

		FOR BHF USE			

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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>1000138</u></p> <p>Facility Name: <u>Evergreen Place Decatur</u></p> <p>Address: <u>4825 East Evergreen</u> <u>Decatur</u> <u>62521</u> <small>Number City Zip Code</small></p> <p>County: <u>Macon</u></p> <p>Telephone Number: (<u>217</u>) <u>864-4300</u> Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>2012</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Underwood</u> Telephone Number: () _____ Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> 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>01/01/13</u> to <u>12/31/13</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>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David M. Underwood</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Sr. VP & CFO</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td>Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>David M. Underwood</u>			(Title) <u>Sr. VP & CFO</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) () _____	Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) () _____	Fax # () _____																																												

Facility Name: Evergreen Place Decatur

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	234,492	242,898		477,390		477,390	1
2	Housekeeping, Laundry and Maintenance	88,336	61,049		149,385		149,385	2
3	Heat and Other Utilities			162,368	162,368		162,368	3
4	Other (specify):							4
5	TOTAL General Services	322,828	303,947	162,368	789,143		789,143	5
B. Health Care and Programs								
6	Health Care/ Personal Care	633,813	6,799		640,612		640,612	6
7	Activities and Social Services	74,704	8,789		83,493		83,493	7
8	Other (specify):			11,534	11,534		11,534	8
9	TOTAL Health Care and Programs	708,517	15,588	11,534	735,639		735,639	9
C. General Administration								
10	Administrative and Clerical	181,702	30,613	247,170	459,485	(34,683)	424,802	10
11	Marketing Materials, Promotions and Advertising			104,226	104,226		104,226	11
12	Employee Benefits and Payroll Taxes			234,069	234,069		234,069	12
13	Insurance-Property, Liability and Malpractice			39,522	39,522		39,522	13
14	Other (specify):							14
15	TOTAL General Administration	181,702	30,613	624,987	837,302	(34,683)	802,619	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,213,047	350,148	798,889	2,362,084	(34,683)	2,327,401	16
Capital Expenses								
D. Ownership								
17	Depreciation			517,466	517,466		517,466	17
18	Interest			595,413	595,413	(7,155)	588,258	18
19	Real Estate Taxes			195,324	195,324		195,324	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			13,675	13,675		13,675	21
22	Other (specify):							22
23	TOTAL Ownership			1,321,878	1,321,878	(7,155)	1,314,723	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,213,047	350,148	2,120,767	3,683,962	(41,838)	3,642,124	24

Facility Name: Evergreen Place Decatur

Report Period Beginning 01/01/13

Ending: 12/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.44	\$ 24.97	1
2	Licensed Practical Nurses	0.77	19.32	2
3	Certified Nurse Assistants	20.30	10.64	3
4	Activity Director & Assistants	1.52	13.62	4
5	Social Service Workers	0.94	15.57	5
6	Head Cook			6
7	Cook Helpers/Assistants	10.53	10.13	7
8	Dishwashers			8
9	Maintenance Workers	1.04	20.31	9
10	Housekeepers	2.73	8.81	10
11	Laundry			11
12	Managers	0.93	30.26	12
13	Other Administrative	2.87	15.92	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	43.06	\$ 12.26	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	\$ 181,573	1
2			2
Total		\$ 181,573	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 Village SLF		Normal IL	
Evergreen Place		Beardstown IL	

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

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 Decatur

Report Period Beginning:

01/01/13

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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	\$ 302,723		\$ 302,723	\$	\$ 453,934	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		2013	22,394						8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,626,810	\$ 302,723		\$ 302,723	\$	\$ 453,934	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	\$ 1,503,200	\$ 214,743	\$ 214,743	\$		\$ 321,882	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 1,503,200	\$ 214,743	\$ 214,743	\$		\$ 321,882	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 Decatur

Report Period Beginning: 01/01/13

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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

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**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	Marine Bank			Mortgage	/ /	\$	\$ 11,919,145	/ /		\$ 595,413	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$ 11,919,145			\$ 595,413	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-7,155	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$ 11,919,145			\$ 588,258	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 Decatur

Report Period Beginning: 01/01/13

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12/31/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 634,004	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	562,471		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,877		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)	\$ 1,219,352	\$	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	10,626,810		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,503,200		16
17	Accumulated Depreciation (book methods)	(775,816)		17
18	Deferred Charges	56,637		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)	\$ 13,396,824	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,616,176	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 101,915	\$	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	135,492		31
32	Accrued Interest Payable	17,299		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)	\$ 254,706	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,919,145		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)	\$ 11,919,145	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 12,173,851	\$	45
46	TOTAL EQUITY	\$ 2,442,325	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 14,616,176	\$	47

*(See instructions.)

Facility Name: Evergreen Place Decatur

Report Period Beginning: 01/01/13

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12/31/13

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,617,137	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,617,137	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	13,732	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 13,732	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	7,155	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 7,155	14
D. Other Revenue (specify):			
15			15
16	Other	600	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 600	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,638,624	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	789,143	19
20	Health Care/ Personal Care	735,639	20
21	General Administration	837,302	21
B. Capital Expense			
22	Ownership	1,321,878	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)	\$ 3,683,962	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (45,338)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (45,338)	31

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	634,004				1,009	1,009 PETTY CASH 634,004
CASH IN BANK					1,100	1,100 ACCTS RECEI 589,471
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR 1 -27,000
ACCOUNTS RECEIVABLE	562,471				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 INSU 22,877
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	22,877				1,310	1,310 SUPPLIES INVENTORY
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 1,985,993
SUPPLIES INVENTORY					1,450	1,450 FURNITURE & 1,503,200
LAND	1,985,993				1,460	-321,882
FURNITURE & EQUIPMENT	1,503,200				1,475	1,475 CODE ALERT 10,626,810
ACCUM DEPR-FURN & EQUIP	-321,882				1,490	1,490 ACCUM DEPR -453,934
BUILDING & IMPROVEMENT	10,626,810				1,530	1,530 RESIDENT FU 0
ACCUM DEPR-BUILDING	-453,934				1,550	1,550 LOAN FEES 56,637
RESIDENT FUNDS	0				1,551	1,551 LOAN FEES ADDED
LOAN FEES	56,637				1,850	1,850 INTERCOMPA 0
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUNTS PA -101,915
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	0				2,100	2,100 ACCRUED PA 0
ACCOUNTS PAYABLE	-101,915				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	0				2,110	2,110 ACCRUED PTC 0
ACCRUED VACATION PAY	0				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAXES F 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
PAYROLL SAVINGS

2,230
2,235

2,230 PAYROLL SAVINGS
2,240 UNITED FUND

