

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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.

<p>I. Facility ID Number: <u>1000097</u></p> <p>Facility Name: <u>Evergreen Place Alton</u></p> <hr/> <p>Address: <u>100 Glenhaven Drive</u> <u>Alton</u> <u>62002</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>462-1500</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>9/2015</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY Individual</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State	<input type="checkbox"/> Trust	<input 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 checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Type or Print Name) <u>David M. Underwood</u></td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Title) <u>Executive VP & CFO</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">(Telephone) () _____ Fax # () _____</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>David M. Underwood</u>			(Title) <u>Executive VP & CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____ Fax # () _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT Charitable Corp.	<input checked="" type="checkbox"/> PROPRIETARY Individual	<input type="checkbox"/> GOVERNMENTAL State																																									
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	(Telephone) () _____ Fax # () _____																																										
<p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Dave Underwood</u> Telephone Number: (<u>309</u>) <u>823-7135</u></p> <p>Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</p> <p align="right">Phone # (217) 782-1630</p>																																										

Facility Name Evergreen Place Alton

Report Period Beginning: 01/01/16 Ending: 12/31/16

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	92	Single Unit Apartment	92	33,672	1
2		Double Unit Apartment			2
3		Other			3
4	92	TOTALS	92	33,672	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	17,921	15,244		33,165	5
6	Double Unit					6
7	Other					7
8	TOTALS	17,921	15,244		33,165	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.49%

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

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)

None

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? 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 Alton

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	261,052	234,981		496,033		496,033	1
2	Housekeeping, Laundry and Maintenance	119,497	91,985		211,482		211,482	2
3	Heat and Other Utilities			205,989	205,989		205,989	3
4	Other (specify):							4
5	TOTAL General Services	380,549	326,966	205,989	913,504		913,504	5
B. Health Care and Programs								
6	Health Care/ Personal Care	565,888	4,643	16,819	587,350		587,350	6
7	Activities and Social Services	33,663	5,812		39,475		39,475	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	599,551	10,455	16,819	626,825		626,825	9
C. General Administration								
10	Administrative and Clerical	186,373	18,630	270,164	475,167	(80,231)	394,936	10
11	Marketing Materials, Promotions and Advertising			34,599	34,599		34,599	11
12	Employee Benefits and Payroll Taxes			251,799	251,799		251,799	12
13	Insurance-Property, Liability and Malpractice			28,638	28,638		28,638	13
14	Other (specify):							14
15	TOTAL General Administration	186,373	18,630	585,200	790,203	(80,231)	709,972	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,166,473	356,051	808,008	2,330,532	(80,231)	2,250,301	16
Capital Expenses								
D. Ownership								
17	Depreciation			241,923	241,923		241,923	17
18	Interest			418,501	418,501	(1,927)	416,574	18
19	Real Estate Taxes			85,853	85,853		85,853	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			19,709	19,709		19,709	21
22	Other (specify):							22
23	TOTAL Ownership			765,986	765,986	(1,927)	764,059	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,166,473	356,051	1,573,994	3,096,518	(82,158)	3,014,360	24

Facility Name: Evergreen Place Alton

Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		\$	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	\$ 178,585	1
2			2
		Total	3
		\$ 178,585	

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
_____		_____	
_____		_____	
_____		_____	
_____		_____	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Evergreen Glenhaven Real Estate		Alton		Real estate	
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

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).

Facility Name: Evergreen Place Alton

Report Period Beginning:

01/01/16

Ending:

12/31/16

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					\$	\$		\$	\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$	\$		\$	\$	\$	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	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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 Alton

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	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

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	Illinois National Bank			Mortgage	/ /	\$	8,270,353	/ /		\$ 418,501
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	8,270,353			\$ 418,501
	B. Non-Facility Related									
8					/ /			/ /		-1,927
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$	8,270,353			\$ 416,574

* 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 Alton

Report Period Beginning: 01/01/16

Ending:

12/31/16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,605,522	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	367,107		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,319		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,036,948	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	343,232		13
14	Buildings, at Historical Cost	8,381,139		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	638,060		16
17	Accumulated Depreciation (book methods)	(2,712,294)		17
18	Deferred Charges	512,184		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)	\$ 7,162,321	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,199,269	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,750	\$	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	89,573		31
32	Accrued Interest Payable	29,773		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)	\$ 235,096	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,270,353		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)	\$ 8,270,353	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,505,449	\$	45
46	TOTAL EQUITY	\$ 693,820	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,199,269	\$	47

*(See instructions.)

Facility Name: Evergreen Place Alton

Report Period Beginning: 01/01/16

Ending:

12/31/16

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	\$ 3,630,401	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,630,401	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	20,295	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 20,295	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,927	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,927	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)	\$ 3,652,623	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	913,504	19
20	Health Care/ Personal Care	626,825	20
21	General Administration	790,203	21
B. Capital Expense			
22	Ownership	765,986	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)	\$ 3,096,518	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 556,105	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 556,105	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

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
PETTY CASH	1,605,522				1,009	1,009 CASH 1,605,522
CASH IN BANK					1,100	1,100 ACCTS RI 476,781
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. I -109,674
ACCOUNTS RECEIVABLE	367,107				1,110	1,110 ACCTS RECEIV-M/C
MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 64,319
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	64,319				1,310	1,310 SUPPLIES INVENTORY
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 343,232
SUPPLIES INVENTORY					1,450	1,450 FURNITU 638,060
LAND	343,232				1,460	ACCUM I -605,335
FURNITURE & EQUIPMENT	638,060				1,475	1,475 BUILDING 8,381,139
ACCUM DEPR-FURN & EQUIP	-605,335				1,490	1,490 ACCUM I -2,106,959
BUILDING & IMPROVEMENT	8,381,139				1,530	1,530 RESIDENT 0
ACCUM DEPR-BUILDING	-2,106,959				1,550	1,550 LOAN FEI 512,184
RESIDENT FUNDS	0				1,551	1,551 LOAN FEES ADDED
LOAN FEES	512,184				1,850	1,850 INTERCO 0
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN' -115,750
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	0				2,100	2,100 ACCRUEI 0
ACCOUNTS PAYABLE	-115,750				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	0				2,110	2,110 ACCRUEI 0
ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAX 0
FICA TAX PAYABLE	0	0			2,130	2,130 FEDERAL W/H TAX PAYABLE
FIT PAYABLE					2,140	2,140 STATE W/H TAX PAYABLE
STATE W/H PAYABLE		0			2,152	2,152 WORKERS COMP ACCRUAL
EARNED INCOME CREDIT					2,225	2,225 EMPLOYEEE INSURANCE REFUND
UC FED CREDIT REDUCTION					2,230	2,230 PAYROLL SAVINGS
PAYROLL SAVINGS					2,235	2,240 UNITED FUND