

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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: 1000107

Facility Name: Evergreen Place Litchfield

Address: 1015 East Tyler Ave Litchfield 62056

County: Montgomery

Telephone Number: (217) 324-1500 Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: 2008

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

xx PROPRIETARY

Individual

xx Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

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 1/1/2020 to 12/31/2020 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)

(Type or Print Name) David M. Underwood

(Title) EVP & CFO

(Signed)

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

In the event there are further questions about this report, please contact:

Name: David M Underwood

Telephone Number: 309 823-7135

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

HFS 3745C (N-4-05)

IL478-2471

Facility Name **Evergreen Place Litchfield**

Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	69	Single Unit Apartment	69	25,254	1		
2		Double Unit Apartment			2		
3		Other			3		
4	69	TOTALS	69	25,254	4		

B. Census-For the entire report period.

	1 Type of Unit	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
Resident Days by Unit and Primary Source of Payment						
5	Single Unit	12,776	8,181		20,957	5
6	Double Unit					6
7	Other					7
8	TOTALS	12,776	8,181		20,957	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **82.98%**

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. None (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

ACCUAL	xx	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? 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? No 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? No If yes, did t

make all of the required payments of interest and principal?

If no, explain.

STATE OF ILLINOIS

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Facility Name: Evergreen Place Litchfield

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

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	163,892	162,344	452	326,688		326,688	1
2	Housekeeping, Laundry and Maintenance	80,719	21,265		101,984		101,984	2
3	Heat and Other Utilities			147,462	147,462		147,462	3
4	Other (specify):							4
5	TOTAL General Services	244,611	183,609	147,914	576,134		576,134	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	358,616	24,660	1,613	384,889		384,889	6
7	Activities and Social Services	31,325	2,845		34,170		34,170	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	389,941	27,505	1,613	419,059		419,059	9
	C. General Administration							
10	Administrative and Clerical	147,930	12,757	149,212	309,899	(8,457)	301,442	10
11	Marketing Materials, Promotions and Advertising			27,791	27,791	(17,473)	10,318	11
12	Employee Benefits and Payroll Taxes			178,997	178,997		178,997	12
13	Insurance-Property, Liability and Malpractice			86,090	86,090		86,090	13
14	Other (specify):							14
15	TOTAL General Administration	147,930	12,757	442,090	602,777	(25,930)	576,847	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	782,482	223,871	591,617	1,597,970	(25,930)	1,572,040	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			260,157	260,157		260,157	17
18	Interest			397,918	397,918	(13,100)	384,818	18
19	Real Estate Taxes			48,892	48,892		48,892	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			27,418	27,418		27,418	21
22	Other (specify): State Income Tax			1,094	1,094	(1,094)		22
23	TOTAL Ownership			735,479	735,479	(14,194)	721,285	23
24	GRAND TOTAL (Sum of lines 16 and 23)	782,482	223,871	1,327,096	2,333,449	(40,124)	2,293,325	24

Facility Name: Evergreen Place Litchfield

Report Period Beginning 1/1/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.02	\$ 34.73	1
2	Licensed Practical Nurses	0.64	19.79	2
3	Certified Nurse Assistants	8.59	14.39	3
4	Activity Director & Assistants	1.04	14.47	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	7.04	11.10	7
8	Dishwashers			8
9	Maintenance Workers	0.89	22.26	9
10	Housekeepers	1.80	10.44	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	3.09	22.93	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	24.11	\$ 15.55	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 Streator LP	Streator

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%		\$ 50,000	1
2	Cinnaire	99.90%		5,000	2
3					3
4					4
5					5
Total				\$ 55000	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Heritage Operations Group LLC	\$ 119,519	1
2			2
Total		\$ 119,519	3

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 Litchfield

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTSA. Purchase price of land 59,450 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	69				\$ 9,158,426	\$ 255,269		\$ 255,269		\$ 3,038,217	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Landscaping			2009	13,600						6
7	Electric Door Opener			2011	3,575						7
8	Flooring			2014	3,052						8
9	10 Ton Compressor Installation			2014	3,767						9
10	Reconstruct fire panels			2014	5,000						10
11	Install new plank flooring			2015	3,312						11
12	New compressor and expansion valve			2016	2,876						12
13	Install new entryway carpet			2016	3,112						13
14	Common area upgrade - new flooring			2017	3,494						14
15	Carpet roll acquisitions - resident rooms			2018	9,464						15
16	Nurse call and Phone system installation			2018	54,116						16
17	TOTAL (lines 1 thru 16)				\$ 9,263,794	\$ 255,269		\$ 255,269		\$ 3,038,217	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	\$ 741,160	\$ 4,888	\$ 4,888			\$ 716,051	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 741,160	\$ 4,888	\$ 4,888			\$ 716,051	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		\$ 9,263,794	\$ 255,269		\$ 255,269	\$	\$ 3,038,217	1
2									2
3	Carpet - Corridors	2019	6,359						3
4	Carpet - Resident Room	2019	3,208						4
5	Carpet - Walkway	2019	3,170						5
6									6
7	Replace flooring - resident rooms	2020	4,213						7
8	Install backup sewer pump	2020	2,888						8
9	Carpet - Walkway	2020	3,926						9
10	Replace elevator packing and valves	2020	7,920						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,295,478	\$ 255,269		\$ 255,269	\$	\$ 3,038,217	34

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

Facility Name: Evergreen Place Litchfield Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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	2	3	4	5	6		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		YES NO
3	Original Building			/ /	\$			3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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	IHDA		XX	Mortgage	/ /	\$	6,779,367	/ /		\$ 397,918	1	
2					/ /			/ /			2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$	6,779,367				\$ 397,918	7
	B. Non-Facility Related											
8	Interest Income				/ /			/ /		-13,100	8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$	6,779,367				\$ 384,818	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.

STATE OF ILLINOIS

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Facility Name: Evergreen Place Litchfield

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,741,914	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced <u>FIFO</u>)	15,965		4
5	Short-Term Investments			5
6	Prepaid Insurance	87,711		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,124)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,840,466	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	788,611		13
14	Buildings, at Historical Cost	8,556,521		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	741,160		16
17	Accumulated Depreciation (book methods)	(3,754,268)		17
18	Deferred Charges	155,678		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):	6,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,494,369	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,334,835	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 60,253	\$	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	59,364		31
32	Accrued Interest Payable	30,005		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Resident Trust</u>	6,667		35
36	<u>Management Fees</u>	662,867		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 819,156	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,779,367		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)	\$ 6,779,367	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,598,523	\$	45
46	TOTAL EQUITY	\$ 736,312	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,334,835	\$	47

*(See instructions.)

Facility Name: Evergreen Place Litchfield

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	\$ 2,162,131	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,162,131	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	54,226	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,659	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 56,885	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	13,100	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 13,100	14
	D. Other Revenue (specify):		
15	Miscellaneous	(848)	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ (848)	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,231,268	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	576,134	19
20	Health Care/ Personal Care	419,059	20
21	General Administration	602,777	21
	B. Capital Expense		
22	Ownership	735,479	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)	\$ 2,333,449	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (102,181)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (102,181)	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

