FOR BHF USE

LL2

Supportive Living Facility

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)

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: 1000107

Facility Name: Evergreen Place Litchfield

Address: 1015 East Tyler Ave (Number) | Litchfield (City) | 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-1500 **Fax #** ( )

Federal Employer ID Number:

Date Current Owners were Certified: 2008

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[xx] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[xx] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] 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 01/01/14 to 12/31/14 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) Executive 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 Litchfield Report Period Beginning: 01/01/14 Ending: 12/31/14

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	69	Single Unit Apartment	69	25,185	1
2		Double Unit Apartment			2
3		Other			3
4	69	TOTALS	69	25,185	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	16,862	7,320		24,182	5
6	Double Unit					6
7	Other					7
8	TOTALS	16,862	7,320		24,182	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.02%

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

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? Yes **If yes, did the facility make all of the required payments of interest and principle?** 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 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 Litchfield **Report Period Beginning: 01/01/14 Ending: 12/31/14**

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	177,409	162,073		339,482		339,482	1
2	Housekeeping, Laundry and Maintenance	73,945	36,428		110,373		110,373	2
3	Heat and Other Utilities			132,403	132,403		132,403	3
4	Other (specify):							4
5	**TOTAL General Services**	251,354	198,501	132,403	582,258		582,258	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	280,912	1,933		282,845		282,845	6
7	Activities and Social Services	28,441	3,949		32,390		32,390	7
8	Other (specify):			6,155	6,155		6,155	8
9	**TOTAL Health Care and Programs**	309,353	5,882	6,155	321,390		321,390	9
	C. General Administration							
10	Administrative and Clerical	145,670	12,399	182,391	340,460	(24,225)	316,235	10
11	Marketing Materials, Promotions and Advertising			42,171	42,171		42,171	11
12	Employee Benefits and Payroll Taxes			163,778	163,778		163,778	12
13	Insurance-Property, Liability and Malpractice			52,694	52,694		52,694	13
14	Other (specify): Sales tax			648	648		648	14
15	**TOTAL General Administration**	145,670	12,399	441,682	599,751	(24,225)	575,526	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	706,377	216,782	580,240	1,503,399	(24,225)	1,479,174	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			319,495	319,495		319,495	17
18	Interest			440,229	440,229	(4,332)	435,897	18
19	Real Estate Taxes			57,848	57,848		57,848	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			17,455	17,455		17,455	21
22	Other (specify):							22
23	**TOTAL Ownership**			835,027	835,027	(4,332)	830,695	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	706,377	216,782	1,415,267	2,338,426	(28,557)	2,309,869	24

Facility Name: Evergreen Place Litchfield Report Period Beginning 01/01/14 Ending: 12/31/14

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.90	$ 28.26	1
2	Licensed Practical Nurses	0.65	19.09	2
3	Certified Nurse Assistants	8.07	10.69	3
4	Activity Director & Assistants			4
5	Social Service Workers	0.94	13.64	5
6	Head Cook			6
7	Cook Helpers/Assistants	7.58	10.19	7
8	Dishwashers			8
9	Maintenance Workers	0.91	17.59	9
10	Housekeepers	1.80	9.21	10
11	Laundry			11
12	Managers			12
13	Other Administrative	2.28	15.89	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	23.12	$ 12.23	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	$ 122,468	1
2			2
		Total $ 122,468	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
Evergreen Streator LP		Streator							

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 Litchfield **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	69				$ 9,151,234	$ 248,492		$ 319,495	$ 71,003	$ 1,528,634	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Landscaping			2009	13,600						6
7	Electric Door Opener			2011	3,575						7
8	Flooring			2014	3,052						8
9	10 Ton Compressor Installation			2014	3,767						9
10	Reconstruct fire panels			2014	5,000						10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 9,180,228	$ 248,492		$ 319,495	$ 71,003	$ 1,528,634	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	$ 704,768	$ 71,003	$ 71,003	$		$ 431,619	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 704,768	$ 71,003	$ 71,003	$		$ 431,619	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 Litchfield Report Period Beginning: 01/01/14 Ending: 12/31/14

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										
	Long-Term										
1	IHDA			Mortgage	/ /	$	$ 7,569,143	/ /		$ 440,229	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 7,569,143			$ 440,229	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-4,332	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 7,569,143			$ 435,897	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 Litchfield **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 909,608	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	299,413		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,622		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Resident Trust	634		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,305,277	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	788,611		13
14	Buildings, at Historical Cost	8,451,633		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	704,768		16
17	Accumulated Depreciation (book methods)	(1,960,253)		17
18	Deferred Charges	200,897		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)**	$ 8,185,656	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,490,933	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 64,154	$	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	60,440		31
32	Accrued Interest Payable	33,376		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Trust	634		35
36	Deferred Development Fees	794,542		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 953,146	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,569,143		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)**	$ 7,569,143	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 8,522,289	$	45
46	**TOTAL EQUITY**	$ 968,644	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 9,490,933	$	47

***(See instructions.)**

Facility Name: Evergreen Place Litchfield **Report Period Beginning: 01/01/14 Ending: 12/31/14**

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	$ 2,241,396	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,241,396	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	7,533	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 7,533	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,332	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 4,332	14
	D. Other Revenue (specify):		
15			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)**	$ 2,253,261	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	582,258	19
20	Health Care/ Personal Care	321,390	20
21	General Administration	599,751	21
	B. Capital Expense		
22	Ownership	835,027	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)**	$ 2,338,426	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (85,165)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (85,165)	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	909,608					
CASH IN BANK						
CASH IN BANK-PAYROLL						
ACCOUNTS RECEIVABLE	299,413					
MEDICARE RECEIVABLES						
IPA INCOME RECEIVABLE						
MEDICARE COST REPORT						
ACCOUNTS RECEIVABLE-IC						
UNAPPLIED CASH RECEIPTS						
A/R SUSPENSE-REFUNDS						
ACCRUED INTEREST REC						
PREPAID INSURANCE	95,622					
OTHER PREPAID EXPENSES						
FOOD INVENTORY						
SUPPLIES INVENTORY						
LAND	788,611					
FURNITURE & EQUIPMENT	704,768					
ACCUM DEPR-FURN & EQUII	-431,619					
BUILDING & IMPROVEMENT	8,451,633					
ACCUM DEPR-BUILDING	-1,528,634					
RESIDENT FUNDS	634					
LOAN FEES	200,897					
REAL ESTATE TAX ESCROW						
REIMBURSABLE PURCHASES						
INTRACOMPANY	0					
ACCOUNTS PAYABLE	-64,154					
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 CASH	909,608
1,100	1,100	ACCTS RECEI	347,326
1,101	1,101	ALLOW. FOR	-47,913
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 INSU	95,622
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	788,611
1,450	1,450	FURNITURE &	704,768
1,460			-431,619
1,475	1,475	BUILDING	8,451,633
1,490	1,490	ACCUM DEPR	-1,528,634
1,530	1,530	RESIDENT FU	634
1,550	1,550	LOAN FEES	200,897
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOMPA	0
2,010	2,010	ACCOUNTS P	-64,154
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED PA	0
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED PT	0
2,120	2,120	U.C. TAXES PAYABLE	
2,125	2,125	FICA TAXES P	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