I SLF

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
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		\$	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	\$ 132,769	1
2			2
		Total	\$ 132,769 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
Eagle Ridge of Decatur II		Decatur	

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 I SLF

Report Period Beginning:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 181,886 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	\$ 5,982,196	\$ 217,558	28	\$ 213,650	\$ (3,908)	\$ 2,075,641	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Land Improvements				351,206	23,415	15	23,414	(1)	216,577	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)				\$ 6,333,402	\$ 240,973		\$ 237,064	\$ (3,909)	\$ 2,292,218	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	\$ 618,481	\$ 15,235	\$ 123,696	108,461	5	\$ 513,183	18
19	Vehicles	35,373	7,075	7,075	(0)	5	7,075	19
20	TOTAL (lines 18 and 19)	\$ 653,854	\$ 22,310	\$ 130,771	108,461		\$ 520,258	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 I SLF

Report Period Beginning: 01/01/12

Ending: 12/31/12

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	IHDA		X	First Mortgage	11/1/02	\$ 5,041,000	\$ 4,692,229	2/1/44	0.0605	\$ 285,515
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,041,000	\$ 4,692,229			\$ 285,515
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,041,000	\$ 4,692,229			\$ 285,515

* 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 I SLF

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	\$ 652,588	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	549,834		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,846		6
7	Other Prepaid Expenses	10,279		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,223,547	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,886		13
14	Buildings, at Historical Cost	5,982,196		14
15	Leasehold Improvements, at Historical Cost	351,206		15
16	Equipment, at Historical Cost	653,854		16
17	Accumulated Depreciation (book methods)	(2,812,476)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	154,921		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(56,567)		20
21	Restricted Funds	966,076		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,421,096	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,644,643	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 156,919	\$	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	66,285		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	778,420		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,001,624	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,692,229		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)	\$ 4,692,229	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,693,853	\$	45
46	TOTAL EQUITY	\$ 950,790	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,644,643	\$	47

*(See instructions.)

Facility Name: Eagle Ridge I SLF

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	\$ 2,531,838	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,531,838	3
B. Other Operating Revenue			
4	Special Services	130,549	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	14,009	8
9	Non-Resident Meals	4,071	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 148,629	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	17,792	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 17,792	14
D. Other Revenue (specify):			
15	Misc other revenue	170	15
16	Insurance adj	5,395	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 5,565	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,703,824	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	280,525	19
20	Health Care/ Personal Care	9,211	20
21	General Administration	1,573,454	21
B. Capital Expense			
22	Ownership	1,386,956	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)	\$ 3,250,146	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (546,322)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (546,322)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	958
Rubbish Removal	3,906
Vehicle Expense	
Transportation Service	
Water Softener	
Misc Operating	
Total	4,864

C. General Administration - Other

Consulting	15,606
Legal	2,019
Accounting	135
Audit	13,710
Contract labor-Serv Prov	1,274,340
Bad Debt	-
Contract labor	804
Total	1,306,614

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	23,635
Mortgage Service Fee	11,795
Partnership Management Fee	1,000
Asset Management Fee	19,000
Incentive Manangement Fee	730,147
Tax Credit Fee & Incentive Fee	1,500

Amortization Expense	5,952
Remarketing and Trustee Fee	
Property Damage Loss	
Gain on Sale	(24,000)
Total	769,029

Reclassifications and Adjustments

Heat & Other Utilities (19,126) Cable

Administrative and Clerical (10,832) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	24,460
Accrued Asset Mgmt Fee	19,000
Accrued Partnership Fee	1,000
Accrued Incentive Mgmt Fee	730,147
Unclaimed Property	97
Unearned Revenue	3,716
Accrued MIP	
Reservation Deposit	

Total Other Current Liabilities 778,420