

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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

County: Macon

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

Federal Employer ID Number:

Date Current Owners were Certified: 2012

Type of Ownership:

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

xx PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
xx 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 1/1/2021 to 12/31/2021 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



**Report Period Beginning: 1/1/2021 Ending: 12/31/2021**

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

/ /

**E. Does page 3 include expenses for services or investments not directly related to SLF services?**

**YES** ☐ **NO** ☒

YES ☐ NO ☒

(E.g., day care, "meals on wheels", outpatient therapy)

None

ACCUAL		MODIFIED	
		CASH*	CASH*
	xx		

**Tax Year:** \_\_\_\_\_ **Fiscal Year:** \_\_\_\_\_

**\* All facilities other than governmental must report on the accrual basis.**

**outstanding?**      No      **If yes, did the facility make all of the**

**required payments of interest and principal?**

**If no, explain.**

**outstanding?**      No      **If yes, did the facility make all of the**

**required payments of interest and principal?**

**If no, explain.**

<b>Economic Opportunity outstanding?</b>	<b>No</b>	<b>If yes, did the facility</b>
--	-----------	---------------------------------

**make all of the required payments of interest and principal?**

**If no, explain.**

**bed days on line 4, column 4.) 76.57%**

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.)**



## STATE OF ILLINOIS

Page 3

Facility Name: Evergreen Place of Decatur

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

## 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			
	<b>A. General Services</b>							
1	Dietary and Food Purchase	274,851	278,274		553,125		553,125	1
2	Housekeeping, Laundry and Maintenance	106,414	93,566		199,980		199,980	2
3	Heat and Other Utilities			226,598	226,598		226,598	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	381,265	371,840	226,598	979,703		979,703	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	912,852	6,613	3,909	923,374		923,374	6
7	Activities and Social Services	17,248	6,867		24,115		24,115	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	930,100	13,480	3,909	947,489		947,489	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	312,362	20,240	243,504	576,106	14,375	590,481	10
11	Marketing Materials, Promotions and Advertising			73,499	73,499	(56,796)	16,703	11
12	Employee Benefits and Payroll Taxes			286,816	286,816		286,816	12
13	Insurance-Property, Liability and Malpractice			33,113	33,113		33,113	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	312,362	20,240	636,932	969,534	(42,421)	927,113	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	1,623,727	405,560	867,439	2,896,726	(42,421)	2,854,305	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			326,874	326,874		326,874	17
18	Interest			448,002	448,002	(1,675)	446,327	18
19	Real Estate Taxes			75,559	75,559		75,559	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			35,053	35,053		35,053	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			885,488	885,488	(1,675)	883,813	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	1,623,727	405,560	1,752,927	3,782,214	(44,096)	3,738,118	24



Facility Name: Evergreen Place of Decatur

Report Period Beginning 1/1/2021 Ending: 12/31/2021

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.25	\$ 31.29	1
2	Licensed Practical Nurses	2.64	24.86	2
3	Certified Nurse Assistants	21.64	15.44	3
4	Activity Director & Assistants	0.67	12.37	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10.18	12.99	7
8	Dishwashers			8
9	Maintenance Workers	1.20	20.36	9
10	Housekeepers	2.27	11.76	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	5.87	25.60	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	45.72	\$ 17.08	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
None			

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	Heritage Enterprises Inc	50.0%		\$ 150,000	1
2	Grand Oaks Estates LLC	50.0%		150,000	2
3					3
4					4
5					5
Total				\$ 300000	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Heritage Operations Group LLC	\$ 209,738	1
2			2
Total		\$ 209,738	3



Facility Name: Evergreen Place of Decatur

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

## VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 Year land was acquired 2012

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	\$ 312,523		\$ 312,523	\$	2,925,155	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	Vertical PTAC cooler			2016	4,705						9
10	Split system installation			2017	5,957						10
11	Install flooring - common areas			2017	18,113						11
12	Install smoke and CO2 detectors			2017	12,937						12
13	Upgrade phone and fire panel			2017	23,591						13
14	Split system installation			2018	4,383						14
15	Carpet rolls for resident rooms			2019	5,013						15
16	Ductless split system installation - elevator room			2019	3,770						16
17	TOTAL (lines 1 thru 16)				\$ 10,733,489	\$ 312,523		\$ 312,523	\$	2,925,155	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	\$ 1,579,902	\$ 9,224	\$ 9,224	\$		\$ 1,543,188	18
19	Vehicles	47,850	5,127	5,127			5,127	19
20	TOTAL (lines 18 and 19)	\$ 1,627,752	\$ 14,351	\$ 14,351	\$		\$ 1,548,315	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



XI. OWNERSHIP COSTS (continued)
 B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 10,733,489	\$ 312,523		\$ 312,523	\$	\$ 2,925,155	1
2									2
3	Acquire carpet roll for resident rooms	2020	4,907						3
4									4
5	Install fire pump packing	2021	2,592						5
6	Install (2) VTAC and (1) PTAC air handling units	2021	9,262						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,750,250	\$ 312,523		\$ 312,523	\$	\$ 2,925,155	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



Facility Name: Evergreen Place of Decatur

Report Period Beginning: 1/1/2021

Ending: 2/31/2021

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	Lancaster Pollard		xx	Mortgage	/ /	\$	10,628,962	/ /		\$ 448,002	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	10,628,962			\$ 448,002	7
	B. Non-Facility Related										
8					/ /			/ /		-1,675	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	10,628,962			\$ 446,327	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.



## STATE OF ILLINOIS

Page 7

Facility Name: Evergreen Place of Decatur

Report Period Beginning: 1/1/2021

Ending: 12/31/2021

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2021

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,896,974	\$	1
2	Cash-Patient Deposits	24,585		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	(13,328)		3
4	Supply Inventory (priced at )	22,378		4
5	Short-Term Investments			5
6	Prepaid Insurance	48,402		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,979,011	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,005,702		13
14	Buildings, at Historical Cost	10,750,250		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,627,752		16
17	Accumulated Depreciation (book methods)	(4,473,470)		17
18	Deferred Charges	450,871		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,361,105	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,340,116	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 105,419	\$	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	251,163		31
32	Accrued Interest Payable	25,510		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Resident Trust	24,585		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 406,677	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,628,962		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 10,628,962	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 11,035,639	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,304,477	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 12,340,116	\$	47

\*(See instructions.)



Facility Name: Evergreen Place of Decatur

Report Period Beginning: 1/1/2021

Ending:

12/31/2021

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

1			
	I. Revenue	Amount	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 4,197,332	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 4,197,332	3
	<b>B. Other Operating Revenue</b>		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	41,234	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	4,478	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$ 45,712	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income	1,675	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	\$ 1,675	14
	<b>D. Other Revenue (specify):</b>		
15	Miscellaneous/Activity Fund	(9,759)	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$ (9,759)	17
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	\$ 4,234,960	18

2			
	II. Expenses	Amount	
	<b>A. Operating Expenses</b>		
19	General Services	979,703	19
20	Health Care/ Personal Care	947,489	20
21	General Administration	969,534	21
	<b>B. Capital Expense</b>		
22	Ownership	885,488	22
	<b>C. Other Expenses</b>		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	\$ 3,782,214	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ 452,746	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ 452,746	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
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	<b>TOTAL (This total must agree to Line 3)</b>	\$	37



