

		FOR BHF USE			

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2015)

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 Decatur 62521

Number City Zip Code

County: Macon

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

Federal Employer ID Number: _____

Date Current Owners were Certified: 2012

Type of Ownership:

<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		_____

In the event there are further questions about this report, please contact:

Name: Dave Underwood Telephone Number: ()

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 01/01/15 to 12/31/15 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) David M. Underwood

(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: 01/01/15 Ending: 12/31/15

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	113	Single Unit Apartment	113	41,245	1
2		Double Unit Apartment			2
3		Other			3
4	113	TOTALS	113	41,245	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	19,631	21,220		40,851	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,631	21,220		40,851	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.04%

D. Indicate the number of paid bed-hold days the SLF had during this year None 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)

None

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.

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Facility Name: Evergreen Place of Decatur

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	252,691	286,920		539,611		539,611	1
2	Housekeeping, Laundry and Maintenance	102,595	36,701		139,296		139,296	2
3	Heat and Other Utilities			212,940	212,940		212,940	3
4	Other (specify):							4
5	TOTAL General Services	355,286	323,621	212,940	891,847		891,847	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	707,831	5,186	15,651	728,668		728,668	6
7	Activities and Social Services	58,203	6,313	312	64,828		64,828	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	766,034	11,499	15,963	793,496		793,496	9
	C. General Administration							
10	Administrative and Clerical	219,454	17,336	341,896	578,686	(66,573)	512,113	10
11	Marketing Materials, Promotions and Advertising			64,384	64,384		64,384	11
12	Employee Benefits and Payroll Taxes			303,478	303,478		303,478	12
13	Insurance-Property, Liability and Malpractice			41,206	41,206		41,206	13
14	Other (specify):							14
15	TOTAL General Administration	219,454	17,336	750,964	987,754	(66,573)	921,181	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,340,774	352,456	979,867	2,673,097	(66,573)	2,606,524	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			522,808	522,808		522,808	17
18	Interest			575,481	575,481	(1,892)	573,589	18
19	Real Estate Taxes			210,454	210,454		210,454	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			11,861	11,861		11,861	21
22	Other (specify):							22
23	TOTAL Ownership			1,320,604	1,320,604	(1,892)	1,318,712	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,340,774	352,456	2,300,471	3,993,701	(68,465)	3,925,236	24

Facility Name: Evergreen Place of Decatur

Report Period Beginning 01/01/15 Ending: 12/31/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3.66	\$ 26.80	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	19.88	11.02	3
4	Activity Director & Assistants	1.99	13.07	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11.38	10.17	7
8	Dishwashers			8
9	Maintenance Workers	0.93	21.50	9
10	Housekeepers	3.09	8.55	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	4.09	17.20	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	45.02	\$ 12.79	17

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

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).

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	\$ 218,835	1
2			2
Total		\$ 218,835	3

Facility Name: Evergreen Place of Decatur Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 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					\$ 10,601,024	\$ 306,032		\$ 306,032	\$	1,065,999	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Five (5) Eyewash Station Construction			2013	3,392						6
7	Cable TV Installation-first installment			2013	22,394						7
8	Cable TV Installation-second installment			2014	28,210						8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,655,020	\$ 306,032		\$ 306,032	\$	1,065,999	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	\$ 615,799	\$ 216,776	\$ 216,776	\$		\$ 754,792	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 615,799	\$ 216,776	\$ 216,776	\$		\$ 754,792	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

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: None

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	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	Marine Bank			Mortgage	/ /	\$	11,393,956	/ /		\$ 575,481	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	11,393,956			\$ 575,481	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-1,892	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	11,393,956			\$ 573,589	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.

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Facility Name: Evergreen Place of Decatur

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 995,842	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	419,036		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,435		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,586		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,444,899	\$	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	10,655,021		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,519,506		16
17	Accumulated Depreciation (book methods)	(1,820,791)		17
18	Deferred Charges	76,514		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)	\$ 12,416,243	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,861,142	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 127,254	\$	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	224,747		31
32	Accrued Interest Payable	16,537		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)	\$ 368,538	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,393,956		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)	\$ 11,393,956	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,762,494	\$	45
46	TOTAL EQUITY	\$ 2,096,062	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 13,858,556	\$	47

*(See instructions.)

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 01/01/15

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 4,359,618	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 4,359,618	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	19,591	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 19,591	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,892	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,892	14
	D. Other Revenue (specify):		
15	Activity Fund	(2,508)	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ (2,508)	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,378,593	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	891,847	19
20	Health Care/ Personal Care	793,496	20
21	General Administration	987,754	21
	B. Capital Expense		
22	Ownership	1,320,604	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)	\$ 3,993,701	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 384,892	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 384,892	31