

		FOR BHF USE			

LL2

Supportive Living Facility

**2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2005)**

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.</p> <p>Facility Name: <u>Emerald Glen</u></p> <p>Address: <u>1301 N East St</u> <u>Olney</u> <u>62450</u> <small>Number City Zip Code</small></p> <p>County: <u>Richland</u></p> <p>Telephone Number: (<u>618</u> 395-4663 Fax # <u>618</u> 392-6313</p> <p>Federal Employer ID Number: <u>33-1092690</u></p> <p>Date Current Owners were Certified: <u>2002</u></p> <p>Type of Ownership:</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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>In the event there are further questions about this report, please contact: Name: <u>Shelley Nuelle</u> Telephone Number: (<u>217</u> 536-6888</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	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>1/1/05</u> to <u>11/15/05</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: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Brad Voyles</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (<u> </u>) _____ Fax # (<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 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Brad Voyles</u>			(Title) <u>President</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____	
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	(Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____																																									

Facility Name Emerald Glen

Report Period Beginning: 1/1/05 Ending: 11/15/05

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	22	Single Unit Apartment	22	7,018	1
2	13	Double Unit Apartment	13	4,147	2
3		Other			3
4	35	TOTALS	35	11,165	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	1,224	3,226		4,450	5
6	Double Unit	510	5,100		5,610	6
7	Other					7
8	TOTALS	1,734	8,326		10,060	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.10%

D. Indicate the number of paid bed-hold days the SLF had during this year 36 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 19 (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: 2005 Fiscal Year: 2005

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? no 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: Emerald Glen

Report Period Beginning:

1/1/05

Ending:

11/15/05

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	27,456	57,598		85,054		85,054	1
2	Housekeeping, Laundry and Maintenance	26,688	32,900		59,588		59,588	2
3	Heat and Other Utilities			40,621	40,621		40,621	3
4	Other (specify):							4
5	TOTAL General Services	54,144	90,498	40,621	185,262		185,262	5
B. Health Care and Programs								
6	Health Care/ Personal Care	80,029		10,263	90,292		90,292	6
7	Activities and Social Services	13,728	1,184		14,912		14,912	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	93,757	1,184	10,263	105,204		105,204	9
C. General Administration								
10	Administrative and Clerical	66,445	1,870	14,148	82,463		82,463	10
11	Marketing Materials, Promotions and Advertising		8,495		8,495		8,495	11
12	Employee Benefits and Payroll Taxes	23,681			23,681		23,681	12
13	Insurance-Property, Liability and Malpractice			20,294	20,294		20,294	13
14	Other (specify):							14
15	TOTAL General Administration	90,126	10,365	34,442	134,933		134,933	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	238,027	102,047	85,326	425,400		425,400	16
Capital Expenses								
D. Ownership								
17	Depreciation			49,458	49,458		49,458	17
18	Interest			84,182	84,182		84,182	18
19	Real Estate Taxes			51,320	51,320		51,320	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			588	588		588	21
22	Other (specify):							22
23	TOTAL Ownership			185,548	185,548		185,548	23
24	GRAND TOTAL (Sum of lines 16 and 23)	238,027	102,047	270,874	610,947		610,947	24

Facility Name: Emerald Glen

Report Period Beginning 1/1/05 Ending: 11/15/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6	7.50	3
4	Activity Director & Assistants	1	7.15	4
5	Social Service Workers			5
6	Head Cook	1	7.15	6
7	Cook Helpers/Assistants	1	7.50	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	7.00	10
11	Laundry			11
12	Managers	1	13.00	12
13	Other Administrative	1	9.50	13
14	Clerical			14
15	Marketing			15
16	Other	2	7.00	16
17	Total (lines 1 thru 16)	14	\$	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	\$	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

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: Emerald Glen

Report Period Beginning: 1/1/05

Ending: 11/15/05

VIII. OWNERSHIP COSTS

A. Purchase price of land 110,265 Year land was acquired 1998

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				1999	\$ 902,402	\$ 29,581	39	\$ 23,139	\$ (6,442)	\$ 330,274	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Renovations			2002	53,097	5,838	15	3,540	(2,298)	17,139	6
7	New addition			2003	599,408	11,552	39	15,369	3,817	22,213	7
8	New air conditioner			2005	7,912						8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,562,819	\$ 46,971		\$ 42,048	\$ (4,923)	\$ 369,626	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	\$	\$	\$	\$		\$	18
19	Vehicles	10,114	2,487	2,023	(464)	5	6,183	19
20	TOTAL (lines 18 and 19)		\$ 10,114	\$ 2,487	\$ 2,023	(464)	\$ 6,183	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: Emerald Glen

Report Period Beginning: 1/1/05

Ending: 11/15/05

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

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	1999	22	/ /	\$			3
4	Additions	2003	13	/ /				4
5				/ /				5
6				/ /				6
7	TOTAL		35		\$			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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	Peoples State Bank		x	Construction (refinanced)	9/24/04	\$ 3,117,233	\$ 2,963,247	8/27/19	6.2500	\$ 82,205
2	City of Olney		x	Construction	10/16/00	100,000	63,970	9/16/16	4.0000	1,977
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 3,217,233	\$ 3,027,217			\$ 84,182
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 3,217,233	\$ 3,027,217			\$ 84,182

* 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.

STATE OF ILLINOIS

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Facility Name: Emerald Glen

Report Period Beginning: 1/1/05

Ending:

11/15/05

11/15/05

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/15/05

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 43,584	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	69,383		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 112,967	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	110,265		13
14	Buildings, at Historical Cost	1,562,819		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	10,114		16
17	Accumulated Depreciation (book methods)	(375,809)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,307,389	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,420,356	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,550		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	172		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 14,722	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,545,593		38
39	Mortgage Payable			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)	\$ 1,545,593	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,560,315	\$	45
46	TOTAL EQUITY	\$ (139,959)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,420,356	\$	47

*(See instructions.)

Facility Name: Emerald Glen

Report Period Beginning: 1/1/05

Ending:

11/15/05

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	\$ 618,982	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 618,982	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	635	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 635	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 619,617	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	185,262	19
20	Health Care/ Personal Care	105,204	20
21	General Administration	134,933	21
B. Capital Expense			
22	Ownership	185,548	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)	\$ 610,947	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 8,670	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 8,670	31