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.

I. Facility ID Number: 1000138

Facility Name: Evergreen Place of Decatur

Address: 4825 East Evergreen (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: (217) 864-4300 **Fax #** ( )

Federal Employer ID Number:

Date Current Owners were Certified: May 2012

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[xx] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[xx] 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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/12 to 12/31/12 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 Ater
(Title) Exec VP & 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 Place of Decatur Report Period Beginning: 05/01/12 Ending: 12/31/12

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	113	Single Unit Apartment	113	26,465	1
2		Double Unit Apartment			2
3		Other			3
4	113	TOTALS	113	26,465	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	3,353	13,142		16,495	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,353	13,142		16,495	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 62.33%

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 [x] MODIFIED CASH* [ ] CASH* [ ]

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 Place of Decatur **Report Period Beginning: 05/01/12 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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	127,662	146,289		273,951		273,951	1
2	Housekeeping, Laundry and Maintenance	53,117	59,147		112,264		112,264	2
3	Heat and Other Utilities			109,985	109,985		109,985	3
4	Other (specify):							4
5	**TOTAL General Services**	180,779	205,436	109,985	496,200		496,200	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	296,938	1,221		298,159		298,159	6
7	Activities and Social Services	27,042	7,225		34,267		34,267	7
8	Other (specify):			7,187	7,187		7,187	8
9	**TOTAL Health Care and Programs**	323,980	8,446	7,187	339,613		339,613	9
	C. General Administration							
10	Administrative and Clerical	138,975	25,821	94,800	259,596		259,596	10
11	Marketing Materials, Promotions and Advertising			354,597	354,597		354,597	11
12	Employee Benefits and Payroll Taxes			102,452	102,452		102,452	12
13	Insurance-Property, Liability and Malpractice			23,880	23,880		23,880	13
14	Other (specify):							14
15	**TOTAL General Administration**	138,975	25,821	575,729	740,525		740,525	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	643,734	239,703	692,901	1,576,338		1,576,338	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			258,351	258,351		258,351	17
18	Interest			320,238	320,238	(3,107)	317,131	18
19	Real Estate Taxes			75,000	75,000		75,000	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			11,145	11,145		11,145	21
22	Other (specify):							22
23	**TOTAL Ownership**			664,734	664,734	(3,107)	661,627	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	643,734	239,703	1,357,635	2,241,072	(3,107)	2,237,965	24

Facility Name: Evergreen Place of Decatur Report Period Beginning 05/01/12 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	$ 85,308	1
2			2
		Total $ 85,308	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	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 Place of Decatur Report Period Beginning: 05/01/12 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	113				$ 10,601,024	$ 151,211		$ 151,211	$	$ 151,211	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											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)				$ 10,601,024	$ 151,211		$ 151,211	$	$ 151,211	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	$ 1,505,598	$ 107,140	$ 107,140	$		$ 107,140	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 1,505,598	$ 107,140	$ 107,140	$		$ 107,140	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 of Decatur Report Period Beginning: 05/01/12 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 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										
1	Marine Bank		x	Mortgage	/ /	$	$ 11,981,880	/ /		$ 320,238	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 11,981,880			$ 320,238	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-3,107	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 11,981,880			$ 317,131	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 of Decatur **Report Period Beginning:** 05/01/12 **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	$ 330,839	$	1
2	Cash-Patient Deposits	962		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	509,037		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,102		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)**	$ 860,940	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,993		13
14	Buildings, at Historical Cost	10,601,024		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,505,598		16
17	Accumulated Depreciation (book methods)	(258,351)		17
18	Deferred Charges	69,234		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)**	$ 13,903,498	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,764,438	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,421	$	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	69,207		31
32	Accrued Interest Payable	17,305		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35		962		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 194,895	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,981,880		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)**	$ 11,981,880	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 12,176,775	$	45
46	**TOTAL EQUITY**	$ 2,587,663	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 14,764,438	$	47

***(See instructions.)**

Facility Name: Evergreen Place of Decatur **Report Period Beginning: 05/01/12 Ending: 12/31/12**

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	$ 1,693,899	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,693,899	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	8,951	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 8,951	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,107	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 3,107	14
	D. Other Revenue (specify):		
15			15
16	**Other**	2,305	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 2,305	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,708,262	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	496,200	19
20	Health Care/ Personal Care	339,613	20
21	General Administration	740,525	21
	B. Capital Expense		
22	Ownership	664,734	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)**	$ 2,241,072	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (532,810)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (532,810)	31

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3, Line #	Sch 5 pg 3, Col #	Sch 6 pg 1, Line #	Adjustment Amount
PETTY CASH	330,839					
CASH IN BANK						
CASH IN BANK-PAYROLL						
ACCOUNTS RECEIVABLE	509,037					
MEDICARE RECEIVABLES						
IPA INCOME RECEIVABLE						
MEDICARE COST REPORT						
ACCOUNTS RECEIVABLE-IC						
UNAPPLIED CASH RECEIPTS						
A/R SUSPENSE-REFUNDS						
ACCRUED INTEREST REC						
PREPAID INSURANCE	20,102					
OTHER PREPAID EXPENSES						
FOOD INVENTORY						
SUPPLIES INVENTORY						
LAND	1,985,993					
FURNITURE & EQUIPMENT	1,505,598					
ACCUM DEPR-FURN & EQUII	-107,140					
BUILDING & IMPROVEMENT	10,601,024					
ACCUM DEPR-BUILDING	-151,211					
RESIDENT FUNDS	962					
LOAN FEES	69,234					
REAL ESTATE TAX ESCROW						
REIMBURSABLE PURCHASES						
INTRACOMPANY	0					
ACCOUNTS PAYABLE	-107,421					
BONUSES PAYABLE						
ACCRUED PAYROLL	0					
ACCRUED VACATION PAY	0					
UC TAXES PAYABLE						
FICA TAX PAYABLE	0		0			
FIT PAYABLE						
STATE W/H PAYABLE			0			
EARNED INCOME CREDIT						

1,009	1,009	PETTY CA	330,839	
1,100	1,100	ACCTS RI	509,037	
1,101	1,101	ALLOW. FOR UNCOLLECTIBLES		
1,110	1,110	ACCTS RECEIV-M/C		
1,125	1,125	ACCTS RECEIV-IPA		
1,135	1,135	ACCTS RECEIV-IC		
1,140	1,140	UNAPPLIED CASH RECEIPTS		
1,145	1,145	A/R SUSPENSE-REFUNDS		
1,200	1,200	PREPAID	20,102	
1,220	1,220	OTHER PREPAID EXPENSES		
1,300	1,300	DIETARY INVENTORY		
1,310	1,310	SUPPLIES INVENTORY		
1,320	1,320	LINEN INVENTORY		
1,409	1,409	LAND	1,985,993	
1,450	1,450	FURNITU	1,505,598	
1,460			-107,140	
1,475	1,475	CODE AL	10,601,024	
1,490	1,490	ACCUM I	-151,211	
1,530	1,530	RESIDEN	962	
1,550	1,550	LOAN FE	69,234	
1,551	1,551	LOAN FEES ADDED		
1,850	1,850	INTERCO	0	
2,010	2,010	ACCOUN	-107,421	
2,100	2,095	BONUSES PAYABLE		
2,100	2,100	ACCRUEI	0	
2,100	2,100	PR CLEARING-BENEFITS		
2,100	2,100	PR CLEARING-LABOR		
2,110	2,110	ACCRUEI	0	
2,120	2,120	U.C. TAXES PAYABLE		
2,125	2,125	FICA TAX	0	
2,130	2,130	FEDERAL W/H TAX PAYABLE		
2,140	2,140	STATE W/H TAX PAYABLE		
2,152	2,152	WORKERS COMP ACCRUAL		
2,225	2,225	EMPLOYEEE INSURANCE REFUND		

UC FED CREDIT REDUCTION PAYROLL SAVINGS	2,230	2,230 PAYROLL SAVINGS
	2,235	2,240 UNITED FUND