

		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: 1000105

Facility Name: Evergreen Place Streator

Address: 1529 East Main St

Streator

61364

Number

City

Zip Code

County: LaSalle

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

Federal Employer ID Number:

Date Current Owners were Certified: 2008

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 checked="" 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 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: 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	
Paid Preparer	(Title)	EVP & CFO	
	(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: 1/1/2021 Ending: 12/31/2021

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	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	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	11,608	6,166		17,774	5
6	Double Unit					6
7	Other					7
8	TOTALS	11,608	6,166		17,774	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 91.88%

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? 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
make all of the required payments of interest and principal? _____
If no, explain. _____

STATE OF ILLINOIS

Page 3

Facility Name: Evergreen Place Streator

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			
	A. General Services							
1	Dietary and Food Purchase	120,815	156,005		276,820		276,820	1
2	Housekeeping, Laundry and Maintenance	91,039	58,681		149,720		149,720	2
3	Heat and Other Utilities			121,577	121,577		121,577	3
4	Other (specify):							4
5	TOTAL General Services	211,854	214,686	121,577	548,117		548,117	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	373,660	10,911	2,009	386,580		386,580	6
7	Activities and Social Services	32,153	4,973		37,126		37,126	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	405,813	15,884	2,009	423,706		423,706	9
	C. General Administration							
10	Administrative and Clerical	222,585	15,499	169,084	407,168	(5,685)	401,483	10
11	Marketing Materials, Promotions and Advertising			33,251	33,251	(23,555)	9,696	11
12	Employee Benefits and Payroll Taxes			108,779	108,779		108,779	12
13	Insurance-Property, Liability and Malpractice			43,783	43,783		43,783	13
14	Other (specify):							14
15	TOTAL General Administration	222,585	15,499	354,897	592,981	(29,240)	563,741	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	840,252	246,069	478,483	1,564,804	(29,240)	1,535,564	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			205,910	205,910		205,910	17
18	Interest			330,551	330,551	(887)	329,664	18
19	Real Estate Taxes			26,188	26,188		26,188	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			20,661	20,661		20,661	21
22	Other (specify):							22
23	TOTAL Ownership			583,310	583,310	(887)	582,423	23
24	GRAND TOTAL (Sum of lines 16 and 23)	840,252	246,069	1,061,793	2,148,114	(30,127)	2,117,987	24

Facility Name: Evergreen Place Streator

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	1.98	\$ 31.08	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.33	16.14	3
4	Activity Director & Assistants	1.02	15.12	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	1.07	20.56	9
10	Housekeepers	1.83	11.86	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	3.97	26.99	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	17.20	\$ 20.12	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	
Heritage Manor Streator		Streator	

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	0.10%		\$ 51,364	1
2	Cinnaire	99.90%		5,431	2
3					3
4					4
5					5
Total				\$ 56,795	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Heritage Operations Group LLC	\$ 87,697	1
2			2
Total		\$ 87,697	3

Facility Name: Evergreen Place Streator

Report Period Beginning:

1/1/2021

Ending:

12/31/2021

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	53				\$ 7,249,339	\$ 190,060		\$ 190,060		\$ 2,474,356	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	\$ 190,060		\$ 190,060		\$ 2,474,356	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	\$ 729,554	\$ 15,850	\$ 15,850				18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 729,554	\$ 15,850	\$ 15,850				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		\$ 7,287,021	\$ 190,060		\$ 190,060	\$	\$ 2,474,356	1
2									2
3	Purchased carpet rolls - resident rooms	2020	3,750						3
4	Replaced flooring - 2nd Floor offices	2020	6,425						4
5									5
6	Purchase carpet roll stock	2021	3,451						6
7	Replace manual reset switches	2021	3,052						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)		\$ 7,303,699	\$ 190,060		\$ 190,060	\$	\$ 2,474,356	34

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

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	IHDA		xx	Mortgage	/ /	\$	5,459,341	/ /		\$ 330,551	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	5,459,341			\$ 330,551	7
	B. Non-Facility Related										
8					/ /			/ /		-887	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	5,459,341			\$ 329,664	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: 1/1/2021

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,406,360	\$	1
2	Cash-Patient Deposits	2,050		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	32,451		3
4	Supply Inventory (priced at)	7,552		4
5	Short-Term Investments			5
6	Prepaid Insurance	57,216		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,873)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,503,756	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	471,195		13
14	Buildings, at Historical Cost	6,717,658		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	729,554		16
17	Accumulated Depreciation (book methods)	(3,131,624)		17
18	Deferred Charges	134,013		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)	\$ 4,920,796	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,424,552	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 66,056	\$	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	35,953		31
32	Accrued Interest Payable	24,894		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Trust	2,050		35
36	Management Fees	848,124		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 977,077	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,459,341		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Deferred Stimulus	58,776		42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,518,117	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 6,495,194	\$	45
46	TOTAL EQUITY	\$ 929,358	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,424,552	\$	47

*(See instructions.)

Facility Name: Evergreen Place Streator

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	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,194,407	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,194,407	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	35,069	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,350	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 37,419	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	887	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 887	14
	D. Other Revenue (specify):		
15	Miscellaneous/Activity Fund	686	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 686	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,233,399	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	548,117	19
20	Health Care/ Personal Care	423,706	20
21	General Administration	592,981	21
	B. Capital Expense		
22	Ownership	583,310	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)	\$ 2,148,114	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 85,285	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 85,285	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

