

		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.

<p><b>I. Facility ID Number:</b> <u>1000091</u></p> <p><b>Facility Name:</b> <u>Evergreen Vlg Sup Lvg Normal</u></p> <p><b>Address:</b> <u>1701 Evergrn Vlg Blv</u> <u>Normal</u> <u>61761</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>McLean</u></p> <p><b>Telephone Number:</b> ( <u>309</u> ) <u>452-7300</u> <b>Fax #</b> ( )</p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>2008</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>David M Underwood</u> <b>Telephone Number:</b> ( ) _____  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP/CFO</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ 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>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP/CFO</u>	<b>Paid Preparer</b>	(Signed) _____ (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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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			
<b>A. General Services</b>								
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	<b>TOTAL General Services</b>	<b>413,190</b>	<b>348,732</b>	<b>232,719</b>	<b>994,641</b>		<b>994,641</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
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	<b>TOTAL Health Care and Programs</b>	<b>627,127</b>	<b>12,235</b>	<b>15,171</b>	<b>654,533</b>		<b>654,533</b>	<b>9</b>
<b>C. General Administration</b>								
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	<b>TOTAL General Administration</b>	<b>227,042</b>	<b>21,574</b>	<b>561,922</b>	<b>810,538</b>	<b>(30,548)</b>	<b>779,990</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,267,359</b>	<b>382,541</b>	<b>809,812</b>	<b>2,459,712</b>	<b>(30,548)</b>	<b>2,429,164</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
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	<b>TOTAL Ownership</b>			<b>762,142</b>	<b>762,142</b>	<b>(20,282)</b>	<b>741,860</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,267,359</b>	<b>382,541</b>	<b>1,571,954</b>	<b>3,221,854</b>	<b>(50,830)</b>	<b>3,171,024</b>	<b>24</b>

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	<b>Total (lines 1 thru 16)</b>	<b>37.59</b>	<b>\$ 14.92</b>	<b>17</b>

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
				<b>Total</b>	<b>\$ 200000 6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	Heritage Operations Group LLC	\$ 182,146 1
2		
		<b>Total \$ 182,146 3</b>

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	City
1 Evergreen Place-Normal, LLC	2 Normal
McLean County Assisted Living, LLC	Normal

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
3	4	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? \$ \_\_\_\_\_

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 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
<b>Improvement Type</b>											
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	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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
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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	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	<b>TOTAL</b>				\$			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			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	Lancaster-Pollard				/ /	\$	7,897,147	/ /		\$ 390,818
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$	7,897,147			\$ 390,818
	<b>B. Non-Facility Related</b>									
8	Interest Income				/ /			/ /		-20,282
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	7,897,147			\$ 370,536

\* 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,646,048	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,304,199	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,950,247	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 250,805	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	7,897,147		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 7,897,147	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 8,147,952	\$	45
46	<b>TOTAL EQUITY</b>	\$ 802,295	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,647,482	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,647,482</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 18,717</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	20,282	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 20,282</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Miscellaneous	715	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 715</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,687,196</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	994,641	19
20	Health Care/ Personal Care	654,533	20
21	General Administration	810,538	21
<b>B. Capital Expense</b>			
22	Ownership	762,142	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 3,221,854</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 465,342</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 465,342</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
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	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$</b>	<b>37</b>