



Facility Name & ID Number EVERGREEN NRSG & REHAB CTR

# 0046417 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,541	1,287	6,802	11,630	8
9	SNF/PED					9
10	ICF	10,182	9,310	29	19,521	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,723	10,597	6,831	31,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.12%

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 6,762

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name &amp; ID Number

EVERGREEN NRSRG &amp; REHAB CTR

# 0046417

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

**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
	<b>A. General Services</b>										
1	Dietary	189,401	8,048	8,996	206,445		206,445		206,445		1
2	Food Purchase		192,257		192,257		192,257	(1,904)	190,353		2
3	Housekeeping	108,311	15,274		123,585		123,585		123,585		3
4	Laundry	52,964	10,295		63,259		63,259		63,259		4
5	Heat and Other Utilities			166,071	166,071		166,071	(8,283)	157,788		5
6	Maintenance	64,508	8,758	38,536	111,802		111,802	9,080	120,882		6
7	Other (specify):* <b>SCAVENGER</b>			7,642	7,642		7,642		7,642		7
8	<b>TOTAL General Services</b>	415,184	234,632	221,245	871,061		871,061	(1,107)	869,954		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	1,774,738	111,559	43,384	1,929,681		1,929,681	4,821	1,934,502		10
10a	Therapy	100,505			100,505		100,505		100,505		10a
11	Activities	49,801	2,325	1,739	53,865		53,865		53,865		11
12	Social Services	41,744		1,860	43,604		43,604		43,604		12
13	CNA Training										13
14	Program Transportation			743	743		743		743		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,966,788	113,884	60,726	2,141,398		2,141,398	4,821	2,146,219		16
	<b>C. General Administration</b>										
17	Administrative	93,364		442,199	535,563		535,563	(218,556)	317,007		17
18	Directors Fees										18
19	Professional Services			35,460	35,460		35,460	(8,956)	26,504		19
20	Dues, Fees, Subscriptions & Promotions			37,034	37,034		37,034	(23,468)	13,566		20
21	Clerical & General Office Expenses	72,363	15,218	78,895	166,476		166,476	(63,192)	103,284		21
22	Employee Benefits & Payroll Taxes			331,313	331,313		331,313	59,055	390,368		22
23	Inservice Training & Education			7,367	7,367	(2,708)	4,659	893	5,552		23
24	Travel and Seminar					2,708	2,708	6,599	9,307		24
25	Other Admin. Staff Transportation			22,521	22,521		22,521	(8,980)	13,541		25
26	Insurance-Prop.Liab.Malpractice			34,263	34,263		34,263	32,484	66,747		26
27	Other (specify):*			106,889	106,889		106,889	(106,889)			27
28	<b>TOTAL General Administration</b>	165,727	15,218	1,095,941	1,276,886		1,276,886	(331,010)	945,876		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,547,699	363,734	1,377,912	4,289,345		4,289,345	(327,296)	3,962,049		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.

Facility Name &amp; ID Number

EVERGREEN NRSRG &amp; REHAB CTR

#0046417

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			18,718	18,718		18,718	15,798	34,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,191	45,191		45,191	(83,329)	(38,138)			32
33	Real Estate Taxes			40,867	40,867		40,867	2,379	43,246			33
34	Rent-Facility & Grounds			534,198	534,198		534,198		534,198			34
35	Rent-Equipment & Vehicles			45,005	45,005		45,005		45,005			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			683,979	683,979		683,979	(65,152)	618,827			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,592	723,515	872,107		872,107		872,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			213,637	213,637		213,637		213,637			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		148,592	937,152	1,085,744		1,085,744		1,085,744			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,547,699	512,326	2,999,043	6,059,068		6,059,068	(392,448)	5,666,620			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(10,892)	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	13,849	30		9
10	Interest and Other Investment Income	(49,735)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,904)	2		13
14	Non-Care Related Interest	(36,280)	32		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				19
20	Contributions	(227)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,386)	27		24
25	Fund Raising, Advertising and Promotional	(23,085)	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	(49,595)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (257,255)		\$	30

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(135,193)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (135,193)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (392,448)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>					
48		49		50	51
					52

EVERGREEN NRSG & REHAB CTRID# 0046417Report Period Beginning: 1/1/2013Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	HEALTHCARE HORIZONS	\$ (19,000)	19	1
2	MARKETING SALARY	(39,583)	21	2
3	MARKETING TRAVEL	(8,980)	25	3
4	CHAMBER OF COMMERCE	(1,537)	20	4
5	CASUALTY LOSS	(3,708)	27	5
6	MARKETING	(3,568)	27	6
7	PRIOR YEAR INSURANCE	30,000	26	7
8	SAGE MARKETING	(3,219)	19	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	<b>Total</b>		(49,595)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN NRSNG & REHAB CTR# 0046417

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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	(1,904)	0	0	0	0	0	0	0	0	0	0	(1,904)	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	(10,892)	2,609	0	0	0	0	0	0	0	0	0	(8,283)	5
6	Maintenance	0	9,080	0	0	0	0	0	0	0	0	0	9,080	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(12,796)</b>	<b>11,689</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,107)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,821	0	0	0	0	0	0	0	0	0	4,821	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>4,821</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,821</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(218,556)	0	0	0	0	0	0	0	0	0	(218,556)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,219)	12,967	296	0	0	0	0	0	0	0	0	(8,956)	19
20	Fees, Subscriptions & Promotions	(24,622)	1,154	0	0	0	0	0	0	0	0	0	(23,468)	20
21	Clerical & General Office Expenses	(39,583)	(24,017)	408	0	0	0	0	0	0	0	0	(63,192)	21
22	Employee Benefits & Payroll Taxes	0	59,055	0	0	0	0	0	0	0	0	0	59,055	22
23	Inservice Training & Education	0	893	0	0	0	0	0	0	0	0	0	893	23
24	Travel and Seminar	0	6,599	0	0	0	0	0	0	0	0	0	6,599	24
25	Other Admin. Staff Transportation	(8,980)	0	0	0	0	0	0	0	0	0	0	(8,980)	25
26	Insurance-Prop.Liab.Malpractice	30,000	2,484	0	0	0	0	0	0	0	0	0	32,484	26
27	Other (specify):*	(106,889)	0	0	0	0	0	0	0	0	0	0	(106,889)	27
28	<b>TOTAL General Administration</b>	<b>(172,293)</b>	<b>(159,421)</b>	<b>704</b>	<b>0</b>	<b>(331,010)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(185,089)</b>	<b>(142,911)</b>	<b>704</b>	<b>0</b>	<b>(327,296)</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number EVERGREEN NRSG & REHAB CTR# 0046417

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	13,849	0	1,949	0	0	0	0	0	0	0	0	15,798	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(86,015)	0	2,686	0	0	0	0	0	0	0	0	(83,329)	32
33	Real Estate Taxes	0	0	2,379	0	0	0	0	0	0	0	0	2,379	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	<b>TOTAL Ownership</b>	<b>(72,166)</b>	<b>0</b>	<b>7,014</b>	<b>0</b>	<b>(65,152)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(257,255)	(142,911)	7,718	0	0	0	0	0	0	0	0	(392,448)	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		

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	\$ 442,199	HI CARE MANAGEMENT		\$ (442,199)	1
2	V	21	HOME OFFICE EXPENSE	60,000	HI CARE MANAGEMENT		(60,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT	9,080	9,080	3
4	V	5	UTILITIES		HI CARE MANAGEMENT	2,609	2,609	4
5	V	10	NURSING		HI CARE MANAGEMENT	4,821	4,821	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT	223,643	223,643	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT	35,983	35,983	7
8	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT	12,967	12,967	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT	1,154	1,154	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT	893	893	10
11	V	24	TRAVEL		HI CARE MANAGEMENT	6,599	6,599	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT	2,484	2,484	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT	59,055	59,055	13
14	Total		\$ 502,199			\$ 359,288	\$ * (142,911)	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.  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		\$ 1,949	\$ 1,949 15
16	V	32 INTEREST		H&I PROPERTIES HOME OFFICE		2,686	2,686 16
17	V	33 REAL ESTATE TAXES		H&I PROPERTIES HOME OFFICE		2,379	2,379 17
18	V	19 PROFESSIONAL FEES		H&I PROPERTIES HOME OFFICE		296	296 18
19	V	21 OFFICE EXPENSE		H&I PROPERTIES HOME OFFICE		408	408 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		\$			\$ 7,718	\$ * 7,718 39

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

Facility Name & ID Number EVERGREEN NRSG & REHAB CTR # 0046417 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

## 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	50.00	137,755	11.494	28.73	SALARY	\$ 55,544	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	132,124	11.494	28.73	SALARY	53,274	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	10,295	11.494	28.73	SALARY	4,151	17-7	3
4	DEREK HEDGES	VP OPERATIONS	VP OPERATIONS	0.00	66,469	11.494	28.73	SALARY	26,801	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 139,770		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 NRSNG & REHAB CTR

# 0046417

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINTENANCE	PER RESIDENT DAY	108,409	5	\$ 31,601	\$ 27,116	31,151	\$ 9,080	1
2	5	UTILITIES	PER RESIDENT DAY	108,409	5	9,081		31,151	2,609	2
3	10	NURSING	PER RESIDENT DAY	108,409	5	16,777	16,777	31,151	4,821	3
4	17	ADMINISTRATION	PER RESIDENT DAY	108,409	5	778,304	778,304	31,151	223,643	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	108,409	5	125,226		31,151	35,983	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	108,409	5	45,127		31,151	12,967	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	108,409	5	4,017		31,151	1,154	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	108,409	5	3,109		31,151	893	8
9	24	TRAVEL	PER RESIDENT DAY	108,409	5	22,964		31,151	6,599	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	108,409	5	8,646		31,151	2,484	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	108,409	5	205,518		31,151	59,055	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					\$ 1,250,370	\$ 822,197		\$ 359,288	25

Facility Name & ID Number EVERGREEN NRSNG & REHAB CTR

# 0046417

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	444	5	\$ 7,213	\$ 120	\$ 1,949	1
2	32	INTEREST	PER LICENSE BED	444	5	9,940	120	2,686	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,803	120	2,379	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	1,095	120	296	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,508	120	408	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					\$ 28,559	\$	\$ 7,718	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	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	US BANK (H&I PROP)		X	MORTGAGE OFFICE		06/29/05	\$	\$ 55,617	06/29/2017	0.0425	\$ 2,686	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		230,000	REVOLV	PRIME +	8,911	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$ 285,617			\$ 11,597	9					
<b>B. Non-Facility Related*</b>																	
10	AVIV		X	WORKING CAPITAL		5/1/2013		305,613	268,658	5/1/2020	0.0800	36,280	10				
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	305,613	\$ 268,658		\$ 36,280	14					
15	<b>TOTALS (line 9+line14)</b>						\$	305,613	\$ 554,275		\$ 47,877	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.)

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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2012 report.		\$ 43,588	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.)		\$ 44,065	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 477	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 42,769	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 43,246	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	40,059	8
	2009	41,649	9
	2010	43,536	10
	2011	43,588	11
	2012	44,065	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN NRSNG & REHAB CTR 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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-11-017-031</u>	<u>NURSING HOME</u>	\$ <u>41,685.68</u>	\$ <u>41,685.68</u>
2. <u>22-03.0-107-018</u>	<u>HOME OFFICE</u>	\$ <u>5,288.24</u>	\$ <u>1,429.14</u>
3. <u>22-03.0-107-017</u>	<u>HOME OFFICE</u>	\$ <u>3,515.00</u>	\$ <u>949.92</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>50,488.92</u></u>	\$ <u><u>44,064.74</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                 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 BRICK Frame METAL Number 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).

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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	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>\$ 15,676</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 15,676</b>	3

## 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	H&I								6
7	PROP								7
8	OFFC BLD		2005	71,053	1,949	39	1,949		8
	Improvement Type**								
9	CARPETING		2004	27,697		5			27,697
10	WATER HEATER		2005	2,785	101	27.5	101		872
11	REPLACE WALKS		2006	11,500	767	15	767		6,039
12	WATER HEATERS		2006	5,820	212	27.5	212		1,580
13									13
14	REHAB THERAPY WING-SIGN		2008	1,744	116	15	116		639
15	REHAB THERAPY WING ARCHITECT FEES		2008	16,693	607	27.5	607		3,465
16	REHAB WING RUNNING PHONE & COMPUTER CABLE		2008	2,303	84	27.5	84		479
17	REHAB THERAPY VERTICAL BLINDS		2008	3,972		5			3,972
18	PATIENT WANDERING SYSTEM		2008	2,852	104	27.5	104		593
19									19
20	ROOF		2008	47,900	1,742	27.5	1,742		8,927
21	LANDSCAPING AND PATIO		2008	10,740	716	15	716		3,222
22	WINDOWS		2010	13,772	501	15	501		1,565
23									23
24	GREASE TRAP		2011	3,327	121	27.5	121		353
25	WINDOWS		2011	18,908	688	27.5	688		1,461
26									26
27	FLOORING		2012	6,967	253	27.5	253		496
28	A/C REPLACEMENT		2012	30,920	1,124	27.5	1,124		2,248
29	PARKING LOT EXPANSION		2012	41,573	1,512	27.5	1,512		2,079
30	WATER HEATER		2012	3,677	134	27.5	134		195
31	A/C UNIT		2013	7,730	190	27.5	190		190
32									32
33									33
34									34
35	REHAB THERAPY WING PAID BY LANDLORD		2008	320,555					
36	PATIENT WANDERING SYSTEM PAID BY LANDLORD		2008	4,380					

\*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	2013	5,634	68	27.5	68		68	38
39	2013	1,278	15	27.5	15		15	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)	\$ 663,780	\$ 11,004		\$ 11,004	\$	\$ 66,155	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	\$ 188,940	\$ 5,045	\$ 18,894	\$ 13,849	10 YRS	\$ 83,547	71
72	Current Year Purchases	28,039	4,618	4,618		5-10YRS	4,618	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 216,979	\$ 9,663	\$ 23,512	\$ 13,849		\$ 88,165	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	\$	\$	\$		\$ 8,000	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 8,000	\$	\$	\$		\$ 8,000	80

**E. Summary of Care-Related Assets**

		1 Reference	2 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)	\$ 904,435	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,849	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 162,320	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	<b>TOTALS</b>	\$	\$	\$	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:	<u>120</u>	<u>09/04/2004</u>	\$ <u>534,198</u>	<u>10</u>		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>120</b>		\$ <b>534,198</b>			<b>7</b>

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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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  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: \$ 32,325 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			\$	\$	17
18	<u>Resident Transport</u>	<u>2013 Ford</u>	<u>#####</u>	<u>12,680</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>#####</b>	\$ <b>12,680</b>	<b>21</b>

\* 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.

Facility Name & ID Number EVERGREEN NRSG & REHAB CTR # 0046417 Report Period Beginning: 1/1/2013 Ending: 12/31/2013  
**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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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**

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

- (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.)**

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	233,782	\$		\$	233,782	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				89,496				89,496	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				400,237				400,237	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 prescripts					148,592			148,592	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	<b>TOTAL</b>			\$		\$	723,515	\$	148,592	\$	872,107	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 NRSNG & REHAB CTR# 0046417Report Period Beginning: 1/1/2013Ending: 12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(70,000)</u> )	<u>1,134,539</u>		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	<u>8,663</u>		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	<u>778,500</u>		8
9	Other(specify): <u>Deposits</u>	<u>127,862</u>		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 2,049,564</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
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	<u>236,123</u>		15
16	Equipment, at Historical Cost	<u>256,648</u>		16
17	Accumulated Depreciation (book methods)	<u>(262,845)</u>		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	<u>33,413</u>		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 263,339</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,312,903</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ <u>322,107</u>	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	<u>230,000</u>		29
30	Accrued Salaries Payable	<u>75,545</u>		30
31	Accrued Taxes Payable (excluding real estate taxes)	<u>40,359</u>		31
32	Accrued Real Estate Taxes(Sch.IX-B)	<u>41,686</u>		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Cheques Outstanding Net</u>	<u>28,488</u>		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 738,185</b>	<b>\$</b>	<b>38</b>
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	<u>268,658</u>		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 268,658</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,006,843</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,306,060</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,312,903</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,050,253	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,050,253	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	307,806	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	(52,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <b>ROUNDING</b>	1	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 255,807</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,306,060</b>	24 *

\* This must agree with page 17, line 47.

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,006,639	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,006,639	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,500	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 310,500	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	49,735	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 49,735	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,366,874	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	871,061	31
32	Health Care	2,141,398	32
33	General Administration	1,276,886	33
<b>B. Capital Expense</b>			
34	Ownership	683,979	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	872,107	35
36	Provider Participation Fee	213,637	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,059,068	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	307,806	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 307,806	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,730,854	44
45	Private Pay - Net Inpatient Revenue	1,517,366	45
46	Medicare - Net Inpatient Revenue	2,747,568	46
47	Other-(specify) <b>INSURANCE</b>	10,851	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,006,639	49

\* This must agree with page 4, line 45, column 4. Tax is cash basis

\*\* Does this agree with taxable income (loss) per Federal Income

Tax Return? No 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.

Facility Name & ID Number **EVERGREEN NRSNG & REHAB CTR**

# **0046417**

Report Period Beginning: **1/1/2013**

Ending:

**12/31/2013**

**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	2,008	2,530	\$ 70,147	\$ 27.73	1
2	Assistant Director of Nursing	1,942	2,113	46,228	21.88	2
3	Registered Nurses	8,324	9,027	172,371	19.10	3
4	Licensed Practical Nurses	20,479	23,264	459,045	19.73	4
5	CNAs & Orderlies	69,968	75,920	734,640	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,172	10,083	100,505	9.97	8
9	Activity Director	1,838	2,125	29,903	14.07	9
10	Activity Assistants	1,770	1,955	19,898	10.18	10
11	Social Service Workers	3,586	4,062	41,744	10.28	11
12	Dietician					12
13	Food Service Supervisor	1,985	2,113	34,096	16.14	13
14	Head Cook	6,553	7,381	73,110	9.91	14
15	Cook Helpers/Assistants	8,571	9,408	82,195	8.74	15
16	Dishwashers					16
17	Maintenance Workers	3,200	3,519	64,508	18.33	17
18	Housekeepers	9,241	10,575	108,311	10.24	18
19	Laundry	5,939	6,440	52,964	8.22	19
20	Administrator	1,905	2,113	93,364	44.19	20
21	Assistant Administrator					21
22	Other Administrative	1,821	2,113	39,583	18.73	22
23	Office Manager	1,913	2,113	32,780	15.51	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	1,739	2,006	24,589	12.26	31
32	Other Health C: <u>MDS,Transport,N</u>	10,193	11,233	267,718	23.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,147	190,093	\$ 2,547,699 *	\$ 13.40	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	192	\$ 8,996	1-3	35
36	Medical Director	MONTHLY	13,000	9-3	36
37	Medical Records Consultant	29	2,076	10-3	37
38	Nurse Consultant	20	3,405	10-3	38
39	Pharmacist Consultant	MONTHLY	3,921	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY	2,375	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,739	11-3	44
45	Social Service Consultant	24	1,739	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	\$ 37,251		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	93,364	Workers' Compensation Insurance	56,149	IDPH License Fee		
				Unemployment Compensation Insurance	51,029	Advertising: Employee Recruitment	(29)	
				FICA Taxes	208,162	Health Care Worker Background Check	600	
				Employee Health Insurance	61,153	(Indicate # of checks performed 15 )		
				Employee Meals		Patient Background Checks	2,363	
				Illinois Municipal Retirement Fund (IMRF)*				
				401K	13,875	SEE ATTACHED SCHEDULE	10,632	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			93,364					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		390,368	Less: Public Relations Expense	( )	
MANAGEMENT FEES			442,199			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			442,199	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
SEE ATTACHED SCHEDULE			26,504				Out-of-State Travel	
							In-State Travel	
							Corp Nurse Consultant	6,599
							IHCA	2,708
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			26,504	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
								9,307

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

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 \$4968
- (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? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,450 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. \$ 213,637  
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 benefits on Schedule V. \$ 0 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? 25%-50%
  - 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.** \$ \_\_\_\_\_
- (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 12/31/13

SCHEDULE OF RENTAL EQUIPMENT

<u>Item</u>	<u>Amount</u>
CONCENTRATORS	\$ 6,202
BEDS	\$ 8,430
WASHING MACHINE	\$ 5,379
COPIERS	\$ 9,092
POSTAGE EQUIPMENT	\$ 1,198
Storage Unit	\$ 1,110
Lift Truck	\$ 275
Computers	\$ 638
TOTAL RENTALS	\$ 32,325

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
 FACILITY ID 0046417  
 SCHEDULES  
 COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
EHEALTH DATA	ANNUAL SUBSCRIPTION	\$ 2,700
CLIA Lab Program	Permit	\$ 150
IHCA	DUES	\$ 4,968
ISOS	FEES	\$ 927
CMS	Fee	\$ 532
Effingham County Health Dept	Permit	\$ 200
		<hr/>
		\$ 9,477
AICPA	DUES	\$ 161
Sangamo Club	DUES	\$ 466
MEDPASS	SUBSCRIPTION	\$ 119
MES HPSI	DUES	\$ 144
Am Express	DUES	\$ 34
INHA	DUES	\$ 29
IL CPA	DUES	\$ 115
Wall St Journal	SUBSCRIPTION	\$ 88
		<hr/>
TOTAL		\$ 10,632

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
FACILITY ID 0046417  
SCHEDULES  
COST REPORT PERIOD ENDING 12/31/13

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	\$	192,257
TOTAL FOOD PURCHASES WITHOUT TAX	\$	-
TOTAL SALES TAX	\$	1,904

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
 FACILITY ID 0046417  
 SCHEDULES  
 COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX (C) PROFESSIONAL SERVICES

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
SOURCETECH	IT	1,933
SIKICH	ACCOUNTING	5,850
AM Profit Recovery	Collection Program	425
MARGEL PEDDICORD	ACCOUNTING	520
CTB	CONTRACT ADMIN	694
INOVATIVE LTC SOLUTIONS	ACCOUNTING	7,038
TOTAL		<u>16,460</u>

CTB	Prof Fees	270
STRATTON, GIGANTI	LEGAL	2,993
SANDBERG PHOENIX & VON GONTARD	LEGAL	263
DUANE MORRIS	LEGAL	1,021
SIKICH	ACCOUNTING	431
TALX Corp	Tax Credit	1,344
Kalin Healthcare Solutions	Nursing/MDS Consultant	879
Benefit Planning Consult	401K Third Party Admin	603
IHD Corp	Interviewing/Supervising	335
Dun & Bradstreet	Credit Monitor	1,836
WAGE WORKS	SECTION 125 COMP	53
CT	AGENT	17
TOTAL		<u>26,504</u>

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
 FACILITY ID 0046417  
 SCHEDULES  
 COST REPORT PERIOD ENDING 12/31/13

INSERVICE TRAINING AND EDUCATION

<u>VENDOR</u>	<u>TYPE</u>	<u>AMOUNT</u>
IHCA	EDUCATION	\$ 2,040
ALTHOFF	CPR	\$ 445
MUSIC & MEMORIES	EDUCATION	\$ 600
IDPH	FOOD SERVICE	\$ 80
IDPH	FOOD SERVICE LIC	\$ 35
LAKE LAND COLLEGE	EDUCATION	\$ 1,459
TOTALS		<u>\$ 4,659</u>
MDI Achieve	Seminar	\$112
Illinois Nursing Home Assoc	Seminar	\$22
IHCA	Seminar	\$582
Illinois CFA Foundation	Seminar	\$50
Illinois Nursing Home Admin	Seminar	\$128
		<u>\$5,552</u>

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
FACILITY ID 0046417  
SCHEDULES  
COST REPORT PERIOD ENDING 12/31/13

OTHER ADMIN STAFF TRANSPORTATION

<u>EMPLOYEE</u>	<u>AMOUNT</u>
TRANSPORT VAN FUEL AND REPAIRS	\$ 5,547
LOLOA WHITE - ADMINISTRATOR	\$ 4,987
THERESA SUTTER - BOM	\$ 1,091
Carol Brockett	\$ 186
Jason Bone	\$ 239
Josh Mathis	\$ 1,044
Karen Redcloud	\$ 268
Melissa Kanizer	\$ 179
TOTAL	\$ 13,541

EVERGREEN NURSING AND REHABILITATION CARE CENTER  
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 SCHEDULES  
 COST REPORT PERIOD ENDING 12/31/13

Reclassification Detail

<u>Vendor</u>	<u>Type</u>	<u>GL</u>	<u>Dr</u>	<u>Cr</u>	<u>Line #</u>
IHCA	TRAVEL	18370	2,353.62		24
		18180		2,353.62	23
JOSH MATHIS	TRAVEL	18370	354.66		24
		18180		354.66	23

EVERGREEN NURSING AND REHAB CENTER  
 FACILITY ID 0046417  
 SCHEDULE VII  
 C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES  
 REPORT PERIOD ENDING 12/31/2013

FACILITY ID	0046235 DOCTORS	0046250 DOUGLAS	0035642 TRANSITIONS	0035659 TAMMERLANE	TOTAL
<u>NAME</u>	<u>NURSING AND REHAB</u>	<u>NURSING AND REHAB</u>	<u>NURSING AND REHAB</u>	<u>HEALTHCARE CENTRE</u>	<u>OTHER</u>
ROBERT HEDGES	\$ 51,398	\$ 26,613	\$ 18,678	\$ 41,066	\$ 137,755
WILLIAM IRVINE	\$ 49,298	\$ 25,525	\$ 17,914	\$ 39,387	\$ 132,124
MARTHA IRVINE	\$ 3,841	\$ 1,989	\$ 1,396	\$ 3,069	\$ 10,295
DEREK HEDGES	\$ 24,801	\$ 12,841	\$ 9,012	\$ 19,815	\$ 66,469
	\$ 129,338	\$ 66,968	\$ 47,000	\$ 103,337	\$ 346,643