

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>1000026</u></p> <p>Facility Name: <u>Eagle Ridge of Decatur, LP</u></p> <p>Address: <u>875 W. McKinley</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%; 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>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>01/01/11</u> to <u>12/31/11</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; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>David J. Mitchell</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>CFO, BMA Management, LTD.</u></td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td 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 # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name Eagle Ridge of Decatur, LP

Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	21,528	5,382		26,910	5
6	Double Unit					6
7	Other					7
8	TOTALS	21,528	5,382		26,910	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.01%

D. Indicate the number of paid bed-hold days the SLF had during this year 375 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 195 (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? 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

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	178,702	153,697	1,334	333,733		333,733	1
2	Housekeeping, Laundry and Maintenance	71,722	9,809	40,815	122,346		122,346	2
3	Heat and Other Utilities			106,623	106,623	(18,521)	88,102	3
4	Other (specify):			11,234	11,234		11,234	4
5	TOTAL General Services	250,424	163,506	160,006	573,936	(18,521)	555,415	5
B. Health Care and Programs								
6	Health Care/ Personal Care	368,976	1,297		370,273		370,273	6
7	Activities and Social Services	27,702	9,408		37,110		37,110	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	396,678	10,705		407,383		407,383	9
C. General Administration								
10	Administrative and Clerical	148,702	8,033	222,086	378,821	(10,829)	367,992	10
11	Marketing Materials, Promotions and Advertising	44,098	1,767	25,564	71,429		71,429	11
12	Employee Benefits and Payroll Taxes			157,691	157,691		157,691	12
13	Insurance-Property, Liability and Malpractice			30,901	30,901		30,901	13
14	Other (specify):			34,223	34,223		34,223	14
15	TOTAL General Administration	192,800	9,800	470,465	673,065	(10,829)	662,236	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	839,902	184,011	630,471	1,654,384	(29,350)	1,625,034	16
Capital Expenses								
D. Ownership								
17	Depreciation			252,011	252,011		252,011	17
18	Interest			288,410	288,410		288,410	18
19	Real Estate Taxes			57,602	57,602		57,602	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			67,257	67,257		67,257	22
23	TOTAL Ownership			665,280	665,280		665,280	23
24	GRAND TOTAL (Sum of lines 16 and 23)	839,902	184,011	1,295,751	2,319,664	(29,350)	2,290,314	24

Facility Name: Eagle Ridge of Decatur, LP

Report Period Beginning 01/01/11

Ending: 12/31/11

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 27.82	1
2	Licensed Practical Nurses	1	18.65	2
3	Certified Nurse Assistants	14	10.09	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	14.26	5
6	Head Cook	1	14.75	6
7	Cook Helpers/Assistants	7	8.82	7
8	Dishwashers			8
9	Maintenance Workers	1	16.84	9
10	Housekeepers	2	8.65	10
11	Laundry			11
12	Managers	1	38.86	12
13	Other Administrative	3	15.35	13
14	Clerical			14
15	Marketing	1	19.91	15
16	Other			16
17	Total (lines 1 thru 16)	33	\$	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	\$ 131,036	1
2			2
		Total	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 LP 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 of Decatur, LP

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	\$ 217,906	28	\$ 213,650	\$ (4,256)	\$ 1,858,083	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Land Improvements				351,206	23,913	15	23,414	(499)	193,162	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	\$ 241,819		\$ 237,064	\$ (4,755)	\$ 2,051,245	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	\$ 605,969	\$ 10,192	\$ 121,194	97,768	5	\$ 497,948	18
19	Vehicles	40,644				5	40,644	19
20	TOTAL (lines 18 and 19)	\$ 646,613	\$ 10,192	\$ 121,194	97,768		\$ 528,400	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

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	11/1/02	\$ 5,041,000	\$ 4,741,661	2/1/44	0.0605	\$ 288,410	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 5,041,000	\$ 4,741,661			\$ 288,410	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 5,041,000	\$ 4,741,661			\$ 288,410	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

Report Period Beginning: 01/01/11

Ending:

12/31/11

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 215,743	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	521,172		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,276		6
7	Other Prepaid Expenses	8,889		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 774,080	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	533,092		13
14	Buildings, at Historical Cost	5,982,196		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	646,613		16
17	Accumulated Depreciation (book methods)	(2,589,837)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	154,921		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(50,615)		20
21	Restricted Funds	1,319,317		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,995,687	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,769,767	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 111,188	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,147		30
31	Accrued Taxes Payable	60,286		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	250,311		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 480,932	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,741,661		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)	\$ 4,741,661	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,222,593	\$	45
46	TOTAL EQUITY	\$ 1,547,174	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,769,767	\$	47

*(See instructions.)

Facility Name: Eagle Ridge of Decatur, LP

Report Period Beginning: 01/01/11

Ending:

12/31/11

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	1	Amount	
	Revenue		
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,486,183	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,486,183	3
	B. Other Operating Revenue		
4	Special Services	117,986	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	15,799	8
9	Non-Resident Meals	5,850	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 139,635	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,067	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,067	14
	D. Other Revenue (specify):		
15	Vending /Insurance Adjustments	5,897	15
16	Contract Services	2,300	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 8,197	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,637,082	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	573,936	19
20	Health Care/ Personal Care	407,383	20
21	General Administration	673,065	21
	B. Capital Expense		
22	Ownership	665,280	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)	\$ 2,319,664	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 317,418	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 317,418	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	3,762
Rubbish Removal	3,566
Vehicle Expense	3,906
Transportation Service	-
Water Softener	-
Misc Operating	-
Total	11,234

C. General Administration - Other

Consulting	5,820
Legal	5,959
Accounting	238
Audit	12,885
Contract labor	804
Bad Debt	8,517
Total	34,223

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	23,889
Mortgage Service Fee	11,918
Partnership Management Fee	10,000
Asset Management Fee	10,000
Incentive Manangement Fee	3,998
Tax Credit Fee & Incentive Fee	1,500
Amortization Expense	5,952
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	67,257

Reclassifications and Adjustments

Heat & Other Utilities (18,521) Cable

Administrative and Clerical (10,829) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	17,705
Accrued Asset Mgmt Fee	10,000
Accrued Partnership Fee	10,000
Accrued Incentive Mgmt Fee	200,249
Unclaimed Property	86
Unearned Revenue	12,271
Accrued MIP	
Reservation Deposit	
Total Other Current Liabilities	250,311