FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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.

I.

Facility Name: Evergreen Village Supportive Living-Normal

Address: 1701 Evergreen Village Blvd (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 452-7300 **Fax #** ( )

Federal Employer ID Number: 208962745

Date Current Owners were Certified: 2008

Type of Ownership:

	VOLUNTARY, NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309 823-7135
Email Address: cater@heritageofcare.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/09 to 12/31/09 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Craig L. Ater
(Title) Executive V.P. & CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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**

Facility Name Evergreen Village Supportive Living-Normal Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	99	Single Unit Apartment	99	36,135	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,135	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	22,366	13,105		35,471	5
6	Double Unit					6
7	Other					7
8	TOTALS	22,366	13,105		35,471	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.16%

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 [x]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [x]

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*
[x]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [x] 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. _____

Facility Name: Evergreen Village Supportive Living-Normal **Report Period Beginning: 01/01/09 Ending: 12/31/09**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	260,756	201,304		462,060		462,060	1
2	Housekeeping, Laundry and Maintenance	98,727	49,868		148,595		148,595	2
3	Heat and Other Utilities			199,579	199,579		199,579	3
4	Other (specify):							4
5	**TOTAL General Services**	359,483	251,172	199,579	810,234		810,234	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	473,879	2,409		476,288		476,288	6
7	Activities and Social Services	33,135	3,348		36,483		36,483	7
8	Other (specify):			18,136	18,136		18,136	8
9	**TOTAL Health Care and Programs**	507,014	5,757	18,136	530,907		530,907	9
	C. General Administration							
10	Administrative and Clerical	218,516	6,075	186,656	411,247	(110)	411,137	10
11	Marketing Materials, Promotions and Advertising			49,191	49,191		49,191	11
12	Employee Benefits and Payroll Taxes			194,733	194,733		194,733	12
13	Insurance-Property, Liability and Malpractice			46,785	46,785		46,785	13
14	Other (specify):							14
15	**TOTAL General Administration**	218,516	6,075	477,365	701,956	(110)	701,846	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,085,013	263,004	695,080	2,043,097	(110)	2,042,987	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			347,810	347,810		347,810	17
18	Interest			559,357	559,357	(7,170)	552,187	18
19	Real Estate Taxes			135,543	135,543		135,543	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,061	4,061		4,061	21
22	Other (specify):							22
23	**TOTAL Ownership**			1,046,771	1,046,771	(7,170)	1,039,601	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,085,013	263,004	1,741,851	3,089,868	(7,280)	3,082,588	24

Facility Name: Evergreen Village Supportive Living-Normal **Report Period Beginning 01/01/09 Ending: 12/31/09**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	$ 25.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	12.00	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.00	5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	10	10.00	7
8	Dishwashers			8
9	Maintenance Workers	2	15.00	9
10	Housekeepers	2	10.00	10
11	Laundry			11
12	Managers	1	40.00	12
13	Other Administrative	2	20.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	34	$	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	Heritage Operations Group LLC	$ 166,259	1
2			2
	Total	$ 166,259	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		
Evergreen Streator LP	Streator		
Evergreen Litchfield LP	Litchfield		
Evergreen Beardstown	Beardstown		

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 [x]

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 [x]

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 Village Supportive Living-Normal Report Period Beginning: 01/01/09 Ending: 12/31/09

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	99			2008	$ 8,204,889	$ 258,981		$ 258,981	$	$ 516,102	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Exterior Sign			2008	12,609						6
7	Patio & Sidewalk & fence			2008	12,506						7
8	Generator			2009	118,123						8
9	Fire Alarm			2009	2,500						9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 8,350,627	$ 258,981		$ 258,981	$	$ 516,102	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	$ 536,935	$ 88,829	$ 88,829	$		$ 175,474	18
19	Vehicles	58,061						19
20	TOTAL (lines 18 and 19)	$ 594,996	$ 88,829	$ 88,829	$		$ 175,474	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 Village Supportive Living-Normal Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	Busey Bank		x	Mortgage	/ /2008	$ 9,087,017	$ 8,898,211	/ /2015	0.0595	$ 542,962	1
2				Loan Fee Amortization	/ /			/ /		16,395	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 9,087,017	$ 8,898,211			$ 559,357	7
	B. Non-Facility Related										
8	Interst Income				/ /			/ /		-7,170	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 9,087,017	$ 8,898,211			$ 552,187	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 Village Supportive Living-Normal **Report Period Beginning:** 01/01/09 **Ending:** 12/31/09

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/09 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	578,738		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,423		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(391,650)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 206,811	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,471		13
14	Buildings, at Historical Cost	8,350,627		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	594,996		16
17	Accumulated Depreciation (book methods)	(691,576)		17
18	Deferred Charges	86,071		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)**	$ 8,617,589	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,824,400	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,141	$	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	132,014		31
32	Accrued Interest Payable	25,000		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)**	$ 233,155	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,898,211		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)**	$ 8,898,211	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 9,131,366	$	45
46	**TOTAL EQUITY**	$ (306,966)	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 8,824,400	$	47

***(See instructions.)**

Facility Name: Evergreen Village Supportive Living-Normal **Report Period Beginning: 01/01/09 Ending: 12/31/09**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,305,573	1
2	Discounts and Allowances	(2,017)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,303,556	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	21,629	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 21,629	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	7,170	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 7,170	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)**	$ 3,332,355	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	810,234	19
20	Health Care/ Personal Care	530,907	20
21	General Administration	701,956	21
	B. Capital Expense		
22	Ownership	1,046,771	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)**	$ 3,089,868	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 242,487	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 242,487	31