

		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>1000048</u></p> <p>Facility Name: <u>Bowman Estates LP</u></p> <p>Address: <u>1968 N. Bowman Ave.</u> <u>Danville</u> <u>61832</u> <small>Number City Zip Code</small></p> <p>County: <u>Vermillion</u></p> <p>Telephone Number: (<u>217</u>) <u>431-4200</u> Fax # (<u>217</u>) <u>431-4252</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10-31-05</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 checked="" 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 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>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>01/01/2011</u> to <u>12/31/2011</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;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>David J. Mitchell</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>CFO, BMA Management, Ltd.</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" 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 # () _____	
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Facility Name Bowman Estates LP

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	19,898	6,284		26,182	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,898	6,284		26,182	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.38%

D. Indicate the number of paid bed-hold days the SLF had during this year 564 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 286 (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: 12/31/11 Fiscal Year: 12/31/11

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____

If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? X 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: Bowman Estates LP

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

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	176,327	127,545	1,615	305,487		305,487	1
2	Housekeeping, Laundry and Maintenance	68,186	13,280	34,036	115,503		115,503	2
3	Heat and Other Utilities			127,704	127,704	(16,435)	111,269	3
4	Other (specify): SEE ATTACHMENTS PG 3			16,442	16,442		16,442	4
5	TOTAL General Services	244,514	140,825	179,798	565,136	(16,435)	548,702	5
B. Health Care and Programs								
6	Health Care/ Personal Care	343,175	2,044		345,219		345,219	6
7	Activities and Social Services	28,847	3,357		32,204		32,204	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	372,022	5,401		377,423		377,423	9
C. General Administration								
10	Administrative and Clerical	94,356	10,098	241,521	345,975	(16,887)	329,088	10
11	Marketing Materials, Promotions and Advertising	44,475	15,449	28,347	88,271		88,271	11
12	Employee Benefits and Payroll Taxes			165,255	165,255		165,255	12
13	Insurance-Property, Liability and Malpractice			31,204	31,204		31,204	13
14	Other (specify): SEE ATTACHMENTS PG 3			28,921	28,921		28,921	14
15	TOTAL General Administration	138,831	25,546	495,248	659,626	(16,887)	642,738	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	755,367	171,772	675,046	1,602,185	(33,322)	1,568,862	16
Capital Expenses								
D. Ownership								
17	Depreciation			293,008	293,008		293,008	17
18	Interest			320,599	320,599		320,599	18
19	Real Estate Taxes			58,908	58,908		58,908	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			62,615	62,615		62,615	22
23	TOTAL Ownership			735,130	735,130		735,130	23
24	GRAND TOTAL (Sum of lines 16 and 23)	755,367	171,772	1,410,176	2,337,315	(33,322)	2,303,992	24

Facility Name: Bowman Estates LP

Report Period Beginning 01/01/2011 Ending: 12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 21.08	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	13	9.48	3
4	Activity Director & Assistants	1	13.82	4
5	Social Service Workers			5
6	Head Cook	1	15.29	6
7	Cook Helpers/Assistants	8	8.96	7
8	Dishwashers			8
9	Maintenance Workers	1	16.65	9
10	Housekeepers	2	8.45	10
11	Laundry			11
12	Managers	1	29.72	12
13	Other Administrative			13
14	Clerical	2	12.98	14
15	Marketing	1	20.40	15
16	Other			16
17	Total (lines 1 thru 16)	31	\$	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	\$ 123,650	1
2			2
Total		\$ 123,650	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: Bowman Estates LP

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land 240,000 Year land was acquired 2004

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			2005	\$ 6,519,739	\$ 237,060	28	\$ 232,848	\$ (4,212)	\$ 1,609,629	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			386,694	47,487	15	25,780	(21,707)	192,612	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)				\$ 6,906,433	\$ 284,547		\$ 258,628	\$ (25,919)	\$ 1,802,241	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	\$ 523,920	\$ 8,461	\$ 104,784	96,323	5	\$ 508,169	18
19	Vehicles	22,608		4,522	4,522	5	22,608	19
20	TOTAL (lines 18 and 19)	\$ 546,528	\$ 8,461	\$ 109,306	100,845		\$ 530,777	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: Bowman Estates LP

Report Period Beginning: 01/01/2011

Ending: 2/31/2011

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**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		The Bank of Carbondale		X	First Mortgage	10/4/04	\$ 4,900,000	\$ 4,542,111	01/01/36	0.0700	\$ 320,599	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 4,900,000	\$ 4,542,111			\$ 320,599	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 4,900,000	\$ 4,542,111			\$ 320,599	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: **Bowman Estates LP**Report Period Beginning: **01/01/2011**

Ending:

12/31/2011**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2011**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 317,766	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	495,618		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,961		6
7	Other Prepaid Expenses	4,354		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R-Affiliate</u>	123,146		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 955,845	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	626,694		13
14	Buildings, at Historical Cost	6,519,739		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	546,528		16
17	Accumulated Depreciation (book methods)	(2,333,018)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	158,234		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,501)		20
21	Restricted Funds	743,411		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,186,086	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,141,931	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,082		30
31	Accrued Taxes Payable	63,408		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>SEE ATTACHMENTS PG 7</u>	194,680		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 331,949	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,542,111		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)	\$ 4,542,111	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 4,874,060	\$	45
46	TOTAL EQUITY	\$ 2,267,871	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,141,931	\$	47

*(See instructions.)

Facility Name: Bowman Estates LP

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

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	\$ 2,378,547	1
2	Discounts and Allowances	(22,858)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,355,689	3
B. Other Operating Revenue			
4	Special Services	117,951	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,023	8
9	Non-Resident Meals	5,397	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 133,371	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	8,822	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 8,822	14
D. Other Revenue (specify):			
15	CONTRACT SERVICES	400	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 400	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,498,282	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	565,136	19
20	Health Care/ Personal Care	377,423	20
21	General Administration	659,626	21
B. Capital Expense			
22	Ownership	735,130	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)	\$ 2,337,315	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 160,968	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 160,968	31

A. General Services - Other

Exterminating	708
Rubbish Removal	8,370
Vehicle Expense	7,337
Transportation Service	<u>28</u>
TOTAL	<u><u>16,442</u></u>

C. General Administrative - Other

Consulting	33
Legal	1,557
Accounting	60
Audit	10,010
Contract Labor	1,200
Bad Debts Expense	<u>16,061</u>
TOTAL	<u><u>28,921</u></u>

D. Ownership - Other

Partnership Management Fee	38,000
Asset Management Fee	7,600
Incentive Management	8,611
Tax Credit Fees & Incentive Fee	1,600
Amortization Expense	<u>6,804</u>
TOTAL	<u><u>62,615</u></u>

Reclassifications and Adjustments

Heat & Other Utilities	(16,435) Cable
Administrative and Clerical	(16,887) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Asset Management Fee	7,600
Accrued Partnership Mgmt Fee	38,000
Accrued Incentive Mgmt Fee	105,729
Accrued Liabilities	19,281
Unclaimed Property	808
Unearned Revenue	<u>23,262</u>
TOTAL	<u>194,680</u>