	FOR BHF USE	

LL2

Supportive Living Facility

2015

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)

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		PROPRIETARY		GOVERNMENTAL
		x			
	Charitable Corp.		Individual		State
	Trust	x	Partnership		County
	IRS Exemption Code		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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 # ( )

In the event there are further questions about this report, please contact:
Name: Dave Underwood Telephone Number: ( )
Email Address:

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: 01/01/15 | Ending: 12/31/15

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	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	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	12,421	11,424		23,845	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,421	11,424		23,845	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.68%

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

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: 01/01/15   Ending: 12/31/15

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclassifications and Adjustments 5	Adjusted Total 6	
	A. General Services							
1	Dietary and Food Purchase	181,551	170,408		351,959		351,959	1
2	Housekeeping, Laundry and Maintenance	69,806	29,069		98,875		98,875	2
3	Heat and Other Utilities			126,420	126,420		126,420	3
4	Other (specify):							4
5	**TOTAL General Services**	251,357	199,477	126,420	577,254		577,254	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	283,521	4,005	7,307	294,833		294,833	6
7	Activities and Social Services	26,543	3,733		30,276		30,276	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	310,064	7,738	7,307	325,109		325,109	9
	C. General Administration							
10	Administrative and Clerical	152,627	18,627	163,720	334,974	(4,054)	330,920	10
11	Marketing Materials, Promotions and Advertising			33,206	33,206		33,206	11
12	Employee Benefits and Payroll Taxes			162,420	162,420		162,420	12
13	Insurance-Property, Liability and Malpractice			54,790	54,790		54,790	13
14	Other (specify):							14
15	**TOTAL General Administration**	152,627	18,627	414,136	585,390	(4,054)	581,336	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	714,048	225,842	547,863	1,487,753	(4,054)	1,483,699	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			320,058	320,058		320,058	17
18	Interest			434,091	434,091	(945)	433,146	18
19	Real Estate Taxes			60,849	60,849		60,849	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			22,094	22,094		22,094	21
22	Other (specify):							22
23	**TOTAL Ownership**			837,092	837,092	(945)	836,147	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	714,048	225,842	1,384,955	2,324,845	(4,999)	2,319,846	24

Facility Name: Evergreen Place Litchfield | Report Period Beginning 01/01/15 Ending: 12/31/15

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.89	$ 28.82	1
2	Licensed Practical Nurses	0.57	18.54	2
3	Certified Nurse Assistants	7.89	11.28	3
4	Activity Director & Assistants	0.13	13.07	4
5	Social Service Workers	0.78	13.55	5
6	Head Cook			6
7	Cook Helpers/Assistants	7.74	10.37	7
8	Dishwashers			8
9	Maintenance Workers	0.80	17.90	9
10	Housekeepers	1.80	9.41	10
11	Laundry			11
12	Managers			12
13	Other Administrative	2.52	14.58	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	23.14	$ 12.36	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	$ 122,495	1
2			2
	Total	$ 122,495	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

Name 1	City 2
Evergreen Streator LP	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 [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: 01/01/15 | Ending: 12/31/15

VIII. OWNERSHIP COSTS

A. Purchase price of land 59,450 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	69				$ 9,151,234	$ 249,055		$ 249,055	$	$ 1,777,689	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	Install new plank flooring			2015	3,312						11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 9,183,540	$ 249,055		$ 249,055	$	$ 1,777,689	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	$		$ 502,622	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 704,768	$ 71,003	$ 71,003	$		$ 502,622	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: 01/01/15 Ending: 12/31/15

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			Mortgage	/ /	$	$ 7,453,706	/ /		$ 434,091	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 7,453,706			$ 434,091	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-945	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 7,453,706			$ 433,146	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:** 01/01/15 | **Ending:** 12/31/15

XI. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 921,351	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	311,836		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,856		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): **Resident Trust**	5,531		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,332,574	$	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	8,454,945		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	704,768		16
17	Accumulated Depreciation (book methods)	(2,280,311)		17
18	Deferred Charges	188,309		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)**	$ 7,856,322	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,188,896	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,197	$	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	62,124		31
32	Accrued Interest Payable	32,885		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	**Resident Trust**	5,531		35
36	**Deferred Development Fees**	669,321		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 837,058	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,453,706		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)**	$ 7,453,706	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 8,290,764	$	45
46	**TOTAL EQUITY**	$ 898,132	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 9,188,896	$	47

*(See instructions.)

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	$ 2,244,552	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,244,552	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	8,835	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 8,835	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	945	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 945	14
	D. Other Revenue (specify):		
15	**Loss on sale of assets**		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)**	$ 2,254,332	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	577,254	19
20	Health Care/ Personal Care	325,109	20
21	General Administration	585,390	21
	B. Capital Expense		
22	Ownership	837,092	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)**	$ 2,324,845	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (70,513)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (70,513)	31