

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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: 1000105

Facility Name: Evergreen Place Streator

Address: 1529 E Main StStreator61364

County: LaSalle

Telephone Number: (815) 672-0903 Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: 2008

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

xx
PROPRIETARY
Individual
xx
Partnership
Corporation
"Sub-S" Corp.
Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: David M Underwood 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 1/1/2019 to 12/31/2019 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) EVP & 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 Streator**

Report Period Beginning: 1/1/2019 Ending: 12/31/2019

III. STATISTICAL DATA

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

Date of change in certified units

1 / 1

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	53	Single Unit Apartment	53	19,345	1		
2		Double Unit Apartment			2		
3		Other			3		
4	53	TOTALS	53	19,345	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	11,173	7,467		18,640	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,173	7,467		18,640	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.36%

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. None (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

ACCUAL	xx	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? Yes If yes, did the facility make all of the

required payments of interest and principal? Yes

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 principal?

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
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make all of the required payments of interest and principal?

If no, explain.

STATE OF ILLINOIS

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Facility Name: Evergreen Place Streator

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

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	126,535	162,486		289,021		289,021	1
2	Housekeeping, Laundry and Maintenance	77,020	36,312		113,332		113,332	2
3	Heat and Other Utilities			132,717	132,717		132,717	3
4	Other (specify):							4
5	TOTAL General Services	203,555	198,798	132,717	535,070		535,070	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	339,609	1,555	4,986	346,150		346,150	6
7	Activities and Social Services	28,690	5,462		34,152		34,152	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	368,299	7,017	4,986	380,302		380,302	9
	C. General Administration							
10	Administrative and Clerical	199,451	13,581	187,365	400,397	(19,765)	380,632	10
11	Marketing Materials, Promotions and Advertising			33,766	33,766	(28,450)	5,316	11
12	Employee Benefits and Payroll Taxes			92,601	92,601		92,601	12
13	Insurance-Property, Liability and Malpractice			40,100	40,100		40,100	13
14	Other (specify):							14
15	TOTAL General Administration	199,451	13,581	353,832	566,864	(48,215)	518,649	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	771,305	219,396	491,535	1,482,236	(48,215)	1,434,021	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			194,271	194,271		194,271	17
18	Interest			344,500	344,500	(27,609)	316,891	18
19	Real Estate Taxes			23,766	23,766		23,766	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			11,987	11,987		11,987	21
22	Other (specify):							22
23	TOTAL Ownership			574,524	574,524	(27,609)	546,915	23
24	GRAND TOTAL (Sum of lines 16 and 23)	771,305	219,396	1,066,059	2,056,760	(75,824)	1,980,936	24

Facility Name: Evergreen Place Streator

Report Period Beginning: 1/1/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.05	\$ 27.85	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.20	14.85	3
4	Activity Director & Assistants	0.87	15.35	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	0.94	21.61	9
10	Housekeepers	1.62	9.39	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	2.63	15.89	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15.31	\$ 16.64	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
Evergreen Litchfield LP	Litchfield

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	Heritage Enterprises	0.10%		\$ 49,369	1
2	Cinnaire	99.90%		5,000	2
3					3
4					4
5					5
Total				\$ 54369	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	Heritage Operations Group LLC	\$ 85,593	1
2			2
Total		\$ 85,593	3

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5

Facility Name: Evergreen Place Streator

Report Period Beginning:

1/1/2019

Ending:

12/31/2019

VIII. OWNERSHIP COSTSA. Purchase price of land 60,980 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	53				\$ 7,249,339	\$ 188,770		\$ 188,770		\$ 2,095,176	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Landscaping			2009	1,570						6
7	Dishwasher			2009	5,026						7
8	Parking Lot Asphalt			2011	7,424						8
9	Patio			2011	3,562						9
10	Parking Lot Sealing			2014	8,192						10
11	Install single CPU and power supply board			2016	2,658						11
12	Install vinyl flooring - 2nd floor family area			2018	5,950						12
13											13
14	Carpet roll purchase - resident room			2019	3,300						14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,287,021	\$ 188,770		\$ 188,770		\$ 2,095,176	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	\$ 649,697	\$ 5,501	\$ 5,501			\$ 630,055	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 649,697	\$ 5,501	\$ 5,501			\$ 630,055	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 Streator

Report Period Beginning: 1/1/2019

Ending: 2/31/2019

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 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	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	IHDA		xx	Mortgage	/ /	\$	5,704,650	/ /		\$ 344,500	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	5,704,650			\$ 344,500	7
	B. Non-Facility Related										
8	Interest Income				/ /			/ /		-27,609	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	5,704,650			\$ 316,891	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 Streator

Report Period Beginning: 1/1/2019

Ending: 12/31/2019

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,984,906	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	70,693		3
4	Supply Inventory (priced <u>FIFO</u>)	4,779		4
5	Short-Term Investments			5
6	Prepaid Insurance	50,714		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(3,927)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,107,165	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,374		13
14	Buildings, at Historical Cost	6,700,980		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	649,697		16
17	Accumulated Depreciation (book methods)	(2,725,231)		17
18	Deferred Charges	145,269		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): <u>Resident Funds</u>	2,294		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,229,383	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,336,548	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,630	\$	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	46,617		31
32	Accrued Interest Payable	26,034		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Resident Trust</u>	2,294		35
36	<u>Management Fees</u>	738,503		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 872,078	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,704,650		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)	\$ 5,704,650	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,576,728	\$	45
46	TOTAL EQUITY	\$ 759,820	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,336,548	\$	47

*(See instructions.)

Facility Name: Evergreen Place Streator

Report Period Beginning: 1/1/2019

Ending:

12/31/2019

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

1			
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,145,898	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,145,898	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	6,312	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 6,312	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	27,609	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 27,609	14
	D. Other Revenue (specify):		
15	Miscellaneous		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)	\$ 2,179,819	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	535,070	19
20	Health Care/ Personal Care	380,302	20
21	General Administration	566,864	21
	B. Capital Expense		
22	Ownership	574,524	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)	\$ 2,056,760	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 123,059	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 123,059	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$	37