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: 1000138

Facility Name: Evergreen Place of Decatur

Address: 4825 East Evergreen (Number) Decatur (City) 62521 (Zip Code)

County: Macon

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

Federal Employer ID Number:

Date Current Owners were Certified: 2012

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[xx] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[xx] 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) 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: 01/01/14 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	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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	19,257	21,035		40,292	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,257	21,035		40,292	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.69%

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? 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.

Facility Name: Evergreen Place of Decatur **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	**241,739**	**276,143**		**517,882**		**517,882**	1
2	Housekeeping, Laundry and Maintenance	**97,057**	**53,928**		**150,985**		**150,985**	2
3	Heat and Other Utilities			**182,590**	**182,590**		**182,590**	3
4	Other (specify):							4
5	**TOTAL General Services**	**338,796**	**330,071**	**182,590**	**851,457**		**851,457**	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	**688,804**	**3,245**		**692,049**		**692,049**	6
7	Activities and Social Services	**60,817**	**9,345**	**166**	**70,328**		**70,328**	7
8	Other (specify):			**13,689**	**13,689**		**13,689**	8
9	**TOTAL Health Care and Programs**	**749,621**	**12,590**	**13,855**	**776,066**		**776,066**	9
	C. General Administration							
10	Administrative and Clerical	**230,788**	**16,521**	**315,324**	**562,633**	**(71,009)**	**491,624**	10
11	Marketing Materials, Promotions and Advertising			**74,294**	**74,294**		**74,294**	11
12	Employee Benefits and Payroll Taxes			**305,990**	**305,990**		**305,990**	12
13	Insurance-Property, Liability and Malpractice			**41,064**	**41,064**		**41,064**	13
14	Other (specify):							14
15	**TOTAL General Administration**	**230,788**	**16,521**	**736,672**	**983,981**	**(71,009)**	**912,972**	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	**1,319,205**	**359,182**	**933,117**	**2,611,504**	**(71,009)**	**2,540,495**	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			**522,165**	**522,165**		**522,165**	17
18	Interest			**586,665**	**586,665**	**(859)**	**585,806**	18
19	Real Estate Taxes			**287,422**	**287,422**		**287,422**	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			**15,142**	**15,142**		**15,142**	21
22	Other (specify):							22
23	**TOTAL Ownership**			**1,411,394**	**1,411,394**	**(859)**	**1,410,535**	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	**1,319,205**	**359,182**	**2,344,511**	**4,022,898**	**(71,868)**	**3,951,030**	24

Facility Name: Evergreen Place of Decatur 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	3.19	$ 27.49	1
2	Licensed Practical Nurses	0.47	19.66	2
3	Certified Nurse Assistants	20.16	10.69	3
4	Activity Director & Assistants	1.63	12.58	4
5	Social Service Workers	0.50	15.62	5
6	Head Cook			6
7	Cook Helpers/Assistants	10.90	10.16	7
8	Dishwashers			8
9	Maintenance Workers	0.96	20.98	9
10	Housekeepers	2.78	8.57	10
11	Laundry			11
12	Managers			12
13	Other Administrative	3.78	16.58	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	44.38	$ 12.58	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	$ 209,544	1
2			2
	Total	$ 209,544	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

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 of Decatur Report Period Beginning: 01/01/14 Ending: 12/31/14

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	113				$ 10,601,024	$ 306,032		$ 306,032	$	$ 759,966	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7	Five (5) Eyewash Station Construction			2013	3,392						7
8	Cable TV Installation-first installment			2013	22,394						8
9	Cable TV Installation-second installment			2014	28,210						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	$	$ 759,966	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	$ 1,516,743	$ 216,133	$ 216,133	$		$ 538,016	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 1,516,743	$ 216,133	$ 216,133	$		$ 538,016	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 of Decatur Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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	Marine Bank			Mortgage	/ /	$	$ 11,665,208	/ /		$ 586,665	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 11,665,208			$ 586,665	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-859	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 11,665,208			$ 585,806	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 of Decatur **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	$ 675,039	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	462,775		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,934		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Resident Trust			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,164,748	$	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	1,516,743		16
17	Accumulated Depreciation (book methods)	(1,297,982)		17
18	Deferred Charges	43,495		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)**	$ 12,903,270	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,068,018	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 98,930	$	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	178,858		31
32	Accrued Interest Payable	13,852		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)**	$ 291,640	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,665,208		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)**	$ 11,665,208	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 11,956,848	$	45
46	**TOTAL EQUITY**	$ 2,111,170	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 14,068,018	$	47

***(See instructions.)**

Facility Name: Evergreen Place of Decatur **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	$ 4,173,673	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 4,173,673	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	16,638	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 16,638	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	859	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 859	14
	D. Other Revenue (specify):		
15			15
16	**Other**	573	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 573	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 4,191,743	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	851,457	19
20	Health Care/ Personal Care	776,066	20
21	General Administration	983,981	21
	B. Capital Expense		
22	Ownership	1,411,394	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)**	$ 4,022,898	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 168,845	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 168,845	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	675,039					
CASH IN BANK						
CASH IN BANK-PAYROLL						
ACCOUNTS RECEIVABLE	462,775					
MEDICARE RECEIVABLES						
IPA INCOME RECEIVABLE						
MEDICARE COST REPORT						
ACCOUNTS RECEIVABLE-IC						
UNAPPLIED CASH RECEIPTS						
A/R SUSPENSE-REFUNDS						
ACCRUED INTEREST REC						
PREPAID INSURANCE	26,934					
OTHER PREPAID EXPENSES						
FOOD INVENTORY						
SUPPLIES INVENTORY						
LAND	1,985,993					
FURNITURE & EQUIPMENT	1,516,743					
ACCUM DEPR-FURN & EQUII	-538,016					
BUILDING & IMPROVEMENT	10,655,021					
ACCUM DEPR-BUILDING	-759,966					
RESIDENT FUNDS	0					
LOAN FEES	43,495					
REAL ESTATE TAX ESCROW						
REIMBURSABLE PURCHASES						
INTRACOMPANY	0					
ACCOUNTS PAYABLE	-98,930					
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	675,039	
1,100	1,100	ACCTS RECEI	553,861	
1,101	1,101	ALLOW. FOR	-91,086	
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	26,934	
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	1,985,993	
1,450	1,450	FURNITURE &	1,516,743	
1,460			-538,016	
1,475	1,475	BUILDING	10,655,021	
1,490	1,490	ACCUM DEPR	-759,966	
1,530	1,530	RESIDENT FU	0	
1,550	1,550	LOAN FEES	43,495	
1,551	1,551	LOAN FEES ADDED		
1,850	1,850	INTERCOMPA	0	
2,010	2,010	ACCOUNTS P	-98,930	
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