FOR BHF USE

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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		

In the event there are further questions about this report, please contact:
Name: David M 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 1/1/2018 to 12/31/2018 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) EVP/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 Streator Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	9,363	8,140		17,503	5
6	Double Unit					6
7	Other					7
8	TOTALS	9,363	8,140		17,503	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.48%

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 principal? Yes
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? N If yes, did the facility make all of the required payments of interest and principal? _____
If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? N If yes, did the facility make all of the required payments of interest and principal? _____
If no, explain.

Facility Name: Evergreen Place Streator **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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	32	260,278		260,310		260,310	1
2	Housekeeping, Laundry and Maintenance	73,114	39,181		112,295		112,295	2
3	Heat and Other Utilities			111,694	111,694		111,694	3
4	Other (specify):							4
5	**TOTAL General Services**	73,146	299,459	111,694	484,299		484,299	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	315,668	2,634	4,206	322,508		322,508	6
7	Activities and Social Services	30,508	4,343		34,851		34,851	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	346,176	6,977	4,206	357,359		357,359	9
	C. General Administration							
10	Administrative and Clerical	189,821	12,094	162,967	364,882	(19,427)	345,455	10
11	Marketing Materials, Promotions and Advertising			28,574	28,574		28,574	11
12	Employee Benefits and Payroll Taxes			88,873	88,873		88,873	12
13	Insurance-Property, Liability and Malpractice			36,065	36,065		36,065	13
14	Other (specify):							14
15	**TOTAL General Administration**	189,821	12,094	316,479	518,394	(19,427)	498,967	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	609,143	318,530	432,379	1,360,052	(19,427)	1,340,625	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			243,128	243,128		243,128	17
18	Interest			350,734	350,734	(23,965)	326,769	18
19	Real Estate Taxes			64,407	64,407		64,407	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,185	8,185		8,185	21
22	Other (specify):							22
23	**TOTAL Ownership**			666,454	666,454	(23,965)	642,489	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	609,143	318,530	1,098,833	2,026,506	(43,392)	1,983,114	24

Facility Name: Evergreen Place Streator **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.85	$ 27.94	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.00	14.63	3
4	Activity Director & Assistants	1.01	14.73	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers	0.96	21.29	9
10	Housekeepers	1.59	9.30	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	2.77	15.23	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15.18	$ 16.23	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	Heritage Enterprises	0.10%		$ 40,500	1
2	Cinnaire	99.90%		5,020	2
3					3
4					4
5					5
			Total	$ 45520	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Heritage Operations Group LLC	$ 75,921	1
2			2
	Total	$ 75,921	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
Evergreen Litchfield LP	Litchfield			

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: 1/1/2018 Ending: 12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 395,394 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				$ 7,249,339	$ 188,373		$ 188,373	$	$ 1,906,406	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	Install single CPU and power supply board			2016	2,658						11
12	Install vinyl flooring - 2nd floor family area			2018	5,950						12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 7,283,721	$ 188,373		$ 188,373	$	$ 1,906,406	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	$ 649,697	$ 54,755	$ 54,755	$		$ 624,555	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 649,697	$ 54,755	$ 54,755	$		$ 624,555	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: 1/1/2018 Ending: 2/31/2018

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		x	Mortgage	/ /	$	$ 5,817,733	/ /		$ 350,734	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 5,817,733			$ 350,734	7
	B. Non-Facility Related										
8	Interest Income				/ /			/ /		-23,965	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 5,817,733			$ 326,769	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:** 1/1/2018 **Ending:** 12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,796,293	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	128,439		3
4	Supply Inventory (priced FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,693		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(682)		8
9	Other(specify): Resident Trust	2,879		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,981,622	$	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	6,697,680		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	649,697		16
17	Accumulated Depreciation (book methods)	(2,530,961)		17
18	Deferred Charges	150,897		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)**	$ 5,423,687	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,405,309	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 190,260	$	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	67,248		31
32	Accrued Interest Payable	26,543		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Trust	2,879		35
36	Deferred Partnership Incentive Fee	663,884		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 950,814	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,817,733		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)**	$ 5,817,733	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 6,768,547	$	45
46	**TOTAL EQUITY**	$ 636,762	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 7,405,309	$	47

***(See instructions.)**

Facility Name: Evergreen Place Streator **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,909,809	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,909,809	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	4,529	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 4,529	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	23,965	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 23,965	14
	D. Other Revenue (specify):		
15	**Miscellaneous**		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)**	$ 1,938,303	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	484,299	19
20	Health Care/ Personal Care	357,359	20
21	General Administration	518,394	21
	B. Capital Expense		
22	Ownership	666,454	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)**	$ 2,026,506	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (88,203)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (88,203)	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