

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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>1000107</u></p> <p>Facility Name: <u>Evergreen Place</u></p> <hr/> <p>Address: <u>1015 East Tyler Avenue</u> <u>Litchfield</u> <u>62056</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Montgomery</u></p> <p>Telephone Number: (<u>217</u>) <u>452-7300</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" 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 checked="" 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 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:</p> <p>Name: <u>Craig Ater</u> Telephone Number: <u>(309-823-7135)</u></p> <p>Email Address: _____</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 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>01/01/2010</u> to <u>12/31/10</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:30%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Craig L Ater</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Executive VP & CFO</u></td> <td></td> </tr> <tr> <td>Paid Preparer</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 & 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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Craig L Ater</u>			(Title) <u>Executive VP & CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
<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 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	_____																																												
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																												
	(Type or Print Name) <u>Craig L Ater</u>																																													
	(Title) <u>Executive VP & CFO</u>																																													
Paid Preparer	(Signed) _____	(Date) _____																																												
	(Print Name and Title) _____																																													
	(Firm Name & Address) _____																																													
	(Telephone) () _____	Fax # () _____																																												

Facility Name: Evergreen Place

Report Period Beginning:

01/01/2010

Ending:

12/31/10

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	160,583	138,213		298,796		298,796	1
2	Housekeeping, Laundry and Maintenance	60,602	47,721		108,323		108,323	2
3	Heat and Other Utilities			121,392	121,392		121,392	3
4	Other (specify):							4
5	TOTAL General Services	221,185	185,934	121,392	528,511		528,511	5
B. Health Care and Programs								
6	Health Care/ Personal Care	237,769	929		238,698		238,698	6
7	Activities and Social Services	29,250	2,344		31,594		31,594	7
8	Other (specify):			6,267	6,267		6,267	8
9	TOTAL Health Care and Programs	267,019	3,273	6,267	276,559		276,559	9
C. General Administration								
10	Administrative and Clerical	144,254	8,938	181,786	334,978	(335)	334,643	10
11	Marketing Materials, Promotions and Advertising			42,973	42,973		42,973	11
12	Employee Benefits and Payroll Taxes			119,049	119,049		119,049	12
13	Insurance-Property, Liability and Malpractice			34,917	34,917		34,917	13
14	Other (specify):							14
15	TOTAL General Administration	144,254	8,938	378,725	531,917	(335)	531,582	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	632,458	198,145	506,384	1,336,987	(335)	1,336,652	16
Capital Expenses								
D. Ownership								
17	Depreciation			317,012	317,012		317,012	17
18	Interest			497,210	497,210	(2,807)	494,403	18
19	Real Estate Taxes			(70,945)	(70,945)		(70,945)	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			18,914	18,914		18,914	21
22	Other (specify):							22
23	TOTAL Ownership			762,191	762,191	(2,807)	759,384	23
24	GRAND TOTAL (Sum of lines 16 and 23)	632,458	198,145	1,268,575	2,099,178	(3,142)	2,096,036	24

Facility Name: Evergreen Place

Report Period Beginning: 01/01/2010 Ending: 12/31/10

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7	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	5	10.00	7
8	Dishwashers			8
9	Maintenance Workers	1	15.00	9
10	Housekeepers	1	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)	20	\$	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

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 <u>1</u>	City <u>2</u>
Evergreen Streator LP	Streator
Evergreen Litchfield LP	Litchfield
Evergreen Beardstown	Beardstown

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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).

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Heritage Operations Group LLC	\$ 75,634	1
2			2
Total		\$ 75,634	3

Facility Name: Evergreen Place

Report Period Beginning:

01/01/2010

Ending:

12/31/10

VIII. OWNERSHIP COSTS

A. Purchase price of land 59,450 Year land was acquired 2008

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	69				\$ 9,151,234	\$ 247,763		\$ 247,763	\$	\$ 535,984	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Landscaping		2009		13,600						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)				\$ 9,164,834	\$ 247,763		\$ 247,763	\$	\$ 535,984	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	\$ 592,490	\$ 69,249	\$ 69,249	\$		\$ 150,039	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 592,490	\$ 69,249	\$ 69,249	\$		\$ 150,039	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: 01/01/2010

Ending: 12/31/10

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	Name of Lender	2		3	4	6		7	8	9						
			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		IHDA		x	Mortgage	/ /	\$	\$ 8,947,080	/ /2043		\$ 497,210	1					
2						/ /			/ /			2					
3						/ /			/ /			3					
		Working Capital															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		TOTAL Facility Related					\$	\$ 8,947,080			\$ 497,210	7					
		B. Non-Facility Related															
8		Interest Income				/ /			/ /		-2,807	8					
9						/ /			/ /			9					
10		TOTALS (lines 7, 8 and 9)					\$	\$ 8,947,080			\$ 494,403	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: 01/01/2010

Ending:

12/31/10

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 904,814	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	80,034		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,027		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,059,875	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	788,611		13
14	Buildings, at Historical Cost	8,435,673		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	692,490		16
17	Accumulated Depreciation (book methods)	(686,023)		17
18	Deferred Charges	225,046		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)	\$ 9,455,797	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,515,672	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,868	\$	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	116,344		31
32	Accrued Interest Payable	35,091		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Funds	8,066		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 215,369	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,947,080		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)	\$ 8,947,080	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,162,449	\$	45
46	TOTAL EQUITY	\$ 1,353,223	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,515,672	\$	47

Facility Name: Evergreen Place

Report Period Beginning: 01/01/2010

Ending:

12/31/10

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	\$ 2,001,026	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 2,001,026	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	6,578	8
9	Non-Resident Meals		9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 6,578	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,807	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 2,807	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)	\$ 2,010,411	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	528,511	19
20	Health Care/ Personal Care	276,559	20
21	General Administration	531,917	21
B. Capital Expense			
22	Ownership	762,191	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):	101	25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,099,279	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (88,868)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (88,868)	31