

FOR BHF USE					

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**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>1000087</u></p> <p><b>Facility Name:</b> <u>John M. Evans Supportive Living</u></p> <p><b>Address:</b> <u>1320 Executive Court</u> <u>Pekin</u> <u>61554</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Tazwell</u></p> <p><b>Telephone Number:</b> ( <u>309</u> ) <u>477-8800</u> <b>Fax #</b> ( <u>309</u> ) <u>477-8801</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>04/28/2008</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <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>Grenshinka Osborne</u> <b>Telephone Number:</b> ( <u>815</u> ) <u>935-1992 EXT 257</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>01/01/2011</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 border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <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 rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) ( <u>   </u> ) _____ <b>Fax #</b> ( <u>   </u> ) _____</td> <td></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 <b>Phone #</b> (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) ( <u>   </u> ) _____ <b>Fax #</b> ( <u>   </u> ) _____	
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Facility Name John M. Evans Supportive Living

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 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	17,098	9,618		26,716	5
6	Double Unit					6
7	Other					7
8	TOTALS	17,098	9,618		26,716	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)       96.31%      

**D. Indicate the number of paid bed-hold days the SLF had during this year**       906       Also, indicate the number of unpaid bed-hold days the SLF had during this year.       115       (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:       12/31/2011       Fiscal Year:       12/31/2011      

\* 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? \_\_\_\_\_  
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: John M. Evans Supportive Living

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase		136,571	2,140	138,711		138,711	1
2	Housekeeping, Laundry and Maintenance		14,944	41,369	56,313		56,313	2
3	Heat and Other Utilities			136,872	136,872	(17,934)	118,938	3
4	Other (specify):			5,062	5,062		5,062	4
5	<b>TOTAL General Services</b>		151,515	185,443	336,958	(17,934)	319,024	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care		1,407		1,407		1,407	6
7	Activities and Social Services		3,749		3,749		3,749	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>		5,156		5,156		5,156	9
<b>C. General Administration</b>								
10	Administrative and Clerical		10,380	178,949	189,329	(14,539)	174,790	10
11	Marketing Materials, Promotions and Advertising		1,535	24,359	25,894		25,894	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			13,642	13,642		13,642	13
14	Other (specify):			1,140,135	1,140,135		1,140,135	14
15	<b>TOTAL General Administration</b>		11,915	1,357,085	1,369,000	(14,539)	1,354,461	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>		168,586	1,542,528	1,711,114	(32,473)	1,678,641	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			413,416	413,416		413,416	17
18	Interest			298,464	298,464		298,464	18
19	Real Estate Taxes			61,167	61,167		61,167	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			280,552	280,552		280,552	22
23	<b>TOTAL Ownership</b>			1,053,599	1,053,599		1,053,599	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>		168,586	2,596,127	2,764,713	(32,473)	2,732,240	24

Facility Name: John M. Evans Supportive Living

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	1	\$ 29.01	1
2	Licensed Practical Nurses	1	18.09	2
3	Certified Nurse Assistants	13	11.45	3
4	Activity Director & Assistants	1	14.57	4
5	Social Service Workers			5
6	Head Cook	1	15.42	6
7	Cook Helpers/Assistants	8	10.04	7
8	Dishwashers			8
9	Maintenance Workers	1	20.89	9
10	Housekeepers	1	9.27	10
11	Laundry			11
12	Managers	1	35.55	12
13	Other Administrative			13
14	Clerical	2	17.44	14
15	Marketing	1	27.18	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>30</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	\$ 136,183	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

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: John M. Evans Supportive Living

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land 184,011 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	76			2007	\$ 7,572,706	\$ 271,024	28	\$ 270,454	\$ (570)	\$ 1,119,098	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Land Improvements			238,207	21,498	15	15,880	(5,618)	88,245	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)				\$ 7,810,913	\$ 292,522		\$ 286,334	\$ (6,188)	\$ 1,207,343	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	\$ 604,471	\$ 120,894	\$ 120,894	0	5	\$ 493,651	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 604,471	\$ 120,894	\$ 120,894	0		\$ 493,651	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: John M. Evans Supportive Living

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 324,240	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	401,298		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,849		6
7	Other Prepaid Expenses	14,766		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>PREPAID MIP</b>	9,613		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 752,766	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	422,218		13
14	Buildings, at Historical Cost	7,572,706		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	604,471		16
17	Accumulated Depreciation (book methods)	(1,700,994)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	140,374		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(29,449)		20
21	Restricted Funds	1,357,811		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>	\$ 8,367,138	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,119,904	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 83,957	\$	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	65,386		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>SEE ATTACHMENT PG 7</b>	270,668		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 420,012	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,024,665		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>	\$ 5,024,665	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 5,444,677	\$	45
46	<b>TOTAL EQUITY</b>	\$ 3,675,227	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 9,119,904	\$	47

\*(See instructions.)

Facility Name: John M. Evans Supportive Living

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,604,440	1
2	Discounts and Allowances	(8,919)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 2,595,521</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	123,368	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	9,745	8
9	Non-Resident Meals	4,506	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 137,619</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	872	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 872</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Insurance Adjustments	4,102	15
16	Vending	177	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 4,279</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 2,738,291</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	336,958	19
20	Health Care/ Personal Care	5,156	20
21	General Administration	1,369,000	21
<b>B. Capital Expense</b>			
22	Ownership	1,053,599	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 (sum of lines 19 thru 27)</b>	<b>\$ 2,764,713</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (26,422)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (26,422)</b>	<b>31</b>

**COST CENTER EXPENSES**

A. General Services - Other

Exterminating	720
Rubbish Removal	2,696
Vehicle Expense	
Transportation Service	
Water Softener	1,646
Misc Operating	
Total	<b>5,062</b>

C. General Administration - Other

Consulting	-
Legal	90
Accounting	50
Audit	11,560
Contract labor	1,122,055
Bad Debt	6,380
Total	<b>1,140,135</b>

D. Ownership

Mortgage Insurance Premium	25,334
Mortgage Service Fee	12,668
Partnership Management Fee	
Asset Management Fee	20,004
Incentive Manangement Fee	213,834
Tax Credit Fee & Incentive Fee	1,500
Amortization Expense	7,212
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	<b>280,552</b>

Reclassifications and Adjustments

Heat & Other Utilities (17,934) Cable

Administrative and Clerical (14,539) Telephone Revenue

C. Current Liabilities

Accrued Asset Management Fees	20,003
Accrued Incentive Mgmt Fee	229,136
Accrued Liabilities	14,452
Unearned Revenue	<u>7,076</u>
<b>Total Other Current Liabilities</b>	<b><u>270,668</u></b>