		FOR BHF USE				

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0046417

Facility Name: EVERGREEN NURSING & REHABILITATION CENTER

Address: 1115 NORTH WENTHE (Number) EFFINGHAM (City) 62401 (Zip Code)

County: EFFINGHAM

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL	
Charitable Corp.		Individual		State	
Trust		Partnership		County	
IRS Exemption Code		Corporation		Other	
		"Sub-S" Corp.			
		Limited Liability Co.	X		
		Trust			
		Other			

In the event there are further questions about this report, please contact:
Name: BILL WEEAKS Telephone Number: (217) 528-2244
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 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) ROBERT HEDGES
	(Title) MEMBER
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	43,920	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	43,920	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,595	506	6,832	8,933	8
9	SNF/PED					9
10	ICF	16,052	6,656	23	22,731	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,647	7,162	6,855	31,664	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.09%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 09/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 6,832

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITAT # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	187,544	6,516	8,707	202,767		202,767		202,767			1
2	Food Purchase		186,373		186,373		186,373	(1,845)	184,528			2
3	Housekeeping	103,328	12,329		115,657		115,657		115,657			3
4	Laundry	52,600	10,503		63,103		63,103		63,103			4
5	Heat and Other Utilities			151,329	151,329		151,329	(8,641)	142,688			5
6	Maintenance	62,481	7,586	29,377	99,444		99,444	13,092	112,536			6
7	Other (specify):* Scavenger			6,637	6,637		6,637		6,637			7
8	**TOTAL General Services**	405,953	223,307	196,050	825,310		825,310	2,606	827,916			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,792,855	122,573	28,392	1,943,820		1,943,820	22,200	1,966,020			10
10a	Therapy	79,145			79,145		79,145		79,145			10a
11	Activities	48,627	1,515	1,771	51,913		51,913		51,913			11
12	Social Services	40,872		1,881	42,753		42,753		42,753			12
13	CNA Training											13
14	Program Transportation			4,218	4,218		4,218		4,218			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,961,499	124,088	45,262	2,130,849		2,130,849	22,200	2,153,049			16
	C. General Administration											
17	Administrative	87,619		457,817	545,436		545,436	(322,885)	222,551			17
18	Directors Fees											18
19	Professional Services			45,968	45,968		45,968	(11,019)	34,949			19
20	Dues, Fees, Subscriptions & Promotions			35,478	35,478		35,478	(17,748)	17,730			20
21	Clerical & General Office Expenses	68,910	16,156	87,623	172,689		172,689	(4,917)	167,772			21
22	Employee Benefits & Payroll Taxes			370,404	370,404		370,404	57,775	428,179			22
23	Inservice Training & Education			6,616	6,616		6,616	838	7,454			23
24	Travel and Seminar							4,533	4,533			24
25	Other Admin. Staff Transportation			17,032	17,032		17,032	(4,676)	12,356			25
26	Insurance-Prop.Liab.Malpractice			66,519	66,519		66,519	3,977	70,496			26
27	Other (specify):*			38,216	38,216		38,216	(38,216)				27
28	**TOTAL General Administration**	156,529	16,156	1,125,673	1,298,358		1,298,358	(332,338)	966,020			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,523,981	363,551	1,366,985	4,254,517		4,254,517	(307,532)	3,946,985			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,873	33,873		33,873	(4,480)	29,393			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,879	63,879		63,879	(34,655)	29,224			32
33	Real Estate Taxes			41,349	41,349		41,349	2,321	43,670			33
34	Rent-Facility & Grounds			568,196	568,196		568,196		568,196			34
35	Rent-Equipment & Vehicles			38,708	38,708		38,708		38,708			35
36	Other (specify):*											36
37	TOTAL Ownership			746,005	746,005		746,005	(36,814)	709,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			847,624	847,624		847,624		847,624			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			340,487	340,487		340,487		340,487			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,188,111	1,188,111		1,188,111		1,188,111			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,523,981	363,551	3,301,101	6,188,633		6,188,633	(344,346)	5,844,287			45

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENT # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	(11,000)	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	(6,429)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,845)	2		13
14	Non-Care Related Interest	(37,726)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,216)	27		24
25	Fund Raising, Advertising and Promotional	(18,815)	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	(83,878)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (197,909)		$	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)	(146,437)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (146,437)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (344,346)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

EVERGREEN NURSING & REHABILITATION CENTER

ID# 0046417

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HEALTHCARE HORIZONS	$ (33,000)	19	1
2	MARKETING SALARY	(37,145)	21	2
3	MARKETING TRAVEL	(4,236)	25	3
4	CHAMBER OF COMMERCE	(440)	25	4
5	PRIOR YR COSTS	(2,894)	19	5
6	NON INCLUDABLE MARKETING	(116)	19	6
7	NON INCLUDABLE LEGAL	(2,986)	19	7
8	NON INCLUDABLE MARKETING	(3,061)	20	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**	(83,878)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,845)	0	0	0	0	0	0	0	0	0	0	(1,845)	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	(11,000)	2,359	0	0	0	0	0	0	0	0	0	(8,641)	5
6	Maintenance	0	13,092	0	0	0	0	0	0	0	0	0	13,092	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,845)	15,451	0	0	0	0	0	0	0	0	0	2,606	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,200	0	0	0	0	0	0	0	0	0	22,200	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	22,200	0	0	0	0	0	0	0	0	0	22,200	16
	C. General Administration													
17	Administrative	0	(322,885)	0	0	0	0	0	0	0	0	0	(322,885)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,996)	27,168	809	0	0	0	0	0	0	0	0	(11,019)	19
20	Fees, Subscriptions & Promotions	(21,876)	4,128	0	0	0	0	0	0	0	0	0	(17,748)	20
21	Clerical & General Office Expenses	(37,145)	31,900	328	0	0	0	0	0	0	0	0	(4,917)	21
22	Employee Benefits & Payroll Taxes	0	57,775	0	0	0	0	0	0	0	0	0	57,775	22
23	Inservice Training & Education	0	838	0	0	0	0	0	0	0	0	0	838	23
24	Travel and Seminar	0	4,533	0	0	0	0	0	0	0	0	0	4,533	24
25	Other Admin. Staff Transportation	(4,676)	0	0	0	0	0	0	0	0	0	0	(4,676)	25
26	Insurance-Prop.Liab.Malpractice	0	3,977	0	0	0	0	0	0	0	0	0	3,977	26
27	Other (specify):*	(38,216)	0	0	0	0	0	0	0	0	0	0	(38,216)	27
28	**TOTAL General Administration**	(140,909)	(192,566)	1,137	0	0	0	0	0	0	0	0	(332,338)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,754)	(154,915)	1,137	0	0	0	0	0	0	0	0	(307,532)	29

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(6,429)	0	1,949	0	0	0	0	0	0	0	0	(4,480)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,726)	0	3,071	0	0	0	0	0	0	0	0	(34,655)	32
33	Real Estate Taxes	0	0	2,321	0	0	0	0	0	0	0	0	2,321	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(44,155)	0	7,341	0	0	0	0	0	0	0	0	(36,814)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(197,909)	(154,915)	8,478	0	0	0	0	0	0	0	0	(344,346)	45

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

	1 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	17	MANAGEMENT FEES	$ 457,817	HI CARE MANAGEMENT		$	$ (457,817)	1
2	V	21	HOME OFFICE EXPENSE	60,000	HI CARE MANAGEMENT			(60,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		13,092	13,092	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		2,359	2,359	4
5	V	10	NURSING		HI CARE MANAGEMENT		22,200	22,200	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		134,932	134,932	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		91,900	91,900	7
8	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		27,168	27,168	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		4,128	4,128	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		838	838	10
11	V	24	TRAVEL		HI CARE MANAGEMENT		4,533	4,533	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		3,977	3,977	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		57,775	57,775	13
14	Total			$ 517,817			$ 362,902	$ * (154,915)	14

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES HOME OFFICE		$ 1,949	$ 1,949	15
16	V	32	INTEREST		H&I PROPERTIES HOME OFFICE		3,071	3,071	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES HOME OFFICE		2,321	2,321	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES HOME OFFICE		809	809	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES HOME OFFICE		328	328	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			$			$ 8,478	$ * 8,478	39

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITA # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	
					Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	$ 54,272	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT			SEE		SALARY	52,055	17-7	2
3	MARTHA IRVINE	BOOKKEEPING				ATTACHED		SALARY	4,055	21-7	3
4	DEREK HEDGES	VP OPERATIONS				SCHEDULE		SALARY	24,550	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 134,932		13

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

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTI # 0046417 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	112,777	5	$ 46,629	$ 39,723	31,664	$ 13,092	1
2	5	UTILITIES	PER RESIDENT DAY	112,777	5	8,403		31,664	2,359	2
3	10	NURSING	PER RESIDENT DAY	112,777	5	79,070	79,070	31,664	22,200	3
4	17	ADMINISTRATION	PER RESIDENT DAY	112,777	5	480,583	480,583	31,664	134,932	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	112,777	5	327,320	265,760	31,664	91,900	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	112,777	5	96,762		31,664	27,168	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	112,777	5	14,702		31,664	4,128	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	112,777	5	2,984		31,664	838	8
9	24	TRAVEL	PER RESIDENT DAY	112,777	5	16,146		31,664	4,533	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	112,777	5	14,166		31,664	3,977	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	112,777	5	205,777		31,664	57,775	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					$ 1,292,542	$ 865,136		$ 362,902	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTI # 0046417 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	444	5	$ 7,213	$	120	$ 1,949	1
2	32	INTEREST	PER LICENSE BED	444	5	11,364		120	3,071	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,587		120	2,321	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	2,993		120	809	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,214		120	328	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					$ 31,371	$		$ 8,478	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITAT # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	US BANK (H&I PROP)		X	MORTGAGE OFFICE		06/29/05	$	$ 59,337	06/29/2017	0.0425	$ 3,071	1
2												2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		425,000	REVOLV	PRIME +	26,153	6
7												7
8												8
9	TOTAL Facility Related						$	$ 484,337			$ 29,224	9
	B. Non-Facility Related*											
10	AVIV		X	WORKING CAPITAL	INTEREST	4/19/2011		305,613	04/30/2013	0.1000	37,726	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 305,613			$ 37,726	14
15	TOTALS (line 9+line14)						$	$ 789,950			$ 66,950	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.)

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2011 report.	$	43,506	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,588	2
3. Under or (over) accrual (line 2 minus line 1).	$	82	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,588	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ____ For ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,670	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2007	31,835	8
2008	40,059	9
2009	41,649	10
2010	43,536	11
2011	43,588	12

ACCRUAL BASED ON PRIOR YR

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN NURSING & REHABILITATION CENTER COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0046417

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-4115

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-11-017-031	NURSING HOME	$ 41,266.64	$ 41,266.64
2.	22-03.0-107-018	HOME OFFICE	$ 5,158.22	$ 1,394.23
3.	22-03.0-107-017	HOME OFFICE	$ 3,428.58	$ 926.72
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,853.44	$ 43,587.59

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	OFFICE BUILDING		2005	$ 15,676	1
2					2
3	TOTALS			$ 15,676	3

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	9
10	WATER HEATER			2005	2,785	101	27.5	101		771	10
11	REPLACE WALKS			2006	11,500	767	15	767		5,272	11
12	WATER HEATERS			2006	5,820	212	27.5	212		1,368	12
13											13
14	REHAB THERAPY WING-SIGN			2008	1,744	116	15	116		523	14
15	REHAB THERAPY WING ARCHITECT FEES			2008	16,693	607	27.5	607		2,858	15
16	REHAB WING RUNNING PHONE & COMPUTER CABLE			2008	2,303	84	27.5	84		395	16
17	REHAB THERAPY VERTICAL BLINDS			2008	3,972	229	5	796	567	3,972	17
18	PATIENT WANDERING SYSTEM			2008	2,852	104	27.5	104		489	18
19											19
20	ROOF			2008	47,900	1,742	27.5	1,742		7,185	20
21	LANDSCAPING AND PATIO			2008	10,740	716	15	716		2,506	21
22	WINDOWS			2010	13,772	501	15	501		1,064	22
23											23
24	GREASE TRAP			2011	3,327	121	27.5	121		232	24
25	WINDOWS			2011	18,908	688	27.5	688		773	25
26											26
27	FLOORING			2012	6,967	243	27.5	243		243	27
28	A/C REPLACEMENT			2012	30,920	1,124	27.5	1,124		1,124	28
29	PARKING LOT EXPANSION			2012	41,573	567	27.5	567		567	29
30	WATER HEATER			2012	3,677	61	27.5	61		61	30
31											31
32											32
33											33
34											34
35	REHAB THERAPY WING PAID BY LANDLORD			2008	320,555						35
36	PATIENT WANDERING SYSTEM PAID BY LANDLORD			2008	4,380						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		$ 649,138	$ 9,932		$ 10,499	$ 567	$ 57,100	70

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION C # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 172,276	$ 8,766	$ 17,228	$ 8,462	10 YRS	$ 64,653	71
72	Current Year Purchases	16,664	16,664	1,666	(14,998)	10 YRS	1,666	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 188,940	$ 25,430	$ 18,894	$ (6,536)		$ 66,319	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	$ 460	$	$ (460)	5	$ 8,000	76
77										77
78										78
79										79
80	TOTALS			$ 8,000	$ 460	$	$ (460)		$ 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)	$ 861,754	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,822	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 29,393	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,429)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 131,419	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTEI # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	09/04/2004	$ 568,196	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 568,196 **			7

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

9. Option to Buy: [ ] YES [X] NO Terms: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 29,202 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENT TRANSPORT	2012 Ford Elkhart	$ #######	$ 9,506	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 9,506	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.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 206,739	$		$ 206,739	1
2	Licensed Speech and Language Development Therapist		hrs			112,212			112,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			341,309			341,309	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				187,364		187,364	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 660,260	$ 187,364		$ 847,624	14

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE] # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 191,177	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 70,000)	1,779,084		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,215		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	178,500		8
9	Other(specify): RE tax escrow	42,505		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,253,481	$	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	267,421		15
16	Equipment, at Historical Cost	182,669		16
17	Accumulated Depreciation (book methods)	(244,127)		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)**	$ 205,963	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,459,444	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 519,386	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	730,613		29
30	Accrued Salaries Payable	117,441		30
31	Accrued Taxes Payable (excluding real estate taxes)	(754)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,505		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,409,191	$	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)**	$ 1,409,191	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,050,253	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,459,444	$	48

*(See instructions.)

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,046,693	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,046,693	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	359,173	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	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Assumption of debt	(305,613)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,560	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)**	$ 1,050,253	24 *

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,539,225	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,539,225	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	171	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	822	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)**	$ 993	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,588	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,588	26
	E. Other Revenue (specify):*****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,547,806	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	825,310	31
32	Health Care	2,130,849	32
33	General Administration	1,298,358	33
	B. Capital Expense		
34	Ownership	746,005	34
	C. Ancillary Expense		
35	Special Cost Centers	847,624	35
36	Provider Participation Fee	340,487	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,188,633	40
41	**Income before Income Taxes (line 30 minus line 40)****	359,173	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 359,173	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,436,457	44
45	Private Pay - Net Inpatient Revenue	1,041,585	45
46	Medicare - Net Inpatient Revenue	3,055,665	46
47	Other-(specify) Insurance	5,518	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,539,225	49

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

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

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

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,848	2,104	$ 62,492	$ 29.70	1
2	Assistant Director of Nursing	1,844	2,064	45,008	21.81	2
3	Registered Nurses	6,324	6,947	154,063	22.18	3
4	Licensed Practical Nurses	24,839	27,680	523,042	18.90	4
5	CNAs & Orderlies	68,856	74,505	730,262	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,813	7,886	79,145	10.04	8
9	Activity Director	1,784	2,088	29,163	13.97	9
10	Activity Assistants	1,742	1,952	19,464	9.97	10
11	Social Service Workers	3,533	3,995	40,872	10.23	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,072	33,853	16.34	13
14	Head Cook	7,178	7,831	76,446	9.76	14
15	Cook Helpers/Assistants	8,395	8,933	77,245	8.65	15
16	Dishwashers					16
17	Maintenance Workers	3,149	3,418	62,481	18.28	17
18	Housekeepers	9,119	10,267	103,328	10.06	18
19	Laundry	5,595	6,197	52,600	8.49	19
20	Administrator	1,992	2,072	87,619	42.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,910	2,121	31,765	14.98	23
24	Clerical	1,743	1,993	37,145	18.64	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	1,651	1,994	24,375	12.22	31
32	Other Health C: MDS,Transport	15,386	16,744	253,613	15.15	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,653	192,863	$ 2,523,981 *	$ 13.09	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	198	$ 8,707	1-3	35
36	Medical Director	MONTHLY	9,000	9-3	36
37	Medical Records Consultant	29	2,089	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,146	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	MONTHLY	858	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,771	11-3	44
45	Social Service Consultant	26	1,772	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	279	$ 27,343		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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION C # 0046417 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LOLA WHITE	ADMINISTRATOR		$ 87,619
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,619

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 457,817
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 457,817

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED		34,949
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 34,949

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,661
Unemployment Compensation Insurance	58,950
FICA Taxes	206,283
Employee Health Insurance	67,750
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT PLAN	12,535
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,179

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 3,980
Advertising: Employee Recruitment		
Health Care Worker Background Check		1,076
(Indicate # of checks performed	60)	
Patient Background Checks	156	2,290
SEE ATTACHED		10,384
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 17,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHED	4,533
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,533

**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
					Amount of Expense Amortized Per Year								
	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													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,751** 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. $ **340,487**
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. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $ **NO**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $

c. What percent of all travel expense relates to transportation of nurses and patients? **5%**

d. Have vehicle usage logs been maintained? **NO**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**

g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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 12/31/12

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 8,151
BEDS	$ 2,751
WOUND CARE VAC	$ 1,165
WASHING MACHINE	$ 5,379
COPIERS	$ 9,444
POSTAGE EQUIPMENT	$ 1,576
PORTABLE UNIT	$ 736
TOTAL RENTALS	$ 29,202

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

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
EHEALTH DATA	ANNUAL SUBSCRIPTION	$ 2,700
GFS	DIETARY SUBSCRIPTION	$ (437)
HI CARE	SUBSCRIPTION	$ 89
IHCA	DUES	$ 6,624
ISOS	FEES	$ 250
PITNEY BOWES	SUBSCRIPTION	$ 64
AICPA	DUES	$ 111
AMEX	FEES	$ 13
IDPL	FEES	$ 70
NOTARY FEE	FEE	$ 1
MEDPASS	SUBSCRIPTION	$ 116
MES HPSI	DUES	$ 281
TROXELL	FEE	$ 14
SECRETARY OF STATE	FEES	$ 488
TOTAL		$ 10,384

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

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	$ 186,373
TOTAL FOOD PURCHASES WITHOUT TA)	$ 184,528
TOTAL SALES TAX	$ 1,845

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

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
SOURCETECH	IT	$ 1,598
KBKB	ACCOUNTING	$ 11,534
BPC	401K ADMIN	$ 593
CCH	TAX	$ 73
EMDEON	IT	$ 232
HORWOOD MARCUS	LEGAL	$ 1,454
ILLINI TECH	IT	$ 865
IVANS	IT	$ 1,075
MARGEL PEDDICORD	ACCOUNTING	$ 104
MDI	IT	$ 10,126
PEHLMAN & DOLD	ACCOUNTING	$ 1,165
STRATTON, GIGANTI	LEGAL	$ 3,308
TALX	TAX	$ 842
CTB	CONTRACT ADMIN	$ 809
INOVATICE LTC SOLUTIONS	ACCOUNTING	$ 1,171
TOTAL		$ 34,949

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

INSERVICE TRAINING AND EDUCATION

VENDOR	TYPE	AMOUNT
MEDPASS	RAI	$ 75
REDILEARNING	MDS	$ 69
IHCA	EDUCATION	$ 3,438
ERNST LAYTON	FIRE SAFETY	$ 130
IHCA	EDUCATION	$ 1,380
IHCA	NURSING	$ 1,250
ALTHOFF	CPR	$ 205
PATHWAY HEALTH	RESTORATIVE	$ 749
ICPAS	CPA	$ 158
TOTALS		$ 7,454

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

SCHEDULE XIX (G) TRAVEL AND SEMINAR

OUT OF STATE TRAVEL	AMOUNT
IN STATE TRAVEL	
CORP DON	$ 3,695
SEMINAR EXPENSE	
IHCA	$ 679
CPA	$ 159
TOTAL	$ 4,533

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

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN FUEL AND REPAIRS	$ 5,136
LOLOA WHITE - ADMINISTRATOR	$ 4,609
THERESA SUTTER - BOM	$ 1,760
NURSING	$ 851
TOTAL	$ 12,356