FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0046417

Facility Name: EVERGREEN NURSING REHAB CTR

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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			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 1/1/2017 to 12/31/2017 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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,176	56	7,401	8,633	8
9	SNF/PED					9
10	ICF	12,123	7,728		19,851	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,299	7,784	7,401	28,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.03%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 7,023

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	210,912	7,564	10,694	229,170		229,170		229,170			1
2	Food Purchase		182,456		182,456		182,456	(1,806)	180,650			2
3	Housekeeping	107,836	14,392		122,228		122,228		122,228			3
4	Laundry	38,637	2,933	113,874	155,444		155,444		155,444			4
5	Heat and Other Utilities			156,072	156,072		156,072	(10,628)	145,444			5
6	Maintenance	66,232	5,145	28,688	100,065	254	100,319	2,475	102,794			6
7	Other (specify):* Scavenger			9,250	9,250		9,250		9,250			7
8	TOTAL General Services	423,617	212,490	318,578	954,685	254	954,939	(9,959)	944,980			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,798,793	110,419	108,013	2,017,225		2,017,225		2,017,225			10
10a	Therapy	38,271			38,271		38,271		38,271			10a
11	Activities	49,447	2,712	1,907	54,066		54,066		54,066			11
12	Social Services	43,605		2,030	45,635		45,635		45,635			12
13	CNA Training											13
14	Program Transportation			1,226	1,226		1,226		1,226			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,930,116	113,131	125,176	2,168,423		2,168,423		2,168,423			16
	C. General Administration											
17	Administrative	132,717		136,500	269,217		269,217	(13,334)	255,883			17
18	Directors Fees											18
19	Professional Services			186,712	186,712		186,712	(33,514)	153,198			19
20	Dues, Fees, Subscriptions & Promotions			48,906	48,906		48,906	(29,742)	19,164			20
21	Clerical & General Office Expenses	89,924	11,823	141,327	243,074		243,074	(157,711)	85,363			21
22	Employee Benefits & Payroll Taxes			336,532	336,532		336,532	39,812	376,344			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,208	2,208	(254)	1,954	(52)	1,902			24
25	Other Admin. Staff Transportation			17,469	17,469		17,469	(7,483)	9,986			25
26	Insurance-Prop.Liab.Malpractice			64,005	64,005		64,005	1,164	65,169			26
27	Other (specify):*			1,472,094	1,472,094		1,472,094	(1,472,094)				27
28	TOTAL General Administration	222,641	11,823	2,405,753	2,640,217	(254)	2,639,963	(1,672,954)	967,009			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,576,374	337,444	2,849,507	5,763,325		5,763,325	(1,682,913)	4,080,412			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 & ID Number EVERGREEN NURSING REHAB CTR #0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			23,717	23,717		23,717	15,211	38,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,963	44,963		44,963	(15,448)	29,515			32
33	Real Estate Taxes			37,137	37,137		37,137	3,576	40,713			33
34	Rent-Facility & Grounds			609,963	609,963		609,963		609,963			34
35	Rent-Equipment & Vehicles			64,020	64,020		64,020		64,020			35
36	Other (specify):*											36
37	**TOTAL Ownership**			779,800	779,800		779,800	3,339	783,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		215,439	892,416	1,107,855		1,107,855		1,107,855			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,968	195,968		195,968		195,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		215,439	1,088,384	1,303,823		1,303,823		1,303,823			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,576,374	552,883	4,717,691	7,846,948		7,846,948	(1,679,574)	6,167,374			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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	(13,312)	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	12,498	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	(1,806)	2		13
14	Non-Care Related Interest	(17,998)	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	(2,013)	19		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35,012)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,470,115)	27		24
25	Fund Raising, Advertising and Promotional	(27,003)	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	(109,227)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,663,988)		$	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)	(15,586)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,586)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,679,574)		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

EVERGREEN NURSING REHAB CTR

ID# 0046417

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (50,618)	21	1
2	Special Events	(1,979)	27	2
3	Other Administrative Salary	(42,809)	17	3
4	Marketing Consulting	(356)	19	4
5	Chamber of Commerce	(785)	20	5
6	Licensure Penalty	(2,200)	20	6
7	Marketing Travel	(9,915)	25	7
8	Chamber of Commerce	(565)	24	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**	(109,227)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,806)	0	0	0	0	0	0	0	0	0	0	(1,806)	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	(13,312)	2,684	0	0	0	0	0	0	0	0	0	(10,628)	5
6	Maintenance	0	2,475	0	0	0	0	0	0	0	0	0	2,475	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,118)	5,159	0	0	0	0	0	0	0	0	0	(9,959)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(42,809)	29,475	0	0	0	0	0	0	0	0	0	(13,334)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37,381)	3,160	707	0	0	0	0	0	0	0	0	(33,514)	19
20	Fees, Subscriptions & Promotions	(29,988)	246	0	0	0	0	0	0	0	0	0	(29,742)	20
21	Clerical & General Office Expenses	(50,618)	(107,700)	607	0	0	0	0	0	0	0	0	(157,711)	21
22	Employee Benefits & Payroll Taxes	0	39,812	0	0	0	0	0	0	0	0	0	39,812	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(565)	513	0	0	0	0	0	0	0	0	0	(52)	24
25	Other Admin. Staff Transportation	(9,915)	2,432	0	0	0	0	0	0	0	0	0	(7,483)	25
26	Insurance-Prop.Liab.Malpractice	0	1,164	0	0	0	0	0	0	0	0	0	1,164	26
27	Other (specify):*	(1,472,094)	0	0	0	0	0	0	0	0	0	0	(1,472,094)	27
28	**TOTAL General Administration**	(1,643,370)	(30,898)	1,314	0	0	0	0	0	0	0	0	(1,672,954)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,658,488)	(25,739)	1,314	0	0	0	0	0	0	0	0	(1,682,913)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	12,498	0	2,713	0	0	0	0	0	0	0	0	15,211	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,998)	0	2,550	0	0	0	0	0	0	0	0	(15,448)	32
33	Real Estate Taxes	0	0	3,576	0	0	0	0	0	0	0	0	3,576	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**	(5,500)	0	8,839	0	0	0	0	0	0	0	0	3,339	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)**	(1,663,988)	(25,739)	10,153	0	0	0	0	0	0	0	0	(1,679,574)	45

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$	HI CARE MANAGEMENT		$	$ (136,500)	1
2	V	21	HOME OFFICE EXPENSE		HI CARE MANAGEMENT			(120,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		2,475	2,475	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		2,684	2,684	4
5	V	10	NURSING		HI CARE MANAGEMENT			0	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		165,975	165,975	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		12,300	12,300	7
8	V	19	PROFESSIONAL SVCS		HI CARE MANAGEMENT		3,160	3,160	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		246	246	9
10	V	24	TRAINING AND EDUCATION		HI CARE MANAGEMENT		513	513	10
11	V	25	TRAVEL		HI CARE MANAGEMENT		2,432	2,432	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,164	1,164	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		39,812	39,812	13
14	Total			$			$ 230,761	$ * (25,739)	14

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

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 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)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES HOME OFFICE		$ 2,713	$ 2,713	15
16	V	32	INTEREST		H&I PROPERTIES HOME OFFICE		2,550	2,550	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES HOME OFFICE		3,576	3,576	17
18	V	21	OFFICE EXPENSE		H&I PROPERTIES HOME OFFICE		607	607	18
19	V	19	PROFESSIONAL SVCS		H&I PROPERTIES HOME OFFICE		707	707	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			$			$ 10,153	$ * 10,153	39

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

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	
	Name	Title	Function	Ownership Interest	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	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00	29,710	16.055	0.40	SALARY	$ 19,921	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	21,380	16.055	0.40	SALARY	14,336	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	8,647	16.055	0.40	SALARY	5,798	17-7	3
4	DEREK HEDGES	COO	OFFICE MGMT	0.00	61,966	16.055	0.40	SALARY	41,550	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 81,605		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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	70,964	3	$ 6,165	$ 1,731	28,484	$ 2,475	1
2	5	UTILITIES	PER RESIDENT DAY	70,964	3	6,687		28,484	2,684	2
3	10	NURSING	PER RESIDENT DAY	70,964	3			28,484	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	70,964	3	413,504	413,504	28,484	165,975	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	70,964	3	30,644		28,484	12,300	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	70,964	3	7,872		28,484	3,160	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	70,964	3	614		28,484	246	7
8	24	TRAINING AND EDUCATION	PER RESIDENT DAY	70,964	3	1,279		28,484	513	8
9	25	TRAVEL	PER RESIDENT DAY	70,964	3	6,059		28,484	2,432	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	70,964	3	2,900		28,484	1,164	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	70,964	3	99,186		28,484	39,812	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					$ 574,910	$ 415,235		$ 230,761	25

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	319	3	$ 7,212	$	120	$ 2,713	1
2	32	INTEREST	PER LICENSE BED	319	3	6,778		120	2,550	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	319	3	9,505		120	3,576	3
4	21	OFFICE EXPENSE	PER LICENSE BED	319	3	1,614		120	607	4
5	19	PROFESSIONAL SVCS	PER LICENSE BED	319	3	1,880		120	707	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					$ 26,989	$		$ 10,153	25

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$	$ 56,085	06/29/2022	0.0425	$ 2,550	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV		325,000	05/31/2018	PRIME +	26,965	6
7												7
8												8
9	TOTAL Facility Related						$	$ 381,085			$ 29,515	9
	B. Non-Facility Related*											
10	OMEGA HEALTHCARE		X	WORKING CAPITAL		05/31/2013	305,613	32,616		0.0800	17,998	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 305,613	$ 32,616			$ 17,998	14
15	TOTALS (line 9+line14)						$ 305,613	$ 413,701			$ 47,513	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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	41,618	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.)	$	40,754	2
3. Under or (over) accrual (line 2 minus line 1).	$	(864)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	41,577	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.	$	40,713	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	44,065	8
	2013	36,331	9
	2014	37,900	10
	2015	39,861	11
	2016	40,754	12

Prior yr plus 2%

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN NURSING REHAB CTR COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0046417

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-0412

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-11-017-031	NURSING HOME	$ 37,178.22	$ 37,178.22
2.	22-03.0-107-018	HOME OFFICE	$ 5,653.08	$ 2,148.00
3.	22-03.0-107-017	HOME OFFICE	$ 3,757.50	$ 1,428.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,588.80	$ 40,754.22

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	OFFICE BUILDING		2005	$ 21,818	1
2					2
3	TOTALS			$ 21,818	3

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	98,895	2,713	39	2,713			8
	Improvement Type**										
9	CARPETING			2004	27,697		5			27,697	9
10	WATER HEATER			2005	2,785	101	27.5	101		1,277	10
11	REPLACE WALKS			2006	11,500	767	15	767		9,106	11
12	WATER HEATERS			2006	5,820	212	27.5	212		2,427	12
13											13
14	REHAB THERAPY WING-SIGN			2008	1,744	116	15	116		1,104	14
15	REHAB THERAPY WING ARCHITECT FEES			2008	16,693	607	27.5	607		5,893	15
16	REHAB WING RUNNING PHONE & COMPUTER CABLE			2008	2,303	84	27.5	84		814	16
17	REHAB THERAPY VERTICAL BLINDS			2008	3,972		5			3,972	17
18	PATIENT WANDERING SYSTEM			2008	2,852	104	27.5	104		1,008	18
19											19
20	ROOF			2008	47,900	1,742	27.5	1,742		15,894	20
21	LANDSCAPING AND PATIO			2008	10,740	716	15	716		6,086	21
22	WINDOWS			2010	13,772	501	15	501		3,568	22
23											23
24	GREASE TRAP			2011	3,327	121	27.5	121		832	24
25	WINDOWS			2011	18,908	688	27.5	688		4,211	25
26											26
27	FLOORING IN LOBBY AND DINING AREA			2012	6,967	253	27.5	253		1,509	27
28	A/C REPLACEMENT			2012	30,920	1,124	27.5	1,124		5,902	28
29	PARKING LOT EXPANSION			2012	41,573	1,512	27.5	1,512		8,125	29
30	WATER HEATER			2012	3,677	134	27.5	134		730	30
31	A/C UNIT			2013	7,730	198	27.5	198		983	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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	AC/MOTOR	2013	$ 5,634	$ 145	27.5	$ 145	$	$ 646	37
38	FLOORING HALLWAY A	2013	1,278	33	27.5	33		146	38
39									39
40	GENERATOR	2014	68,644	1,760	27.5	1,760		6,676	40
41	T8 LIGHTING IN DINING ROOM AND ALL HALLWAYS(A-E	2014	7,198	262	27.5	262		1,014	41
42	RTU AND ECONOMIZER A HALL	2015	5,816	211	27.5	211		537	42
43	WATER LINE REPAIR BETWEEN HALL & KITCHEN	2016	1,815	47	27.5	47		49	43
44									44
45	NEW ROOF EAST WING	2017	11,474	135	27.5	135		135	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)		$ 786,569	$ 14,286		$ 14,286	$	$ 110,341	70

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

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 278,161	$ 12,024	$ 24,522	$ 12,498	5-10YRS	$ 192,416	71
72	Current Year Purchases	2,400	120	120		5-10YRS	120	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 280,561	$ 12,144	$ 24,642	$ 12,498		$ 192,536	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,088,948	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,430	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,928	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,498	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 302,877	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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: EFFINGHAM ASSOCIATES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	09/04/2004	$ 609,963	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 609,963 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 52,681 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	Resident Transport	2013 Ford	$ #######	$ 11,339	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 11,339	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.

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 327,975	$		$ 327,975	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			117,835			117,835	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			446,606			446,606	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				215,439		215,439	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			$		$ 892,416	$ 215,439		$ 1,107,855	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.

STATE OF ILLINOIS

Facility Name & ID Number EVERGREEN NURSING REHAB CTR **#** 0046417 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 114,278	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 111,000)	1,291,133		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,090		6
7	Other Prepaid Expenses	5,365		7
8	Accounts Receivable (owners or related parties)	223,650		8
9	Other(specify): Medicare PIP	31,184		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,680,700	$	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	331,070		15
16	Equipment, at Historical Cost	312,230		16
17	Accumulated Depreciation (book methods)	(355,994)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	37,401		21
22	Other Long-Term Assets (spe Deposits	60,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 384,707	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,065,407	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 897,187	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	325,000		29
30	Accrued Salaries Payable	108,412		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,770		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,189		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Advance Billing	146,694		36
37	RTF	17,360		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,546,612	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,616		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Rent	241,577		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 274,193	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,820,805	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 244,602	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,065,407	$	48

***(See instructions.)**

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,212,739	1
2	Restatements (describe):		2
3			3
4	Corr prior distributions	(1,000)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,211,739	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(956,137)	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	(11,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (967,137)	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)**	$ 244,602	24 *

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

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 6,662,985	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,662,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	227,671	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 227,671	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	135	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 135	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20	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)**	$ 6,890,811	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	954,939	31
32	Health Care	2,168,423	32
33	General Administration	2,639,963	33
	B. Capital Expense		
34	Ownership	779,800	34
	C. Ancillary Expense		
35	Special Cost Centers	1,107,855	35
36	Provider Participation Fee	195,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,846,948	40
41	**Income before Income Taxes (line 30 minus line 40)****	(956,137)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (956,137)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,725,071	44
45	Private Pay - Net Inpatient Revenue	1,172,843	45
46	Medicare - Net Inpatient Revenue	3,601,386	46
47	Other-(specify) INSURANCE	163,685	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,662,985	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 IS 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 REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,044	$ 97,760	$ 47.83	1
2	Assistant Director of Nursing	1,824	2,148	55,882	26.02	2
3	Registered Nurses	6,001	6,507	163,197	25.08	3
4	Licensed Practical Nurses	25,624	27,901	552,099	19.79	4
5	CNAs & Orderlies	67,512	71,043	791,709	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,977	3,452	38,271	11.09	8
9	Activity Director	1,971	2,111	29,341	13.90	9
10	Activity Assistants	1,964	2,080	20,106	9.67	10
11	Social Service Workers	3,198	3,830	43,605	11.39	11
12	Dietician					12
13	Food Service Supervisor	2,216	2,399	49,454	20.61	13
14	Head Cook	6,357	7,183	77,255	10.76	14
15	Cook Helpers/Assistants	8,350	9,122	84,203	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,875	3,150	66,232	21.03	17
18	Housekeepers	9,255	10,289	107,836	10.48	18
19	Laundry	3,687	3,941	38,637	9.80	19
20	Administrator	2,056	2,504	89,908	35.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,985	2,167	39,306	18.14	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					31
32	Other Health Care(specify)					32
33	Other(specify) MDS.Central Supp	6,410	7,632	138,146	18.10	33
34	TOTAL (lines 1 - 33)	156,142	169,503	$ 2,482,947 *	$ 14.65	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	189	$ 10,694	1-3	35
36	Medical Director	36	12,000	9-3	36
37	Medical Records Consultant	24	1,747	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	157	3,956	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant			10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,907	11-3	44
45	Social Service Consultant	28	1,907	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	462	$ 32,211		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	72	$ 4,858	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	2,544	74,048	10-3	52
53	TOTAL (lines 50 - 52)	2,616	$ 78,906		53

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
AUDRA BALDWIN	ADMINISTRATOR	0	16,422
JOSH MATHIS	ADMINISTRATOR	0	73,486
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 89,908

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 136,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 136,500

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		153,198
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 153,198

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,056
Unemployment Compensation Insurance	36,827
FICA Taxes	198,621
Employee Health Insurance	74,644
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	7,337
Post Screening	859
TOTAL (agree to Schedule V, line 22, col.8)	$ 376,344

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	722
Health Care Worker Background Check	784
(Indicate # of checks performed 16)	
Patient Background Checks 130	2,018
SEE ATTACHED SCHEDULE	13,650
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,164

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Seminars	1,902
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,902

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EVERGREEN NURSING REHAB CTR # 0046417 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 $7920**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,365** 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. $ **195,968**
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? **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE OF RENTAL EQUIPMENT

Item	Facility Amount	Allocated Amount	Total Amount
CONCENTRATORS	$ 1,406		$ 1,406
BEDS	$ 11,506		$ 11,506
IV PUMP	$ 425		$ 425
DEFIBRILLATOR	$ 3,100		$ 3,100
WASHING MACHINE	$ 3,822		$ 3,822
COPIERS	$ 9,563		$ 9,563
POSTAGE EQUIPMENT	$ 1,712		$ 1,712
STORAGE UNIT	$ 660		$ 660
WOUND CARE	$ 8,251		$ 8,251
COMPUTERS	$ 12,236		$ 12,236
TOTAL RENTALS	$ 52,681	$ -	$ 52,681

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SALES TAX EXCLUSION

TOTAL FOOD PURCHASES WITH TAX	$	182,456
TOTAL FOOD PURCHASES WITHOUT TAX	$	180,650
TOTAL SALES TAX	$	1,806

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	Facility Amount	Allocated Amount	Total Amount
SIKICH	ACCOUNTING	$ 14,400	$ 3,511	$ 17,911
MATRIX CARE	E-H-R	$ 36,037		$ 36,037
SMARTLINX	IT	$ 9,201		$ 9,201
ESOLUTIONS	IT	$ 719		$ 719
INOVATIVE LTC SOLUTIONS	BILLING	$ 4,528		$ 4,528
TALX Corp	PAYROLL	$ 5,778		$ 5,778
COMPASS CFO SERVICES	ACCOUNTING	$ 74,991		$ 74,991
BPC	401k ADMIN	$ 390	$ 282	$ 672
WAGE WORKS	SECTION 125 COMP		$ 74	$ 74
WILLIAM RADKEY	LEGAL	$ 308		$ 308
MB Financial	Credit Renewal Legal	$ 2,979	$ -	$ 2,979
TOTAL		$ 149,331	$ 3,867	$ 153,198

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	Facility Amount	Allocated Amount	Total Amount
ABILITY	ANNUAL SUBSCRIPTION	$ 4,161		$ 4,161
MES	ANNUAL DUES	$ 46	$ 80	$ 126
IHCA	DUES	$ 7,920		$ 7,920
SECRETARY OF STATE	Fee	$ 527		$ 527
EFFINGHAM COUNTY HEALTH	Permit	$ 200		$ 200
CLIA	Lab Renewal	$ 150		$ 150
Old Republic	RTF Bond	$ 400		$ 400
Med Pass	Subscription	$ -	$ 166	$ 166
		$ -	$ -	$ -
TOTAL		$ 13,404	$ 246	$ 13,650

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULES
COST REPORT PERIOD ENDING 12/31/17

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	Facility Amount	Allocated Amount	Total Amount
TRANSPORT VAN FUEL AND REPAIRS	$ 6,000		$ 6,000
ADMINISTRATOR	$ 1,409		$ 1,409
OTHER STAFF	$ 145		$ 145
CORP STAFF	$ -	$ 2,432	$ 2,432
TOTAL	$ 7,554	$ 2,432	$ 9,986

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 12/31/2017

FACILITY ID	0046235 DOCTORS	0046250 DOUGLAS	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	OTHER
ROBERT HEDGES	$ 19,680	$ 10,030	$ 29,710
WILLIAM IRVINE	$ 14,162	$ 7,218	$ 21,380
MARTHA IRVINE	$ 5,728	$ 2,919	$ 8,647
DEREK HEDGES	$ 41,047	$ 20,919	$ 61,966
	$ 80,617	$ 41,086	$ 121,703

EVERGREEN NURSING AND REHABILITATION CARE CENTER
FACILITY ID 0046417

Schedule of Reclassification

From	To	Amount	Description
Travel and Seminar	Maintenance	$ 254	Reclassify fire system maintenance