

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><b>I. Facility ID Number:</b> <u>1000026-ii</u></p> <p><b>Facility Name:</b> <u>Eagle Ridge of Decatur LP II</u></p> <p><b>Address:</b> <u>875 W. McKinley</u> <u>Decatur</u> <u>62526</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Macon</u></p> <p><b>Telephone Number:</b> <u>217-872-1282</u> <b>Fax #</b> <u>217-872-1227</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>08-02-07</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Selena Edgington</u> <b>Telephone Number:</b> <u>815-935-1992 EXT 232</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></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%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David J. Mitchell</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CFO, BMA Management, LTD.</u></td> <td></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) ( ) _____</td> <td>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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>David J. Mitchell</u>			(Title) <u>CFO, BMA Management, LTD.</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) ( ) _____	Fax # ( ) _____
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	(Telephone) ( ) _____	Fax # ( ) _____																																												

Facility Name Eagle Ridge of Decatur LP II

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	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	11,221	2,137		13,358	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,221	2,137		13,358	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.91%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 42 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 30 (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)

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**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 II

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	72,990	75,103	651	148,744		148,744	1
2	Housekeeping, Laundry and Maintenance	38,436	4,774	18,842	62,052		62,052	2
3	Heat and Other Utilities			51,897	51,897	(8,719)	43,178	3
4	Other (specify):			5,470	5,470		5,470	4
5	<b>TOTAL General Services</b>	111,426	79,877	76,860	268,163	(8,719)	259,444	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	150,707	631		151,338		151,338	6
7	Activities and Social Services	2,086	4,497		6,583		6,583	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	152,793	5,128		157,921		157,921	9
<b>C. General Administration</b>								
10	Administrative and Clerical	20,279	3,910	122,643	146,832	(4,992)	141,840	10
11	Marketing Materials, Promotions and Advertising	5,681	861	12,055	18,597		18,597	11
12	Employee Benefits and Payroll Taxes			54,286	54,286		54,286	12
13	Insurance-Property, Liability and Malpractice			15,014	15,014		15,014	13
14	Other (specify):			25,439	25,439		25,439	14
15	<b>TOTAL General Administration</b>	25,960	4,771	229,437	260,168	(4,992)	255,176	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	290,179	89,776	306,297	686,252	(13,711)	672,541	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			242,447	242,447		242,447	17
18	Interest			188,897	188,897		188,897	18
19	Real Estate Taxes			41,440	41,440		41,440	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			121,218	121,218		121,218	22
23	<b>TOTAL Ownership</b>			594,002	594,002		594,002	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	290,179	89,776	900,299	1,280,254	(13,711)	1,266,543	24

Facility Name: Eagle Ridge of Decatur LP II

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	0	\$ 27.82	1
2	Licensed Practical Nurses	0	18.65	2
3	Certified Nurse Assistants	6	10.09	3
4	Activity Director & Assistants			4
5	Social Service Workers	0	14.26	5
6	Head Cook	1	14.75	6
7	Cook Helpers/Assistants	3	8.82	7
8	Dishwashers			8
9	Maintenance Workers	1	16.84	9
10	Housekeepers	1	8.65	10
11	Laundry			11
12	Managers	0	38.86	12
13	Other Administrative	0	15.35	13
14	Clerical			14
15	Marketing	0	19.91	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>12</b>	<b>\$</b>	<b>17</b>

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
				<b>Total</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	BMA Management LTD	\$ 65,340	1
2			2
		<b>Total</b>	<b>3</b>

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		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 II

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	\$ 142,532	28	\$ 139,986	\$ (2,740)	\$ 629,412	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Land Improvements			476,265	34,291	15	31,751	(3,445)	175,884	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	\$ 176,823		\$ 171,737	\$ (6,185)	\$ 805,296	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	\$ 608,864	\$ 65,624	\$ 121,773	56,149	5	\$ 524,112	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 608,864	\$ 65,624	\$ 121,773	56,149		\$ 524,112	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: 01/01/11

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 96,890	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	303,945		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,743		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 409,578	\$	10
	<b>B. Long-Term Assets</b>			
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	608,864		16
17	Accumulated Depreciation (book methods)	(1,329,408)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	192,143		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(23,198)		20
21	Restricted Funds	802,231		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,696,518	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,106,096	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 8,620	\$	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	43,762		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	See Page 7 Attachment	115,807		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 168,189	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,286,432		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 4,286,432	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 4,454,621	\$	45
46	<b>TOTAL EQUITY</b>	\$ 651,475	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 5,106,096	\$	47

\*(See instructions.)

Facility Name: Eagle Ridge of Decatur LP II

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	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,237,053	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 1,237,053	3
<b>B. Other Operating Revenue</b>			
4	Special Services	65,483	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	7,938	8
9	Non-Resident Meals	104	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 73,525	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	1,631	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 1,631	14
<b>D. Other Revenue (specify):</b>			
15	Deposit Fee	50	15
16	Property Tax Adjustment	67,256	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 67,306	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 1,379,515	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	268,163	19
20	Health Care/ Personal Care	157,921	20
21	General Administration	260,168	21
<b>B. Capital Expense</b>			
22	Ownership	594,002	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 1,280,254	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 99,261	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 99,261	31

**COST CENTER EXPENSES**

## A. General Services - Other

Exterminating	1,833
Rubbish Removal	1,734
Vehicle Expense	1,903
Transportation Service	-
Water Softener	-
Misc Operating	-
Total	<b>5,470</b>

## C. General Administration - Other

Consulting	6,394
Legal	5,720
Accounting	117
Audit	11,625
Contract labor	396
Bad Debt	1,187
Total	<b>25,439</b>

## D. Ownership

Letter of Credit	
Mortgage Insurance Premium	17,058
Mortgage Service Fee	
Partnership Management Fee	45,000
Asset Management Fee	10,000
Incentive Manangement Fee	43,000
Tax Credit Fee & Incentive Fee	700
Amortization Expense	5,460
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	<b>121,218</b>

## Reclassifications and Adjustments

Heat & Other Utilities (8,718) Cable

Administrative and Clerical (4,992) Telephone Revenue

**BALANCE SHEET**

C. Current Liabilities

Accrued Liabilities	8,825
Accrued Asset Mgmt Fee	10,000
Accrued Partnership Fee	45,000
Accrued Incentive Mgmt Fee	43,000
Unclaimed Property	
Unearned Revenue	8,314
Accrued MIP	668
Reservation Deposit	
<b>Total Other Current Liabilities</b>	<b>115,807</b>