

		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>1000043</u></p> <p>Facility Name: <u>Prairie Living at Chautauqua</u></p> <p>Address: <u>955 Villa Court</u> <u>Carbondale</u> <u>62901</u> <small>Number City Zip Code</small></p> <p>County: <u>Jackson</u></p> <p>Telephone Number: <u>618-351-7955</u> Fax # <u>618-351-7955</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11-22-04</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;">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 Prairie Living at Chautauqua

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	68	Single Unit Apartment	68	24,820	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	75	TOTALS	75	27,375	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	16,738	4,721		21,459	5
6	Double Unit					6
7	Other					7
8	TOTALS	16,738	4,721		21,459	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 78.39%

D. Indicate the number of paid bed-hold days the SLF had during this year 274 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 103 (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: Prairie Living at Chautauqua

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		106,816	1,015	107,831		107,831	1
2	Housekeeping, Laundry and Maintenance		11,038	41,046	52,084		52,084	2
3	Heat and Other Utilities			86,843	86,843	(8,357)	78,486	3
4	Other (specify):			3,708	3,708		3,708	4
5	TOTAL General Services		117,854	132,612	250,466	(8,357)	242,109	5
B. Health Care and Programs								
6	Health Care/ Personal Care		1,954		1,954		1,954	6
7	Activities and Social Services		2,967		2,967		2,967	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		4,921		4,921		4,921	9
C. General Administration								
10	Administrative and Clerical		7,368	127,599	134,967	(12,284)	122,683	10
11	Marketing Materials, Promotions and Advertising		2,542	35,808	38,350		38,350	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			10,694	10,694		10,694	13
14	Other (specify):			1,001,037	1,001,037		1,001,037	14
15	TOTAL General Administration		9,910	1,175,138	1,185,048	(12,284)	1,172,764	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		132,685	1,307,750	1,440,435	(20,641)	1,419,794	16
Capital Expenses								
D. Ownership								
17	Depreciation			285,804	285,804		285,804	17
18	Interest			271,253	271,253		271,253	18
19	Real Estate Taxes			70,428	70,428		70,428	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			74,151	74,151		74,151	22
23	TOTAL Ownership			701,636	701,636		701,636	23
24	GRAND TOTAL (Sum of lines 16 and 23)		132,685	2,009,386	2,142,071	(20,641)	2,121,430	24

Facility Name: **Prairie Living at Chautauqua**

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	\$ 26.89	1
2	Licensed Practical Nurses	1	16.98	2
3	Certified Nurse Assistants	14	9.51	3
4	Activity Director & Assistants	1	13.29	4
5	Social Service Workers			5
6	Head Cook	1	17.05	6
7	Cook Helpers/Assistants	9	9.34	7
8	Dishwashers			8
9	Maintenance Workers	1	13.38	9
10	Housekeepers	2	8.36	10
11	Laundry			11
12	Managers	1	30.88	12
13	Other Administrative	1	13.34	13
14	Clerical			14
15	Marketing	1	19.97	15
16	Other			16
17	Total (lines 1 thru 16)	32	\$	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	\$ 89,798	1
2			2
Total		\$ 89,798	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
Prairie Living West LLC		Carbondale	

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: **Prairie Living at Chautauqua**

Report Period Beginning:

01/01/11

Ending:

12/31/11

VIII. OWNERSHIP COSTS

A. Purchase price of land 400,000 Year land was acquired 2003

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	75			2004	\$ 7,514,459	\$ 273,377	28	\$ 268,374	\$ (5,003)	\$ 1,918,423	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements			89,246	5,216	15	5,950	734	45,073	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)				\$ 7,603,705	\$ 278,593		\$ 274,323	\$ (4,270)	\$ 1,963,496	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	\$ 924,982	\$ 7,211	\$ 184,996	177,785	5	\$ 903,360	18
19	Vehicles	44,552		8,910	8,910	5	44,552	19
20	TOTAL (lines 18 and 19)	\$ 969,534	\$ 7,211	\$ 193,907	186,696		\$ 947,912	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: **Prairie Living at Chautauqua**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	\$ 112,255	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	427,160		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,375		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Utility Security Deposit	500		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 541,290	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	489,246		13
14	Buildings, at Historical Cost	7,514,459		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	969,534		16
17	Accumulated Depreciation (book methods)	(2,911,407)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	315,447		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(146,770)		20
21	Restricted Funds	603,592		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,834,101	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,375,391	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 81,638	\$	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	68,850		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	141,027		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 291,515	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,211,631		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)	\$ 5,211,631	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,503,146	\$	45
46	TOTAL EQUITY	\$ 1,872,245	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,375,391	\$	47

*(See instructions.)

Facility Name: Prairie Living at Chautauqua

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	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,755,937	1
2	Discounts and Allowances	(22,660)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,733,277	3
B. Other Operating Revenue			
4	Special Services	60,500	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,950	8
9	Non-Resident Meals	9,450	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 80,900	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,239	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,239	14
D. Other Revenue (specify):			
15	Vending	237	15
16	Insurance Adjustments/A/P credits	7,285	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 7,522	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,822,938	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	250,466	19
20	Health Care/ Personal Care	4,921	20
21	General Administration	1,185,048	21
B. Capital Expense			
22	Ownership	701,636	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)	\$ 2,142,071	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (319,133)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (319,133)	31

COST CENTER EXPENSES

A. General Services - Other

Exterminating	1,008
Rubbish Removal	2,681
Vehicle Expense	-
Transportation Service	19
Water Softener	
Misc Operating	
Total	3,708

C. General Administration - Other

Consulting	120
Legal	54
Accounting	60
Audit	12,310
Contract labor	972,727
Bad Debt	15,766
Total	1,001,037

D. Ownership

Assessment Loss	11,269
Mortgage Insurance Premium	21,268
Mortgage Service Fee	10,611
Partnership Management Fee	-
Asset Management Fee	17,911
Incentive Manangement Fee	-
Tax Credit Fee & Incentive Fee	1,700
Amortization Expense	8,892
Remarketing and Trustee Fee	-
Property Damage Loss	2,500
Interest Income	-
Total	74,151

Reclassifications and Adjustments

Heat & Other Utilities (8,357) Cable

Administrative and Clerical (12,284) Telephone Revenue

BALANCE SHEET

C. Current Liabilities

Accrued Liabilities	35,763
Accrued Asset Mgmt Fee	17,911
Accrued Partnership Fee	46,627
Accrued Incentive Mgmt Fee	
Unclaimed Property	3,343
Unearned Revenue	15,378
Accrued MIP	22,005
Reservation Deposit	
Total Other Current Liabilities	141,027