

		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: 1000091

Facility Name: Evergreen Vlg Sup Lvg Normal

Address: 1701 Evergrn Vlg Blv Normal 61761

County: McLean

Telephone Number: (309) 452-7300 Fax # ()

Federal Employer ID Number: _____

Date Current Owners were Certified: 2008

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
 ☒ PROPRIETARY
 ☐ GOVERNMENTAL

☐ Charitable Corp.
 ☐ Individual
 ☐ State

☐ Trust
 ☐ Partnership
 ☐ County

IRS Exemption Code _____
 ☐ Corporation
 ☐ Other _____

☒ 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name **Evergreen Vlg Sup Lvg Normal****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		2		3		4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period			
1	99	Single Unit Apartment	99	36,135	1		
2		Double Unit Apartment			2		
3		Other			3		
4	99	TOTALS	99	36,135	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	20,788	14,787		35,575	5
6	Double Unit					6
7	Other					7
8	TOTALS	20,788	14,787		35,575	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.45%

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)**

H. ACCOUNTING BASIS

ACCUAL		MODIFIED	
		CASH*	CASH*
	X		

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? N If yes, did the facility make all of the required payments of interest and principal?
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.

STATE OF ILLINOIS

Page 3

Facility Name: Evergreen Vlg Sup Lvg Normal

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 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	279,401	282,359		561,760		561,760	1
2	Housekeeping, Laundry and Maintenance	133,789	66,373		200,162		200,162	2
3	Heat and Other Utilities			232,719	232,719		232,719	3
4	Other (specify):							4
5	TOTAL General Services	413,190	348,732	232,719	994,641		994,641	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	591,644	4,385	15,171	611,200		611,200	6
7	Activities and Social Services	35,483	7,850		43,333		43,333	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	627,127	12,235	15,171	654,533		654,533	9
	C. General Administration							
10	Administrative and Clerical	227,042	21,574	217,300	465,916	(30,548)	435,368	10
11	Marketing Materials, Promotions and Advertising			67,502	67,502		67,502	11
12	Employee Benefits and Payroll Taxes			251,103	251,103		251,103	12
13	Insurance-Property, Liability and Malpractice			26,017	26,017		26,017	13
14	Other (specify):							14
15	TOTAL General Administration	227,042	21,574	561,922	810,538	(30,548)	779,990	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,267,359	382,541	809,812	2,459,712	(30,548)	2,429,164	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			255,837	255,837		255,837	17
18	Interest			390,818	390,818	(20,282)	370,536	18
19	Real Estate Taxes			90,784	90,784		90,784	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			24,703	24,703		24,703	21
22	Other (specify):							22
23	TOTAL Ownership			762,142	762,142	(20,282)	741,860	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,267,359	382,541	1,571,954	3,221,854	(50,830)	3,171,024	24

Facility Name: Evergreen Vlg Sup Lvg Normal

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	2.33	\$ 32.49	1
2	Licensed Practical Nurses	0.61	21.64	2
3	Certified Nurse Assistants	13.96	14.31	3
4	Activity Director & Assistants	0.96	17.42	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11.94	11.30	7
8	Dishwashers			8
9	Maintenance Workers	1.93	18.42	9
10	Housekeepers	2.34	9.94	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	3.52	17.56	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	37.59	\$ 14.92	17

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 Place-Normal, LLC	Normal
McLean County Assisted Living, LLC	Normal

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).

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	40.00%		\$ 80,000	1
2	Bromenn Physicians Mgmt	40.00%		80,000	2
3	Seniors Bloomington LLC	20.00%		40,000	3
4					4
5					5
Total				\$ 200000	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Heritage Operations Group LLC	\$ 182,146	1
2			2
Total		\$ 182,146	3

Facility Name: Evergreen Vlg Sup Lvg Normal

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	99		2008		\$ 8,230,004	\$ 239,938		\$ 239,938		\$ 2,821,683	1
2			2010		65,761						2
3											3
4											4
5											5
	Improvement Type										
6	Generator			2009	118,123						6
7	Fire Alarm			2009	2,500						7
8	Power Supply			2010	7,360						8
9	Video Surveillance			2011	10,345						9
10	Boulevard Construction			2012	10,017						10
11	Replace accelerator			2014	2,790						11
12	Install carpet - (3) resident rooms			2017	12,267						12
13	Fire alarm system upgrade			2017	2,620						13
14	Water mixing valve replacement			2017	3,406						14
15	Replace natural gas heater			2017	9,179						15
16											16
17	TOTAL (lines 1 thru 16)				\$ 8,474,372	\$ 239,938		\$ 239,938		\$ 2,821,683	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	\$ 734,372	\$ 9,673	\$ 9,673			\$ 638,650	18
19	Vehicles	43,583	6,226	6,226				19
20	TOTAL (lines 18 and 19)	\$ 777,955	\$ 15,899	\$ 15,899			\$ 638,650	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 8,474,372	\$ 239,938		\$ 239,938	\$	\$ 2,821,683	1
2									2
3	Carpet roll purchases for various resident rooms	2018	22,564						3
4	Furnace replacement - dining room	2018	3,524						4
5	Ductless split system replacement	2018	2,950						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,503,410	\$ 239,938		\$ 239,938	\$	\$ 2,821,683	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Evergreen Vlg Sup Lvg Normal

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	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	Lancaster-Pollard				/ /	\$	7,897,147	/ /		\$ 390,818	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	7,897,147			\$ 390,818	7
	B. Non-Facility Related										
8	Interest Income				/ /			/ /		-20,282	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	7,897,147			\$ 370,536	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 Vlg Sup Lvg Normal

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	\$ 1,805,926	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	456,819		3
4	Supply Inventory (priced <u>FIFO</u>)	17,224		4
5	Short-Term Investments			5
6	Prepaid Insurance	52,941		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	313,138		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,646,048	\$	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	8,439,626		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	777,955		16
17	Accumulated Depreciation (book methods)	(3,460,333)		17
18	Deferred Charges	145,654		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): <u>CIP</u>	58,065		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,304,199	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,950,247	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,917	\$	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	94,248		31
32	Accrued Interest Payable	27,640		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)	\$ 250,805	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,897,147		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)	\$ 7,897,147	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,147,952	\$	45
46	TOTAL EQUITY	\$ 802,295	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,950,247	\$	47

*(See instructions.)

Facility Name: Evergreen Vlg Sup Lvg Normal

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.)

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 3,647,482	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,647,482	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	18,717	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 18,717	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	20,282	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 20,282	14
	D. Other Revenue (specify):		
15	Miscellaneous	715	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 715	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,687,196	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	994,641	19
20	Health Care/ Personal Care	654,533	20
21	General Administration	810,538	21
	B. Capital Expense		
22	Ownership	762,142	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)	\$ 3,221,854	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 465,342	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 465,342	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