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: 1000105

Facility Name: Evergreen Place Streator

Address: 1525 East Main St (Number) Streator (City) 61364 (Zip Code)

County: LaSalle

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

Federal Employer ID Number:

Date Current Owners were Certified: 2008

Type of Ownership:

	VOLUNTARY, NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	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 Streator 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 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	10,002	9,119		19,121	5
6	Double Unit					6
7	Other					7
8	TOTALS	10,002	9,119		19,121	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.84%

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 Streator **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				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase		242,433		242,433		242,433	1
2	Housekeeping, Laundry and Maintenance	72,450	32,697		105,147		105,147	2
3	Heat and Other Utilities			99,435	99,435		99,435	3
4	Other (specify):							4
5	**TOTAL General Services**	72,450	275,130	99,435	447,015		447,015	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	273,030	771	6,272	280,073		280,073	6
7	Activities and Social Services	14,364	4,829		19,193		19,193	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	287,394	5,600	6,272	299,266		299,266	9
	C. General Administration							
10	Administrative and Clerical	187,490	5,524	160,773	353,787	(21,176)	332,611	10
11	Marketing Materials, Promotions and Advertising			29,683	29,683		29,683	11
12	Employee Benefits and Payroll Taxes			85,856	85,856		85,856	12
13	Insurance-Property, Liability and Malpractice			40,832	40,832		40,832	13
14	Other (specify):							14
15	**TOTAL General Administration**	187,490	5,524	317,144	510,158	(21,176)	488,982	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	547,334	286,254	422,851	1,256,439	(21,176)	1,235,263	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			251,713	251,713		251,713	17
18	Interest			368,021	368,021	(638)	367,383	18
19	Real Estate Taxes			45,241	45,241		45,241	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,722	6,722		6,722	21
22	Other (specify):							22
23	**TOTAL Ownership**			671,697	671,697	(638)	671,059	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	547,334	286,254	1,094,548	1,928,136	(21,814)	1,906,322	24

Facility Name: Evergreen Place Streator **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	1.21	$ 27.33	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.89	12.38	3
4	Activity Director & Assistants	0.04	13.50	4
5	Social Service Workers	0.37	15.14	5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	0.90	20.20	9
10	Housekeepers	1.36	9.30	10
11	Laundry			11
12	Managers			12
13	Other Administrative	2.38	17.90	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	13.15	$ 15.05	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	$ 125,318	1
2			2
	Total	$ 125,318	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 Litchfield LP		Litchfield	

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 Streator Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. OWNERSHIP COSTS

A. Purchase price of land 60,980 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	53				$ 7,058,692	$ 188,031		$ 188,031	$	$ 1,341,749	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											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 7,084,466	$ 188,031		$ 188,031	$	$ 1,341,749	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	$ 615,799	$ 63,682	$ 63,682	$		$ 442,080	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 615,799	$ 63,682	$ 63,682	$		$ 442,080	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 Streator 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 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	/ /	$	$ 6,122,658	/ /		$ 368,021	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 6,122,658			$ 368,021	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-638	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 6,122,658			$ 367,383	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:** 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	$ 1,457,549	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	153,533		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,334		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Resident Trust	2,586		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,677,002	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	456,374		13
14	Buildings, at Historical Cost	6,689,072		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	631,207		16
17	Accumulated Depreciation (book methods)	(1,783,829)		17
18	Deferred Charges	167,473		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)**	$ 6,160,297	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,837,299	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 62,202	$	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	48,490		31
32	Accrued Interest Payable	27,912		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Trust	2,586		35
36	Deferred Development Fees	428,784		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 569,974	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,122,658		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)**	$ 6,122,658	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,692,632	$	45
46	**TOTAL EQUITY**	$ 1,144,667	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 7,837,299	$	47

***(See instructions.)**

Facility Name: Evergreen Place Streator **Report Period Beginning: 01/01/15 Ending: 12/31/15**

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	$ 1,989,329	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,989,329	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	6,117	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 6,117	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	638	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 638	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)**	$ 1,996,084	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	447,015	19
20	Health Care/ Personal Care	299,266	20
21	General Administration	510,158	21
	B. Capital Expense		
22	Ownership	671,697	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)**	$ 1,928,136	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 67,948	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 67,948	31