

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0054932

Facility Name: Evergreen Nursing Rehab Ctr

Address: 1115 North 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: 05/07/18

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller Telephone Number: (618) 465-7717
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 01/01/2020 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) _____ (Date) _____
(Type or Print Name) Jason Mills
(Title) Chief Financial Officer

Paid
Preparer

(Signed) See Accountant's Preparation Report (Date) _____
(Print Name and Title) Cindy A. Tefteller Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing Rehab Ctr

0054932 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 N/A

	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>43,920</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	<u>7</u>

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>12,018</u>	<u>4,916</u>	<u>3,830</u>	<u>20,764</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>12,018</u>	<u>4,916</u>	<u>3,830</u>	<u>20,764</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.28%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 05/07/2018

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/07/2018 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 3,568

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing Rehab Ctr # 0054932 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	178,315	7,796	7,392	193,503		193,503		193,503			1
2	Food Purchase		136,977		136,977		136,977	(161)	136,816			2
3	Housekeeping	105,917	12,978	200	119,095		119,095		119,095			3
4	Laundry	40,312	8,380	103	48,795		48,795		48,795			4
5	Heat and Other Utilities			145,102	145,102		145,102	(16,488)	128,614			5
6	Maintenance	55,599	11,241	25,706	92,546		92,546		92,546			6
7	Other (specify):*											7
8	TOTAL General Services	380,143	177,372	178,503	736,018		736,018	(16,649)	719,369			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,278,606	87,166	144,239	1,510,011		1,510,011	23,105	1,533,116			10
10a	Therapy			1,843	1,843		1,843		1,843			10a
11	Activities	42,413	1,236	1,792	45,441		45,441		45,441			11
12	Social Services	36,451	16	2,131	38,598		38,598		38,598			12
13	CNA Training											13
14	Program Transportation			465	465		465		465			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,357,470	88,418	162,470	1,608,358		1,608,358	23,105	1,631,463			16
	C. General Administration											
17	Administrative	87,870		258,900	346,770		346,770	(238,074)	108,696			17
18	Directors Fees											18
19	Professional Services			26,494	26,494		26,494	6,762	33,256			19
20	Dues, Fees, Subscriptions & Promotions			53,577	53,577		53,577	(30,179)	23,398			20
21	Clerical & General Office Expenses	81,340	13,914	120,676	215,930		215,930	105,010	320,940			21
22	Employee Benefits & Payroll Taxes			192,395	192,395		192,395	12,093	204,488			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,344	1,344		1,344	1,823	3,167			24
25	Other Admin. Staff Transportation			11,570	11,570		11,570	2,603	14,173			25
26	Insurance-Prop.Liab.Malpractice			35,439	35,439		35,439	17,533	52,972			26
27	Other (specify):*											27
28	TOTAL General Administration	169,210	13,914	700,395	883,519		883,519	(122,429)	761,090			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,906,823	279,704	1,041,368	3,227,895		3,227,895	(115,973)	3,111,922			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			12,267	12,267		12,267	2,960	15,227			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,738	8,738		8,738	(151)	8,587			32
33	Real Estate Taxes			39,600	39,600		39,600	32	39,632			33
34	Rent-Facility & Grounds			197,141	197,141		197,141	5,475	202,616			34
35	Rent-Equipment & Vehicles			36,497	36,497		36,497	813	37,310			35
36	Other (specify):*											36
37	TOTAL Ownership			294,243	294,243		294,243	9,129	303,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,287	558,505	684,792		684,792		684,792			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,169	174,169		174,169		174,169			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,287	732,674	858,961		858,961		858,961			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,906,823	405,991	2,068,285	4,381,099		4,381,099	(106,844)	4,274,255			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(16,901)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(161)	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				18
19	Entertainment	(2,402)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,925)	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	(3,356)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,896)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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)	(55,948)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (55,948)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (106,844)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	\$ (1,787)	20	1
2	To Eliminate PAC Dues & Lobbying Expense	(2,950)	20	2
3	To Record Full Year IDPH License Fee	1,447	20	3
4	To Eliminate Chamber of Commerce Fees	(66)	20	4
5				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	(3,356)		49

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
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcar	St. Ann, MO	Management Co
		Hillside Rehab & Care Center	Yorkville, IL	Helia Healthcare Servi	Benton, IL	Laundry Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Palladian Management	O'Fallon, IL	Management Co
		Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO	Palladian Taylorville A	Taylorville, IL	Assisted Living
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Palladian Mt. Vernon	Mt. Vernon, IL	Assisted Living
		Helia Southbelt Healthcare	Belleville, IL			

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 413	\$ 413	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	23,105	23,105	2
3	V	17	Management Fees	258,900	Bridgemark Healthcare, LLC	100.00%	20,826	(238,074)	3
4	V	19	Professional Fees		Bridgemark Healthcare, LLC	100.00%	6,762	6,762	4
5	V	20	Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	1,102	1,102	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	107,412	107,412	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	12,093	12,093	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	1,823	1,823	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	2,603	2,603	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	17,533	17,533	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	2,960	2,960	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	32	32	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	5,475	5,475	13
14	Total			\$ 258,900			\$ 202,139	\$ * (56,761)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.

☒ 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	35	Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 813	\$ 813	15
16	V								16
17	V								17
18	V								18
19	V								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			\$			\$ 813	\$ * 813	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Evergreen Nursing Rehab Ctr

0054932

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Healthcare of Hillsboro	Hillsboro, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Belleville	Belleville, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Helia Richland Healthcare, LLC	Olney, IL				7
8			Palladian Aviston SNF, LLC	Aviston, IL				8
9			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				9
10			Palladian Taylorville SNF, LLC	Taylorville, IL				10
11			Helia Healthcare of Newton	Newton, IL				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing Rehab Ctr # 0054932 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Stephen P. Miller	Owner	Administrative	100.00	385,602	2.56	5.12	Distribution	\$ 20,826	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,826		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2020

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

SEE ACCOUNTANTS' PREPARATION REPORT

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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MidCap Funding IV Trust		X	Line of Credit							Var.	8,123	6
7	Medline		X	Vendor Note							8.0000	615	7
8													8
9	TOTAL Facility Related						\$		\$			\$ 8,738	9
	B. Non-Facility Related*												
10	Interest Income Offset											(151)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (151)	14
15	TOTALS (line 9+line14)						\$		\$			\$ 8,587	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Nursing Rehab Ctr COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0054932

CONTACT PERSON REGARDING THIS REPORT Jason Mills

TELEPHONE (314) 317-2003 FAX #: (314) 754-9176

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>03-11-017-031</u>	<u>Nursing Home</u>	\$ <u>39,929.94</u>	\$ <u>39,929.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>39,929.94</u></u>	\$ <u><u>39,929.94</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies 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.☒ (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.☒ (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ 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	Section N/A			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	B Hall Vinyl and Ceiling Lights			2018	20,753	2,075	10	2,075		4,324
10	Sewer Line in Kitchen			2018	13,157	658	20	658		1,316
11	Replace Facility Roof			2019	30,296	3,030	10	3,030		6,059
12	New Roof C & D Halls			2019	21,265	2,127	10	2,127		2,304
13	Phone System			2020	25,758	1,073	10	1,073		1,073
14										14
15										15
16	Related Party Allocation - Bridgemark									16
17	New Office Build Out			2011	6,959		20	368	368	3,484
18	Conference Rm Chair Rail & Paint			2012	79		5			79
19	AC Unit in Server Room			2018	540		20	27	27	67
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

*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
SEE ACCOUNTANTS' PREPARATION REPORT

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)		\$ 118,807	\$ 8,963		\$ 9,358	\$ 395	\$ 18,706	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 24,025	\$ 2,714	\$ 4,937	\$ 2,223	3-15 Yrs	\$ 10,513	71
72	Current Year Purchases	9,007	590	932	342	3-15 Yrs	932	72
73	Fully Depreciated Assets	2,462					2,462	73
74								74
75	TOTALS	\$ 35,494	\$ 3,304	\$ 5,869	\$ 2,565		\$ 13,907	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	154,301
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	12,267
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	15,227
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	2,960
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	32,613

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	Section N/A	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Section N/A	\$
93		
94		
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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:OMG Effingham Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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		\$ 196,301			3
4	Additions							4
5	Storage Rental				840			5
6	Related Party Allocation - Bridgemark				5,475			6
7	TOTAL		120		\$ 202,616			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

N/A

N/A
9. Option to Buy:

☐ YES

☒ NO

Terms:*

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

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$ 37,310Description: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	Section N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Effingham
Attachment to Schedule XII B
Equipment Rental
12/31/2020

Description		
16A	Specialty Beds	6,070
16B	Respiratory Equipment	22,462
16C	Copier Lease	7,965
16E	Related Party Allocation - Bridgemark	813
		<u>37,310</u>

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

C. CONTRACTUAL INCOME

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)	\$			

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				94,137		94,137	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39, 2					32,151		32,151	12
13	Other (specify): <u>X-Rays, Labs, Therapy</u>	39, 3				558,505			558,505	13
14	TOTAL			\$		\$ 558,505	\$ 126,288		\$ 684,793	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	235,469		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,248		7
8	Accounts Receivable (owners or related parties)	2,682,220		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,921,937	\$	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	111,229		15
16	Equipment, at Historical Cost	23,068		16
17	Accumulated Depreciation (book methods)	(21,558)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 112,739	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,034,676	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 472,698	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,498		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	8,990		36
37	Deferred CARES Funds	696,787		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,305,137	\$	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)	\$ 1,305,137	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,729,539	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,034,676	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 984,260	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 984,260	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	745,279	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	()	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)	\$ 745,279	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)	\$ 1,729,539	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing Rehab Ctr

0054932

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,947,269	1
2	Discounts and Allowances for all Levels	(187,432)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,759,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,193	6
7	Oxygen	16,135	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 238,328	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 151	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	62	28
28a	CARES Funds	128,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 128,062	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,126,378	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	736,018	31
32	Health Care	1,608,358	32
33	General Administration	883,519	33
	B. Capital Expense		
34	Ownership	294,243	34
	C. Ancillary Expense		
35	Special Cost Centers	684,792	35
36	Provider Participation Fee	174,169	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,381,099	40
41	Income before Income Taxes (line 30 minus line 40)**	745,279	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 745,279	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,007,183	44
45	Private Pay - Net Inpatient Revenue	904,447	45
46	Medicare - Net Inpatient Revenue	1,755,876	46
47	Other-(specify) Insurance	76,031	47
48	Other-(specify) Hospice	16,300	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,759,837	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Filed Yet If not, please attach a reconciliation.

*** 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,394	2,394	\$ 84,294	\$ 35.21	1
2	Assistant Director of Nursing	2,358	2,571	87,417	34.00	2
3	Registered Nurses	1,905	2,148	77,860	36.25	3
4	Licensed Practical Nurses	17,249	18,744	490,452	26.17	4
5	CNAs & Orderlies	32,016	34,230	530,304	15.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,129	3,254	42,413	13.03	10
11	Social Service Workers	2,150	2,305	36,451	15.81	11
12	Dietician					12
13	Food Service Supervisor	2,315	2,315	58,298	25.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,666	9,152	120,017	13.11	15
16	Dishwashers					16
17	Maintenance Workers	1,910	2,100	55,599	26.48	17
18	Housekeepers	6,802	7,307	105,917	14.50	18
19	Laundry	3,239	3,538	40,312	11.39	19
20	Administrator	2,137	2,219	87,870	39.60	20
21	Assistant Administrator					21
22	Other Administrative	1,798	1,990	36,117	18.15	22
23	Office Manager	2,039	2,267	45,223	19.95	23
24	Clerical					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	355	355	8,279	23.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,462	96,889	\$ 1,906,823 *	\$ 19.68	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		\$ 7,392	1, 3	35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant		3,694	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,285	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,792	11, 3	44
45	Social Service Consultant		2,131	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,294		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	4,518	137,260	10, 3	52
53	TOTAL (lines 50 - 52)	4,518	\$ 137,260		53

SEE ACCOUNTANTS' PREPARATION REPORT

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 Dues \$6,266

(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?

N/A

(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?

3-15 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 9,317

Line 10

(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.

N/A

(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.

\$ 174,169

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?

None

(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 benefits on Schedule V.

\$ None

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A

(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.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

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?

N/A

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.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' PREPARATION REPORT