

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046417

Facility Name: EVERGREEN NURSING & REHABILITATION CENTER LLC

Address: 1115 N WENTHE 1115 N WENTHE EFFINGHAM 62401
Number City Zip Code

County: EFFINGHAM

Telephone Number: (217) 347-7121 Fax # (217) 342-5525

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2003

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: BILL WEEAKS Telephone Number: (217) 528-2244
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 1/1/2011 to 12/31/2011 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) ROBERT HEDGES

(Title) MEMBER

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER LLC

0046417 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>26</u>	<u>17</u>	<u>6,126</u>	<u>6,169</u>	8
9	SNF/PED					9
10	ICF	<u>19,717</u>	<u>7,125</u>		<u>26,842</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,743</u>	<u>7,142</u>	<u>6,126</u>	<u>33,011</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 09/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/01/2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 120 and days of care provided 6,126

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	183,958	8,790	8,851	201,599		201,599		201,599			1
2	Food Purchase		182,174		182,174		182,174	(1,804)	180,370			2
3	Housekeeping	98,548	13,680		112,228		112,228		112,228			3
4	Laundry	56,269	11,409		67,678		67,678		67,678			4
5	Heat and Other Utilities			138,494	138,494		138,494	2,513	141,007			5
6	Maintenance	62,833	8,340	25,403	96,576		96,576	11,015	107,591			6
7	Other (specify):* SCAVENGER			5,911	5,911		5,911		5,911			7
8	TOTAL General Services	401,608	224,393	178,659	804,660		804,660	11,724	816,384			8
	B. Health Care and Programs											
9	Medical Director			8,750	8,750		8,750		8,750			9
10	Nursing and Medical Records	1,674,278	137,424	40,522	1,852,224		1,852,224	17,791	1,870,015			10
10a	Therapy	65,849			65,849		65,849		65,849			10a
11	Activities	47,906	2,582	1,747	52,235		52,235		52,235			11
12	Social Services	38,509		1,872	40,381		40,381		40,381			12
13	CNA Training											13
14	Program Transportation			1,570	1,570		1,570		1,570			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,826,542	140,006	54,461	2,021,009		2,021,009	17,791	2,038,800			16
	C. General Administration											
17	Administrative	85,078		436,681	521,759		521,759	(330,116)	191,643			17
18	Directors Fees											18
19	Professional Services			86,311	86,311		86,311	(42,075)	44,236			19
20	Dues, Fees, Subscriptions & Promotions			36,759	36,759		36,759	(21,109)	15,650			20
21	Clerical & General Office Expenses	67,952	16,996	89,423	174,371		174,371	(11,191)	163,180			21
22	Employee Benefits & Payroll Taxes			333,936	333,936		333,936	56,461	390,397			22
23	Inservice Training & Education			2,758	2,758		2,758	57	2,815			23
24	Travel and Seminar			5,217	5,217		5,217	4,624	9,841			24
25	Other Admin. Staff Transportation			15,048	15,048		15,048	(2,952)	12,096			25
26	Insurance-Prop.Liab.Malpractice			64,400	64,400		64,400	2,528	66,928			26
27	Other (specify):*			52,368	52,368		52,368	(52,368)				27
28	TOTAL General Administration	153,030	16,996	1,122,901	1,292,927		1,292,927	(396,141)	896,786			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,381,180	381,395	1,356,021	4,118,596		4,118,596	(366,626)	3,751,970			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			37,036	37,036		37,036	(11,576)	25,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,877	30,877		30,877	(784)	30,093			32
33	Real Estate Taxes			43,612	43,612		43,612	1,781	45,393			33
34	Rent-Facility & Grounds			626,096	626,096		626,096		626,096			34
35	Rent-Equipment & Vehicles			51,855	51,855		51,855		51,855			35
36	Other (specify):*											36
37	TOTAL Ownership			789,476	789,476		789,476	(10,579)	778,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,135	633,643	812,778		812,778		812,778			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		179,135	699,343	878,478		878,478		878,478			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,381,180	560,530	2,844,840	5,786,550		5,786,550	(377,205)	5,409,345			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,307)	30		9
10	Interest and Other Investment Income	(4,003)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,804)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,825)	27		18
19	Entertainment				19
20	Contributions	(977)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(29,771)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,566)	27		24
25	Fund Raising, Advertising and Promotional	(20,250)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>SEE 5A</u>	(75,334)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (196,837)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(180,368)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (180,368)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (377,205)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	<u>Barber and Beauty Shops</u>					41
42	<u>Laboratory and Radiology</u>					42
43	<u>Prescription Drugs</u>					43
44						44
45	<u>Other-Attach Schedule</u>					45
46	<u>Other-Attach Schedule</u>					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0046417

Report Period Beginning:1/1/2011

Ending:12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	HEALTHCARE HORIZONS	\$ (33,000)	19	1
2	MARKETING SALARY	(36,795)	21	2
3	MARKETING TRAVEL	(2,952)	25	3
4	CHAMBER OF COMMERCE	(1,187)	20	4
5	TRAVEL AND SEMINAR	(1,400)	24	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(75,334)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER# 0046417

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,804)	0	0	0	0	0	0	0	0	0	0	(1,804)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,513	0	0	0	0	0	0	0	0	0	2,513	5
6	Maintenance	0	11,015	0	0	0	0	0	0	0	0	0	11,015	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,804)	13,528	0	0	0	0	0	0	0	0	0	11,724	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	17,791	0	0	0	0	0	0	0	0	0	17,791	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	17,791	0	0	0	0	0	0	0	0	0	17,791	16
	C. General Administration													
17	Administrative	0	(330,116)	0	0	0	0	0	0	0	0	0	(330,116)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(62,771)	20,036	660	0	0	0	0	0	0	0	0	(42,075)	19
20	Fees, Subscriptions & Promotions	(21,437)	328	0	0	0	0	0	0	0	0	0	(21,109)	20
21	Clerical & General Office Expenses	(36,795)	25,419	185	0	0	0	0	0	0	0	0	(11,191)	21
22	Employee Benefits & Payroll Taxes	0	56,461	0	0	0	0	0	0	0	0	0	56,461	22
23	Inservice Training & Education	0	57	0	0	0	0	0	0	0	0	0	57	23
24	Travel and Seminar	(1,400)	6,024	0	0	0	0	0	0	0	0	0	4,624	24
25	Other Admin. Staff Transportation	(2,952)	0	0	0	0	0	0	0	0	0	0	(2,952)	25
26	Insurance-Prop.Liab.Malpractice	0	2,528	0	0	0	0	0	0	0	0	0	2,528	26
27	Other (specify):*	(52,368)	0	0	0	0	0	0	0	0	0	0	(52,368)	27
28	TOTAL General Administration	(177,723)	(219,263)	845	0	0	0	0	0	0	0	0	(396,141)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,527)	(187,944)	845	0	0	0	0	0	0	0	0	(366,626)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,307)	0	1,731	0	0	0	0	0	0	0	0	(11,576)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,003)	0	3,219	0	0	0	0	0	0	0	0	(784)	32
33	Real Estate Taxes	0	0	1,781	0	0	0	0	0	0	0	0	1,781	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,310)	0	6,731	0	0	0	0	0	0	0	0	(10,579)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,837)	(187,944)	7,576	0	0	0	0	0	0	0	0	(377,205)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	50	DOCTORS NURSING	SALEM	HI CARE MGMT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	50	DOUGLAS NURSING	MATTOON	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
		TRANSITIONS NURSING	ROCK FALLS	HEALTHCARE	SPRINGFIELD	NURSE CONSULT
		TAMMERLANE HEALTHCARE	STERLING	HORIZONS		
		WESTERN, NORTHWESTERN, NORTHEASTERN MISSOURI NURSING				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 436,681	HI CARE MANAGEMENT		\$	(436,681)	1
2	V	21	HOME OFFICE EXPENSE	60,000	HI CARE MANAGEMENT			(60,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		11,015	11,015	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		2,513	2,513	4
5	V	10	NURSING		HI CARE MANAGEMENT		17,791	17,791	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		106,565	106,565	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		85,419	85,419	7
8	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		20,036	20,036	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		328	328	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		57	57	10
11	V	24	TRAVEL		HI CARE MANAGEMENT		6,024	6,024	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		2,528	2,528	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		56,461	56,461	13
14	Total			\$ 496,681			\$ 308,737	\$ * (187,944)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	\$	H&I PROPERTIES HOME OFFICE		\$ 1,731	\$ 1,731	15
16	V	32	INTEREST		H&I PROPERTIES HOME OFFICE		3,219	3,219	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES HOME OFFICE		1,781	1,781	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES HOME OFFICE		660	660	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES HOME OFFICE		185	185	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 7,576	\$ * 7,576	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EVERGREEN NURSING & REHABILITA' # 0046417 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	\$ 44,362	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT			SEE		SALARY	42,550	17-7	2
3	MARTHA IRVINE	BOOKKEEPING				ATTACHED		SALARY	3,315	21-7	3
4	DEREK HEDGES	VP OPERATIONS				SCHEDULE		SALARY	19,654	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 109,881		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization HI CARE MANAGEMENT
Street Address 1625 S 6TH ST
City / State / Zip Code SPRINGFIELD, IL 62703
Phone Number (217) 528-0044
Fax Number (217) 528-4115

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	143,838	8	\$ 47,997	\$ 38,912	33,011	\$ 11,015	1
2	5	UTILITIES	PER RESIDENT DAY	143,838	8	10,952		33,011	2,513	2
3	10	NURSING	PER RESIDENT DAY	143,838	8	77,520	77,520	33,011	17,791	3
4	17	ADMINISTRATION	PER RESIDENT DAY	143,838	8	464,334	464,334	33,011	106,565	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	143,838	8	372,195	290,523	33,011	85,419	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	143,838	8	87,301		33,011	20,036	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	143,838	8	1,428		33,011	328	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	143,838	8	250		33,011	57	8
9	24	TRAVEL	PER RESIDENT DAY	143,838	8	26,248		33,011	6,024	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	143,838	8	11,015		33,011	2,528	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	143,838	8	246,018		33,011	56,461	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,345,258	\$ 871,289		\$ 308,737	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization H&I PROPERTIES OFFICE BUILDING
Street Address 1625 S 6TH ST
City / State / Zip Code SPRINGFIELD, IL 62703
Phone Number (217) 528-0044
Fax Number (217) 528-0412

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	564	8	\$ 8,134	\$	120	\$ 1,731	1
2	32	INTEREST	PER LICENSE BED	564	8	15,128		120	3,219	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	564	8	8,372		120	1,781	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	564	8	3,100		120	660	4
5	21	OFFICE EXPENSE	PER LICENSE BED	564	8	869		120	185	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 35,603	\$		\$ 7,576	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE													
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)													
	1	2		3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	US BANK (H&I PROP)		X	MORTGAGE OFFICE		06/29/05	\$	48,872	06/29/12	0.0635	\$	3,219	1
2													2
3													3
4													4
5													5
	Working Capital												
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		500,000	REVOLV	PRIME +		5,163	6
7	AVIV		X	WORKING CAPITAL	INTEREST							25,714	7
8													8
9	TOTAL Facility Related						\$	548,872			\$	34,096	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	548,872			\$	34,096	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

HFS 3745 (N-4-99)

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION CENTER LLC**

0046417 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2010 report.	\$	41,649	1	
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	43,536	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	1,887	3	
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	43,506	4	
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	45,393	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	30,044	8	
		2007	31,835	9	
		2008	40,059	10	
		2009	41,649	11	
		2010	43,536	12	
ACCRUAL BASED ON PRIOR YR PLUS 4%					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

EVERGREEN NURSING & REHABILITATION CENTER

COUNTY

EFFINGHAM

FACILITY IDPH LICENSE NUMBER

0046417

CONTACT PERSON REGARDING THIS REPORT

BILL WEEAKS

TELEPHONE

(217) 528-2244

FAX #:

(217) 528-4115

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-017-031</u>	<u>NURSING HOME</u>	\$ <u>41,755.12</u>	\$ <u>41,755.12</u>
2. <u>22-03.0-107-018</u>	<u>HOME OFFICE</u>	\$ <u>5,029.40</u>	\$ <u>1,070.00</u>
3. <u>22-03.0-107-017</u>	<u>HOME OFFICE</u>	\$ <u>3,342.98</u>	\$ <u>711.00</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>50,127.50</u></u>	\$ <u><u>43,536.12</u></u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 29,535
- B. General Construction Type: Exterior BRICKFrame METALNumber of Stories 1
- C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (X) (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	OFFICE BUILDING		2005	\$ 15,080	1
2					2
3	TOTALS			\$ 15,080	3

XI. OWNERSHIP COSTS (continued) B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6	H&I										6
7	PROP										7
8	OFFC BLD			2005	55,935	1,731	39	1,731			8
	Improvement Type**										
9	CARPETING			2004	27,697		5			27,697	9
10	WATER HEATER			2005	2,785	100	27.5	100		668	10
11	REPLACE WALKS			2006	11,500	767	15	767		4,218	11
12	WATER HEATERS			2006	5,820	212	27.5	212		1,157	12
13											13
14	REHAB THERAPY WING-SIGN			2008	1,744	116	15	116		406	14
15	REHAB THERAPY WING ARCHITECT FEES			2008	16,693	607	27.5	607		2,251	15
16	REHAB WING RUNNING PHONE & COMPUTER CABLE			2008	2,303	84	27.5	84		312	16
17	REHAB THERAPY VERTICAL BLINDS			2008	3,972	229	5	794	565	3,176	17
18	PATIENT WANDERING SYSTEM			2008	2,852	104	27.5	104		386	18
19											19
20	ROOF			2008	47,900	1,742	27.5	1,742		5,444	20
21	LANDSCAPING AND PATIO			2008	10,740	716	15	716		2,148	21
22	WINDOWS			2010	13,772	501	15	501		564	22
23											23
24	GREASE TRAP			2011	3,327	106	27.5	111	5	111	24
25	WINDOWS			2011	18,908	86	27.5	86		86	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	REHAB THERAPY WING PAID BY LANDLORD			2008	320,555						35
36	PATIENT WANDERING SYSTEM PAID BY LANDLORD			2008	4,380						36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 550,883	\$ 7,101		\$ 7,671	\$ 570	\$ 48,624	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 143,680	\$ 9,492	\$ 14,368	\$ 4,876	10 YRS	\$ 45,604	71
72	Current Year Purchases	28,596	21,252	1,821	(19,431)	10 YRS	1,821	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 172,276	\$ 30,744	\$ 16,189	\$ (14,555)		\$ 47,425	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 15 PASS CHE VAN	2007	\$ 8,000	\$ 922	\$ 1,600	\$ 678	5	\$ 8,000	76
77										77
78										78
79										79
80	TOTALS			\$ 8,000	\$ 922	\$ 1,600	\$ 678		\$ 8,000	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 746,239	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,767	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,460	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,307)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 104,049	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: EFFINGHAM ASSOCIATES
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	09/04/2004	\$ 626,096	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 626,096			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☒ X NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: \$ 43,262 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENT TRANSPORT	2011 FORD BRAUN	\$ 656.00	\$ 8,593	17
18					18
19					19
20					20
21	TOTAL		\$ 656.00	\$ 8,593	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 168,384	\$		\$ 168,384	1
2	Licensed Speech and Language Development Therapist		hrs			92,712			92,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			372,547			372,547	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				179,135		179,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 633,643	\$ 179,135		\$ 812,778	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION CENTER** # **0046417** Report Period Beginning: **1/1/2011** Ending: **12/31/2011**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2011** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 462,513	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 70,000)	1,367,463		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,778		6
7	Other Prepaid Expenses	235		7
8	Accounts Receivable (owners or related parties)	128,500		8
9	Other(specify): <u>ESCROW</u>	33,941		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,995,430	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	170,013		15
16	Equipment, at Historical Cost	180,276		16
17	Accumulated Depreciation (book methods)	(210,254)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	56,667		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,702	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,192,132	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 466,291	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	126,076		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,567		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,505		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,145,439	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,145,439	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,046,693	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,192,132	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 727,761	1
2	Restatements (describe):		2
3	POST CLOSE	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 727,767	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,516	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(118,590)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 318,926	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,046,693	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION (# 0046417 Report Period Beginning: 1/1/2011Ending: 12/31/2011**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,097,071	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,097,071	3
	B. Ancillary Revenue		
4	Day Care	350	4
5	Other Care for Outpatients		5
6	Therapy	1,130,172	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,130,522	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	482	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	253	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 735	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,003	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,003	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,232,331	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	804,660	31
32	Health Care	2,021,009	32
33	General Administration	1,292,927	33
	B. Capital Expense		
34	Ownership	789,476	34
	C. Ancillary Expense		
35	Special Cost Centers	812,778	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,786,550	40
41	Income before Income Taxes (line 30 minus line 40)**	445,781	41
42	Income Taxes	(8,265)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 437,516	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION CENTER**# **0046417**

Report Period Beginning:

1/1/2011

Ending:

12/31/2011**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,080	\$ 60,336	\$ 29.01	1
2	Assistant Director of Nursing	1,880	2,080	43,820	21.07	2
3	Registered Nurses	6,265	6,654	147,278	22.13	3
4	Licensed Practical Nurses	23,994	26,390	496,963	18.83	4
5	CNAs & Orderlies	69,828	74,654	729,347	9.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,600	6,351	65,849	10.37	8
9	Activity Director	1,783	2,095	28,674	13.69	9
10	Activity Assistants	1,813	1,969	19,232	9.77	10
11	Social Service Workers	3,512	3,850	38,509	10.00	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,080	33,192	15.96	13
14	Head Cook	8,436	9,194	86,500	9.41	14
15	Cook Helpers/Assistants	7,083	7,505	64,266	8.56	15
16	Dishwashers					16
17	Maintenance Workers	3,203	3,521	62,833	17.85	17
18	Housekeepers	8,961	9,965	98,548	9.89	18
19	Laundry	6,217	6,765	56,269	8.32	19
20	Administrator	1,984	2,080	85,078	40.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,016	2,121	31,157	14.69	23
24	Clerical	1,928	2,080	36,795	17.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,733	1,994	23,869	11.97	31
32	Other Health Care <u>MDS,AID, C SUP</u>	10,284	10,841	172,665	15.93	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	170,480	184,269	\$ 2,381,180 *	\$ 12.92	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	201	\$ 8,851	1-3	35
36	Medical Director	MONTHLY	8,750	9-3	36
37	Medical Records Consultant	31	2,262	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,126	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY	2,638	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,747	11-3	44
45	Social Service Consultant	24	1,746	12-3	45
46	Other(specify) _____				46
47	_____				47
48	_____				48
49	TOTAL (lines 35 - 48)	280	\$ 29,120		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
LOLA WHITE		ADMINISTRATOR	0	\$ 85,078	Workers' Compensation Insurance		\$ 70,472	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		53,482	Advertising: Employee Recruitment				
					FICA Taxes		188,953	Health Care Worker Background Check				
					Employee Health Insurance		51,578	(Indicate # of checks performed 96)		1,645		
					Employee Meals			Patient Background Checks 135		2,576		
					Illinois Municipal Retirement Fund (IMRF)*							
					RETIREMENT PLAN		10,018	SEE ATTACHED		9,439		
					EMPLOYEE BENEFITS OTHER		15,894					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 85,078								
B. Administrative - Other												
Description				Amount								
MANAGEMENT FEES				\$ 436,681								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 436,681	TOTAL (agree to Schedule V, line 22, col.8)			\$ 390,397	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,650
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount	
				\$				\$	Out-of-State Travel		\$	
SEE ATTACHED				44,236								
									In-State Travel			
									SEE ATTACHED		9,841	
									Seminar Expense			
									Entertainment Expense		(	
									(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 44,236	TOTAL			\$	TOTAL		\$ 9,841	

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA \$6624

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,247 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? NO Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 2,497
BEDS	\$ 19,741
WOUND CARE VAC	\$ 5,459
DISHWASHER	\$ 814
PRONE TANK	\$ 35
WASHING MACHINE	\$ 2,634
COPIERS	\$ 9,910
POSTAGE EQUIPMENT	\$ 1,512
PORTABLE UNIT	\$ 660
 TOTAL RENTALS	 \$ 43,262

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IHCA	DUES	\$ 6,624
EHEALTH	ANNUAL SUBSCRIPTION	\$ 1,350
GFS	CARD FEE	\$ 687
CITY OF EFFINGHAM	FOOD PERMIT	\$ 200
ILLINOIS SECRETARY OF STATE	REGISTRATION	\$ 250
ALEXANDER HAMILTON	EMPLOYEE LAW	\$ 10
WOLTERS	OSHA GUIDE	\$ 33
MEDPASS	MANUALS	\$ 95
AICPA	ACCTG GUIDE	\$ 168
TAX	TAX	\$ 22
TOTALS		\$ 9,439

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	\$	182,174
TOTAL FOOD PURCHASES WITHOUT TAX	\$	180,370
TOTAL SALES TAX	\$	1,804

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
CTB	LEGAL	\$ 815
MDI ACHIEVE	IT	\$ 14,347
IIT SOURCETECH	IT	\$ 545
INNOVATIVE SOLUTIONS	PULSE OX	\$ 2,164
KBKB	ACCOUNTING	\$ 15,178
RICHARD PEELO	COST REPORTS	\$ 3,000
BPC	401K ADMIN	\$ 1,579
CT CORP	CORP AGENT	\$ 155
ILLINOIS DEP OF REGULATION		\$ 28
MARGEL PEDDICORD	CONSULTING	\$ 391
STRATTON	LEGAL	\$ 3,355
SANDBERG	LEGAL	\$ 231
IVANS	SOFTWARE SUPPORT	\$ 1,082
EMDEON	IT	\$ 228
PEHLMAN	ACCTG SVC	\$ 952
ILLINI TECH	IT	\$ 186
TOTALS		\$ 44,236

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

INSERVICE TRAINING AND EDUCATION

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
JOHN ALTHOFF	CPR	\$ 275
IHCA	NURSING	\$ 2,200
IHCA	FINAL RULES	\$ 125
POLARIS	NURSING	\$ 158
INHAA	TRAINING	\$ 21
IPC	TRAINING	\$ 36
TOTALS		\$ 2,815

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (G) TRAVEL AND SEMINAR

<u>OUT OF STATE TRAVEL</u>	<u>AMOUNT</u>
<u>IN STATE TRAVEL</u>	
CORP DON	\$ 6,024
IHCA CONFERENCE	\$ 2,267
<u>SEMINAR EXPENSE</u>	
IHCA	\$ 1,550
TOTAL	\$ 9,841

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 5,978
LOLOA WHITE - ADMINISTRATOR	\$ 4,057
THERESA SUTTER - BOM	\$ 1,624
CAROL STICH - DON	\$ 185
AMIE TIPSWORD - REHAB	\$ 252

TOTAL \$ 12,096