

FOR BHF USE					

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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>1000091</u></p> <p>Facility Name: <u>Evergreen Village Supportive Living</u></p> <p>Address: <u>1701 Evergreen Village Blvd</u> <u>Normal</u> <u>61761</u> <small>Number City Zip Code</small></p> <p>County: <u>McLean</u></p> <p>Telephone Number: (<u>309</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%; 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 type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" 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>(309)823-7135</u> 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 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 checked="" 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>01/01/12</u> to <u>12/31/12</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%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Craig Ater</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Exec VP & CFO</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(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 Ater</u>		(Title) <u>Exec 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																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name Evergreen Village Supportive Living

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

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	99	Single Unit Apartment	99	36,234	1
2		Double Unit Apartment			2
3		Other			3
4	99	TOTALS	99	36,234	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	26,629	9,305		35,934	5
6	Double Unit					6
7	Other					7
8	TOTALS	26,629	9,305		35,934	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.17%

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. _____

Facility Name: Evergreen Village Supportive Living

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	254,533	239,523		494,056		494,056	1
2	Housekeeping, Laundry and Maintenance	117,669	63,714		181,383		181,383	2
3	Heat and Other Utilities			187,775	187,775		187,775	3
4	Other (specify):							4
5	TOTAL General Services	372,202	303,237	187,775	863,214		863,214	5
B. Health Care and Programs								
6	Health Care/ Personal Care	531,415	2,860		534,275		534,275	6
7	Activities and Social Services	35,991	2,702		38,693		38,693	7
8	Other (specify):			18,424	18,424		18,424	8
9	TOTAL Health Care and Programs	567,406	5,562	18,424	591,392		591,392	9
C. General Administration								
10	Administrative and Clerical	189,266	6,379	188,069	383,714	(35)	383,679	10
11	Marketing Materials, Promotions and Advertising			38,997	38,997		38,997	11
12	Employee Benefits and Payroll Taxes			213,987	213,987		213,987	12
13	Insurance-Property, Liability and Malpractice			47,003	47,003		47,003	13
14	Other (specify):							14
15	TOTAL General Administration	189,266	6,379	488,056	683,701	(35)	683,666	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,128,874	315,178	694,255	2,138,307	(35)	2,138,272	16
Capital Expenses								
D. Ownership								
17	Depreciation			361,316	361,316		361,316	17
18	Interest			520,426	520,426	(19,078)	501,348	18
19	Real Estate Taxes			107,576	107,576		107,576	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			11,884	11,884		11,884	21
22	Other (specify):							22
23	TOTAL Ownership			1,001,202	1,001,202	(19,078)	982,124	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,128,874	315,178	1,695,457	3,139,509	(19,113)	3,120,396	24

Facility Name: Evergreen Village Supportive Living

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

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

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Heritage Operations Group LLC	\$ 172,398	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
Evergreen Streator LP		Streator	
Evergreen Litchfield LP		Litchfield	
Evergreen Beardstown		Beardstown	
Evergreen Village		Normal	

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 Village Supportive Living

Report Period Beginning:

01/01/12

Ending:

12/31/12

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				\$ 8,204,889	\$ 299,438		\$ 299,438	\$	\$ 1,326,250	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		Power Supply		2010	7,360						10
11		Video Surveillance		2011	10,345						11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 8,368,332	\$ 299,438		\$ 299,438	\$	\$ 1,326,250	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	\$ 600,660	\$ 61,878	\$ 61,878	\$		\$ 443,244	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 600,660	\$ 61,878	\$ 61,878	\$		\$ 443,244	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

Report Period Beginning: 01/01/12

Ending: 12/31/12

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				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Busey Bank			Mortgage	/ /	\$	8,228,345	/ /		\$	520,426
2						/ /			/ /			
3						/ /			/ /			
		Working Capital										
4						/ /			/ /			
5						/ /			/ /			
6						/ /			/ /			
7		TOTAL Facility Related					\$	8,228,345			\$	520,426
		B. Non-Facility Related										
8		Interest				/ /			/ /			-19,078
9						/ /			/ /			
10		TOTALS (lines 7, 8 and 9)					\$	8,228,345			\$	501,348

* 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

Report Period Beginning: 01/01/12

Ending:

12/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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)	588,808		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,225		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)	\$ 606,333	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	343,232		13
14	Buildings, at Historical Cost	8,378,349		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	600,660		16
17	Accumulated Depreciation (book methods)	(1,769,494)		17
18	Deferred Charges	576,866		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)	\$ 8,129,613	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,735,946	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,767	\$	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	112,187		31
32	Accrued Interest Payable	62,558		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)	\$ 300,512	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,228,345		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)	\$ 8,228,345	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,528,857	\$	45
46	TOTAL EQUITY	\$ 207,089	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,735,946	\$	47

*(See instructions.)

Facility Name: Evergreen Village Supportive Living

Report Period Beginning: 01/01/12

Ending:

12/31/12

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	\$ 3,426,005	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,426,005	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	21,959	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 21,959	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	19,078	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 19,078	14
D. Other Revenue (specify):			
15			15
16	Other	45,558	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 45,558	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,512,600	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	863,214	19
20	Health Care/ Personal Care	591,392	20
21	General Administration	683,701	21
B. Capital Expense			
22	Ownership	1,001,202	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)	\$ 3,139,509	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 373,091	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 373,091	31

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg : Adjustment Line #	Amount
PETTY CASH	300				1,009	1,009 PETTY C/ 300
CASH IN BANK					1,100	1,100 ACCTS RI 588,808
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBLES
ACCOUNTS RECEIVABLE	588,808				1,110	1,110 ACCTS RECEIV-M/C
MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 17,225
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	17,225				1,310	1,310 SUPPLIES INVENTORY
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 343,232
SUPPLIES INVENTORY					1,450	1,450 FURNITU 600,660
LAND	343,232				1,460	-443,244
FURNITURE & EQUIPMENT	600,660				1,475	1,475 CODE AL 8,378,349
ACCUM DEPR-FURN & EQUIP	-443,244				1,490	1,490 ACCUM I -1,326,250
BUILDING & IMPROVEMENT	8,378,349				1,530	1,530 RESIDEN' 0
ACCUM DEPR-BUILDING	-1,326,250				1,550	1,550 LOAN FEI 576,866
RESIDENT FUNDS	0				1,551	1,551 LOAN FEES ADDED
LOAN FEES	576,866				1,850	1,850 INTERCO 0
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN' -125,767
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	0				2,100	2,100 ACCRUEI 0
ACCOUNTS PAYABLE	-125,767				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	0				2,110	2,110 ACCRUEI 0
ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAX 0
FICA TAX PAYABLE	0	0			2,130	2,130 FEDERAL W/H TAX PAYABLE
FIT PAYABLE					2,140	2,140 STATE W/H TAX PAYABLE
STATE W/H PAYABLE		0			2,152	2,152 WORKERS COMP ACCRUAL
EARNED INCOME CREDIT					2,225	2,225 EMPLOYEEE INSURANCE REFUND

UC FED CREDIT REDUCTION
PAYROLL SAVINGS

2,230
2,235

2,230 PAYROLL SAVINGS
2,240 UNITED FUND

