

		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>1000043-ii</u></p> <p><b>Facility Name:</b> <u>Prairie Living at Chautauqua II</u></p> <p><b>Address:</b> <u>955 Villa Court</u> <u>Carbondale</u> <u>62901</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Jackson</u></p> <p><b>Telephone Number:</b> <u>618-351-7955</u> <b>Fax #</b> <u>618-351-6955</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>07/20/10</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 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 checked="" 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 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 checked="" 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 # ( ) _____
<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 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 checked="" type="checkbox"/> Limited Liability Co.																																													
	<input type="checkbox"/> Trust																																													
	<input type="checkbox"/> Other _____																																													
<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 # ( ) _____																																												



Facility Name: Prairie Living at Chautauqua 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		81,881	777	82,658		82,658	1
2	Housekeeping, Laundry and Maintenance		7,359	28,848	36,207		36,207	2
3	Heat and Other Utilities			55,848	55,848	(6,455)	49,393	3
4	Other (specify):			2,474	2,474		2,474	4
5	<b>TOTAL General Services</b>		89,240	87,947	177,187	(6,455)	170,732	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care		1,302		1,302		1,302	6
7	Activities and Social Services		1,963		1,963		1,963	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>		3,265		3,265		3,265	9
<b>C. General Administration</b>								
10	Administrative and Clerical		4,911	113,991	118,902	(8,843)	110,059	10
11	Marketing Materials, Promotions and Advertising		1,674	29,323	30,997		30,997	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			20,282	20,282		20,282	13
14	Other (specify):			538,114	538,114		538,114	14
15	<b>TOTAL General Administration</b>		6,585	701,710	708,295	(8,843)	699,452	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>		99,090	789,657	888,747	(15,298)	873,449	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			343,287	343,287		343,287	17
18	Interest			419,136	419,136		419,136	18
19	Real Estate Taxes			42,162	42,162		42,162	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			3,712	3,712		3,712	22
23	<b>TOTAL Ownership</b>			808,297	808,297		808,297	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>		99,090	1,597,954	1,697,044	(15,298)	1,681,746	24

Facility Name: **Prairie Living at Chautauqua 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	\$ 26.89	1
2	Licensed Practical Nurses	1	16.98	2
3	Certified Nurse Assistants	6	9.51	3
4	Activity Director & Assistants	0	13.29	4
5	Social Service Workers			5
6	Head Cook	0	17.05	6
7	Cook Helpers/Assistants	4	9.34	7
8	Dishwashers			8
9	Maintenance Workers	1	13.38	9
10	Housekeepers	1	8.36	10
11	Laundry			11
12	Managers	0	30.88	12
13	Other Administrative	1	13.34	13
14	Clerical			14
15	Marketing	0	19.97	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>16</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>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

		Amount of Fee	
1	BMA Management LTD	\$ 80,059	1
2			2
<b>Total</b>		<b>\$ 80,059</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	City
1 Carbondale SLF	2 Carbondale

**OTHER RELATED BUSINESS ENTITIES**

Name	City	Type of Business
3	4	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 II**

Report Period Beginning:

01/01/11

Ending:

12/31/11

**VIII. OWNERSHIP COSTS**

A. Purchase price of land \_\_\_\_\_ Year land was acquired 2009

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	50			2010	\$ 5,360,377	\$ 194,903	28	\$ 191,442	\$ (3,461)	\$ 268,019	1
2											2
3											3
4											4
5											5
	<b>Improvement Type</b>										
6	Land Improvements				409,950	26,976	15	27,330	354	40,444	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)				\$ 5,770,327	\$ 221,879		\$ 218,772	\$ (3,107)	\$ 308,463	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	\$ 613,380	\$ 121,408	\$ 122,676	1,268	5	\$ 182,113	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 613,380	\$ 121,408	\$ 122,676	1,268		\$ 182,113	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 II

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	<b>TOTAL</b>				\$			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				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		Peoples National Bank		X	First Mortgage	10/9/09	\$ 6,210,000	\$ 6,204,263	10/9/34	0.0675	\$ 419,136	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 6,210,000	\$ 6,204,263			\$ 419,136	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 6,210,000	\$ 6,204,263			\$ 419,136	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: **Prairie Living at Chautauqua 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	\$ 51,924	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	202,575		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,838		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Utility Security Deposit</b>	500		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 266,837	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	821,981		13
14	Buildings, at Historical Cost	5,360,377		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	613,380		16
17	Accumulated Depreciation (book methods)	(490,576)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	92,798		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,259)		20
21	Restricted Funds	204,746		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>	\$ 6,597,447	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,864,284	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,053	\$	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	42,162		31
32	Accrued Interest Payable	25,242		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>See Page 7 Attachment</b>	77,972		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 147,429	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,204,263		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>	\$ 6,204,263	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 6,351,692	\$	45
46	<b>TOTAL EQUITY</b>	\$ 512,592	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,864,284	\$	47

\*(See instructions.)

Facility Name: Prairie Living at Chautauqua 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	\$ 1,431,695	1
2	Discounts and Allowances	(5,813)	2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,425,882</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services	34,711	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	7,486	8
9	Non-Resident Meals	1,134	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 43,331</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	421	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 421</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,469,634</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	177,187	19
20	Health Care/ Personal Care	3,265	20
21	General Administration	708,295	21
<b>B. Capital Expense</b>			
22	Ownership	808,297	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>\$ 1,697,044</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (227,410)</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>\$ (227,410)</b>	<b>31</b>

**COST CENTER EXPENSES**

A. General Services - Other

Exterminating	672
Rubbish Removal	1,789
Vehicle Expense	-
Transportation Service	13
Water Softener	-
Misc Operating	-
Total	<b>2,474</b>

C. General Administration - Other

Consulting	80
Legal	9,427
Accounting	50
Audit	30,920
Contract labor	486,483
Bad Debt	11,154
Total	<b>538,114</b>

D. Ownership

Letter of Credit	
Mortgage Insurance Premium	
Mortgage Service Fee	
Partnership Management Fee	
Asset Management Fee	
Incentive Manangement Fee	
Tax Credit Fee & Incentive Fee	
Amortization Expense	3,712
Remarketing and Trustee Fee	
Property Damage Loss	
Interest Income	
Total	<b>3,712</b>

Reclassifications and Adjustments

Heat & Other Utilities (6,455) Cable

Administrative and Clerical (8,843) Telephone Revenue

**BALANCE SHEET**

C. Current Liabilities

Accrued Liabilities	15,688
Accrued Asset Mgmt Fee	
Accrued Partnership Fee	
Accrued Developer Fee	34,143
Unclaimed Property	2,071
Unearned Revenue	26,070
Accrued MIP	
Reservation Deposit	
<b>Total Other Current Liabilities</b>	<b>77,972</b>