

		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>Evergreen Place</u></p> <hr/> <p>Address: <u>R.T. 3 P.O. Box 446</u> <u>Beardstown</u></p> <p style="text-align: center;">Number City Zip Code</p> <p>County: <u>Cass</u></p> <hr/> <p>Telephone Number: (<u>217</u>) Fax # ()</p> <p>Federal Employer ID Number: <u>37-0909086</u></p> <p>Date Current Owners were Certified: <u>1999</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 checked="" 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 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 checked="" 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>Craig Ater</u> Telephone Number: (<u>217</u>) <u>7135</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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>01/01/05</u> to <u>12/31/05</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px; text-align: right;">(Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Craig L Ater</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>Sr. V. P. & CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px; text-align: right;">(Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(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>Craig L Ater</u>		(Title) <u>Sr. V. P. & CFO</u>	Paid Preparer	(Signed) _____		(Date)		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____
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Facility Name Evergreen Place

Report Period Beginning: 01/01/05 Ending: 12/31/05

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	26	Single Unit Apartment	26	9,490	1
2		Double Unit Apartment			2
3		Other			3
4	26	TOTALS	26	9,490	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	5,168	4,104		9,272	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,168	4,104		9,272	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.70%

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

* 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.

STATE OF ILLINOIS

Page 3

Facility Name: Evergreen Place

Report Period Beginning:

01/01/05

Ending:

12/31/05

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	39,294	44,074		83,368		83,368	1
2	Housekeeping, Laundry and Maintenance	38,326	9,797		48,123		48,123	2
3	Heat and Other Utilities			42,812	42,812		42,812	3
4	Other (specify):							4
5	TOTAL General Services	77,620	53,871	42,812	174,302		174,302	5
B. Health Care and Programs								
6	Health Care/ Personal Care	119,659	77		119,736		119,736	6
7	Activities and Social Services		1,581		1,581		1,581	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	119,659	1,658		121,317		121,317	9
C. General Administration								
10	Administrative and Clerical	43,545	3,171		46,716		46,716	10
11	Marketing Materials, Promotions and Advertising		968		968		968	11
12	Employee Benefits and Payroll Taxes		51,605		51,605		51,605	12
13	Insurance-Property, Liability and Malpractice		18,272		18,272		18,272	13
14	Other (specify):							14
15	TOTAL General Administration	43,545	74,016		117,561		117,561	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	240,824	129,544	42,812	413,180		413,180	16
Capital Expenses								
D. Ownership								
17	Depreciation			20,194	20,194		20,194	17
18	Interest							18
19	Real Estate Taxes			15,007	15,007		15,007	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			35,201	35,201		35,201	23
24	GRAND TOTAL (Sum of lines 16 and 23)	240,824	129,544	78,012	448,381		448,381	24

Facility Name: Evergreen Place

Report Period Beginning 01/01/05 Ending: 12/31/05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 20.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	5	9.00	3
4	Activity Director & Assistant			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	15.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	7	\$	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
attached schedule	

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: Evergreen Place

Report Period Beginning:

01/01/05

Ending:

12/31/05

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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	26		1999		\$ 648,948	\$ 16,653		\$ 16,653	\$	\$ 105,884	1
2											2
3											3
4											4
5											5
Improvement Type											
6	A/C Repair			2005	11,067						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)				\$ 660,015	\$ 16,653		\$ 16,653	\$	\$ 105,884	17

C. Equipment Depreciation -- Including Transportatio

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 24,786	\$ 3,541	\$ 3,541	\$		\$ 23,015	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)		\$ 24,786	\$ 3,541	\$ 3,541	\$	\$ 23,015	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: Evergreen Place

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			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				Amount of Note					
		Related**			Date of Note	Original	Balance	Maturity Date			
		YES	NO								
A. Directly Facility Related											
Long-Term											
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
Working Capital											
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$	7
B. Non-Facility Related											
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$	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: Evergreen Place

Report Period Beginning: 01/01/05

Ending:

12/31/05

12/31/05

XI. BALANCE SHEET - Unrestricted Operating Fund

As of 12/31/05

(last day of reporting year)

	1	2	
	Operating	After	
		Consolidation*	
A. Current Assets			
1	Cash on Hand and in Bank	\$ 5,556	\$ 1
2	Cash-Patient Deposits	7,455	2
3	Accounts & Short-Term Notes Receivable Patients (less allowance)	497,279	3
4	Supply Inventory (priced a)		4
5	Short-Term Investments		5
6	Prepaid Insurance	28,154	6
7	Other Prepaid Expense:		7
8	Accounts Receivable (owners or related parties: Other(specify)	(1,434,489)	8
9			9
10	TOTAL Current Assets: (sum of lines 1 thru 9)	\$ (896,045)	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investment		12
13	Land	25,000	13
14	Buildings, at Historical Cost	2,703,587	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	654,237	16
17	Accumulated Depreciation (book methods)	(1,273,791)	17
18	Deferred Charges:		18
19	Organization & Pre-Operating Cost		19
20	Accumulated Amortization Organization & Pre-Operating Cost		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify)		22
23	Other(specify)	31,069	23
24	TOTAL Long-Term Assets: (sum of lines 11 thru 23)	\$ 2,140,102	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,244,057	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 76,737	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposit	7,455	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	130,996	30
31	Accrued Taxes Payable	17,724	31
32	Accrued Interest Payable	5,568	32
33	Deferred Compensation		33
34	Federal and State Income Tax:		34
35	Other Current Liabilities(specify):		
36		62,467	35
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 300,947	\$ 37
D. Long-Term Liabilities			
38	Long-Term Notes Payable		38
39	Mortgage Payable	935,842	39
40	Bonds Payable		40
41	Deferred Compensation		41
42	Other Long-Term Liabilities(specify):		
43			42
44	TOTAL Long-Term Liabilities: (sum of lines 38 thru 43)	\$ 935,842	\$ 44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,236,789	\$ 45
46	TOTAL EQUITY	\$ 7,268	\$ 46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,244,057	\$ 47

*(See instructions.)

Facility Name: Evergreen Place

Report Period Beginning: 01/01/05

Ending:

12/31/05

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	\$ 561,557	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 561,557	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 561,557	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	174,302	19
20	Health Care/ Personal Care	121,317	20
21	General Administration	117,561	21
B. Capital Expense			
22	Ownership	35,201	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 448,381	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 113,176	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 113,176	31

Allocated			Direct	
G&A			G&A	
benefits	13676	3,730	Salary	43545
health ins	77961	21,262	supplies	3171
liab ins	66999	18,272	Promo	968
work comp	46579	12,703	Taxes	13910
		55,967		61594
Maint			Maint	
wages	78213	21,330	Repairs	3863
utilities	156979	42,812		
r/e taxes	55026	15,007		
		79,149		3863
Dietary			Dietary	
Wages	144081	39,294		
Food	151222	41,242		180
Supplies	9695	2,644		8
	304998	83,180		188
Laundry				
Wages	46305	12,628		
Supplies	16244	4,430		0
	62549	17,058		0
Total Allo		235,354	Housekeeping	
			Salary	4367
			Supplies	1504
				5871
			Nursing	
			Salaries	119659
			Supplies	77
				119736
			Activities	
			Supplies	1581
			Total Direct	192833
			Grnd Tot	428,187