

		FOR BHF USE					

LL1

**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)**

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.

<p>I. IDPH License ID Number: <u>0054932</u></p> <p>Facility Name: <u>Evergreen Nursing & Rehab Ctr</u></p> <p>Address: <u>1115 North Wenthe</u> <u>Effingham</u> <u>62401</u> <small>Number City Zip Code</small></p> <p>County: <u>Effingham</u></p> <p>Telephone Number: <u>(217) 347-7121</u> Fax # <u>(217) 342-5525</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>5/7/18</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>05/07/2018</u> to <u>12/31/2018</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Jason Mills</u> (Title) <u>Chief Financial Officer</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u> </td> </tr> </table> <p style="text-align: right;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jason Mills</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Jason Mills</u> (Title) <u>Chief Financial Officer</u>							
Paid Preparer	(Signed) <u>See Accountant's Preparation Report</u> (Print Name and Title) <u>Cindy A. Tefteller Partner</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>							

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing & Rehab Ctr

0054932 Report Period Beginning: 05/07/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	28,680	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	28,680	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,428	4,155	2,868	17,451	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,428	4,155	2,868	17,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.85%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/07/2018

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/07/2018 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 2,762

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Evergreen Nursing & Rehab Ctr # 0054932 Report Period Beginning: 05/07/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,694	4,817	5,426	148,937		148,937		148,937		1
2	Food Purchase		116,092		116,092		116,092	(137)	115,955		2
3	Housekeeping	78,745	10,693	1,038	90,476		90,476		90,476		3
4	Laundry	23,769	68,020	5,293	97,082		97,082		97,082		4
5	Heat and Other Utilities			88,647	88,647		88,647	(12,294)	76,353		5
6	Maintenance	39,169	7,253	18,611	65,033		65,033		65,033		6
7	Other (specify):*										7
8	TOTAL General Services	280,377	206,875	119,015	606,267		606,267	(12,431)	593,836		8
	B. Health Care and Programs										
9	Medical Director			8,000	8,000		8,000		8,000		9
10	Nursing and Medical Records	980,370	65,135	120,858	1,166,363		1,166,363	12,301	1,178,664		10
10a	Therapy										10a
11	Activities	30,835	78	1,056	31,969		31,969		31,969		11
12	Social Services	37,221	1,160	1,236	39,617		39,617		39,617		12
13	CNA Training										13
14	Program Transportation			88	88		88		88		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,048,426	66,373	131,238	1,246,037		1,246,037	12,301	1,258,338		16
	C. General Administration										
17	Administrative	52,434		110,828	163,262		163,262	(97,079)	66,183		17
18	Directors Fees										18
19	Professional Services			8,680	8,680		8,680	10,624	19,304		19
20	Dues, Fees, Subscriptions & Promotions			36,113	36,113		36,113	(18,557)	17,556		20
21	Clerical & General Office Expenses	31,833	12,580	44,135	88,548		88,548	95,369	183,917		21
22	Employee Benefits & Payroll Taxes			202,182	202,182		202,182	11,708	213,890		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,549	2,549		2,549	3,429	5,978		24
25	Other Admin. Staff Transportation			3,100	3,100		3,100	3,973	7,073		25
26	Insurance-Prop.Liab.Malpractice			68,413	68,413		68,413	702	69,115		26
27	Other (specify):*										27
28	TOTAL General Administration	84,267	12,580	476,000	572,847		572,847	10,169	583,016		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,070	285,828	726,253	2,425,151		2,425,151	10,039	2,435,190		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Evergreen Nursing & Rehab Ctr

#0054932

Report Period Beginning:

05/07/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			985	985		985	984	1,969			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,707	23,707		23,707		23,707			32
33	Real Estate Taxes			66,199	66,199		66,199	35	66,234			33
34	Rent-Facility & Grounds			126,874	126,874		126,874	5,049	131,923			34
35	Rent-Equipment & Vehicles			24,820	24,820		24,820	461	25,281			35
36	Other (specify):*											36
37	TOTAL Ownership			242,585	242,585		242,585	6,529	249,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,866	439,414	554,280		554,280		554,280			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,602	130,602		130,602		130,602			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		114,866	570,016	684,882		684,882		684,882			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,070	400,694	1,538,854	3,352,618		3,352,618	16,568	3,369,186			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(12,656)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(137)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(785)	20		17
18	Fines and Penalties				18
19	Entertainment	(753)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,076)	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	(2,510)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,917)		\$	30

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

		1	2	
		Amount	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)	49,485	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 49,485		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 16,568		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' PREPARATION REPORT

Evergreen Nursing & Rehab Ctr

ID# 0054932

Report Period Beginning: 05/07/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	\$ (242)	20	1
2	To Eliminate Lobbying/PAC Dues	(1,052)	20	2
3	To Eliminate Unallowed IDPH Fees	(1,216)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,510)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evergreen Nursing & Rehab Ctr# 0054932

Report Period Beginning:

05/07/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(137)	0	0	0	0	0	0	0	0	0	0	(137)	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	(12,656)	362	0	0	0	0	0	0	0	0	0	(12,294)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,793)	362	0	0	0	0	0	0	0	0	0	(12,431)	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	12,301	0	0	0	0	0	0	0	0	0	12,301	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	12,301	0	0	0	0	0	0	0	0	0	12,301	16
	C. General Administration													
17	Administrative	0	(97,079)	0	0	0	0	0	0	0	0	0	(97,079)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,624	0	0	0	0	0	0	0	0	0	10,624	19
20	Fees, Subscriptions & Promotions	(19,371)	814	0	0	0	0	0	0	0	0	0	(18,557)	20
21	Clerical & General Office Expenses	(753)	96,122	0	0	0	0	0	0	0	0	0	95,369	21
22	Employee Benefits & Payroll Taxes	0	11,708	0	0	0	0	0	0	0	0	0	11,708	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,429	0	0	0	0	0	0	0	0	0	3,429	24
25	Other Admin. Staff Transportation	0	3,973	0	0	0	0	0	0	0	0	0	3,973	25
26	Insurance-Prop.Liab.Malpractice	0	702	0	0	0	0	0	0	0	0	0	702	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,124)	30,293	0	0	0	0	0	0	0	0	0	10,169	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,917)	42,956	0	0	0	0	0	0	0	0	0	10,039	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evergreen Nursing & Rehab Ctr# 0054932

Report Period Beginning:

05/07/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	984	0	0	0	0	0	0	0	0	0	984	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	35	0	0	0	0	0	0	0	0	0	35	33
34	Rent-Facility & Grounds	0	5,049	0	0	0	0	0	0	0	0	0	5,049	34
35	Rent-Equipment & Vehicles	0	0	461	0	0	0	0	0	0	0	0	461	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	6,068	461	0	0	0	0	0	0	0	0	6,529	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)	(32,917)	49,024	461	0	0	0	0	0	0	0	0	16,568	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcar	St. Louis, MO	Management Co
		Helia Healthcare of Champaign	Champaign, IL	Helia Healthcare Servi	Benton, IL	Laundry Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Louis, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	NW Rehab, LLC	St. Louis, MO	Therapy
		Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			
		Helia Southbelt Healthcare	Belleville, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	Bridgemark Healthcare, LLC	100.00%	\$ 362	\$	362	1
2	V	10 Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	12,301		12,301	2
3	V	17 Management Fees	110,828	Bridgemark Healthcare, LLC	100.00%	13,749		(97,079)	3
4	V	19 Professional Fees		Bridgemark Healthcare, LLC	100.00%	10,624		10,624	4
5	V	20 Dues & Subscriptions		Bridgemark Healthcare, LLC	100.00%	814		814	5
6	V	21 Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	96,122		96,122	6
7	V	22 Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	11,708		11,708	7
8	V	24 Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	3,429		3,429	8
9	V	25 Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	3,973		3,973	9
10	V	26 Insurance		Bridgemark Healthcare, LLC	100.00%	702		702	10
11	V	30 Depreciation		Bridgemark Healthcare, LLC	100.00%	984		984	11
12	V	33 Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	35		35	12
13	V	34 Rent		Bridgemark Healthcare, LLC	100.00%	5,049		5,049	13
14	Total		\$ 110,828			\$ 159,852	\$ *	49,024	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Equipment Rental	\$	Bridgemark Healthcare, LLC	100.00%	\$ 461	\$	461	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 461	\$ *	461	39

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

Facility Name & ID Number

Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning:

05/07/2018

Ending:

12/31/2018

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Hillside Rehab & Care Center	Yorkville, IL				1
2			Helia Healthcare of Hillsboro	Hillsboro, IL				2
3			Helia Healthcare of Jerseyville	Jerseyville, IL				3
4			Helia Healthcare of Florissant	Florissant, MO				4
5			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				5
6			Helia Healthcare of Belleville	Belleville, IL				6
7			Helia Healthcare of Salem	Salem, IL				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing & Rehab Ctr # 0054932 Report Period Beginning: 05/07/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	286,251	2.29	4.58	Distribution	\$ 13,749	17, 8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,749		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning:

05/07/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Bridgemark Healthcare LLC
 Street Address 11970 Borman Drive, Suite 100
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 431-0511
 Fax Number (314) 754-9176

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	Utilities	Resident Days	380,780	15	\$ 7,897	\$ 17,451	\$ 362	1	
2	10	Nursing & Med	Resident Days	380,780	15	268,418	268,418	17,451	12,301	2
3	17	Owners Compensation	Resident Days	380,780	15	300,000		17,451	13,749	3
4	19	Professional Services	Resident Days	380,780	15	231,817		17,451	10,624	4
5	20	Dues & Subscriptions	Resident Days	380,780	15	17,755		17,451	814	5
6	21	Salaries - Other	Resident Days	380,780	15	1,800,224	1,800,224	17,451	82,504	6
7	21	Clerical & Office Supplies	Resident Days	380,780	15	297,152		17,451	13,618	7
8	22	Employee Benefits	Resident Days	380,780	15	255,471		17,451	11,708	8
9	24	Travel & Seminar	Resident Days	380,780	15	74,815		17,451	3,429	9
10	25	Other Admin Transp	Resident Days	380,780	15	86,690		17,451	3,973	10
11	26	Insurance	Resident Days	380,780	15	15,316		17,451	702	11
12	30	Depreciation	Resident Days	380,780	15	21,481		17,451	984	12
13	33	Real Estate Taxes	Resident Days	380,780	15	753		17,451	35	13
14	34	Building Rent	Resident Days	380,780	15	102,060		17,451	4,677	14
15	34	Rental - Storage Unit	Resident Days	380,780	15	8,118		17,451	372	15
16	35	Equipment Rental	Resident Days	380,780	15	10,066		17,451	461	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,498,033	\$ 2,068,642	\$ 160,313		25

SEE ACCOUNTANTS' PREPARATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10
			Related**	Related**				Monthly Payment Required	Date of Note				
			YES	NO				Original	Balance				
		A. Directly Facility Related											
		Long-Term											
1								\$	\$			\$	1
2													2
3													3
4													4
5													5
		Working Capital											
6		MidCap Funding I, LLC										23,707	6
7													7
8													8
9		TOTAL Facility Related						\$	\$			\$ 23,707	9
		B. Non-Facility Related*											
10													10
11													11
12													12
13													13
14		TOTAL Non-Facility Related						\$	\$			\$	14
15		TOTALS (line 9+line14)						\$	\$			\$ 23,707	15

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

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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.

1. Real Estate Tax accrual used on 2017 report.		\$		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.)		\$	66,199	2
3. Under or (over) accrual (line 2 minus line 1).		\$	66,199	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$	66,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>36,331</u>	8
	2014	<u>37,900</u>	9
	2015	<u>39,861</u>	10
	2016	<u>40,754</u>	11
	2017	<u>37,977</u>	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

66,199 Line 7, Portion of Lease Payments allocated to Real Estate Taxes

35 Related Party Allocation - Bridgemark

66,234 Total Schedule V, Line 33

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.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Nursing & Rehab Ctr COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0054932

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-017-031</u>	<u>Nursing Home</u>	\$ <u>37,977.04</u>	\$ <u>37,977.04</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>37,977.04</u></u>	\$ <u><u>37,977.04</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,535 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Section N/A, Row 2: (blank), Row 3: TOTALS

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	B Hall Vinyl and Ceiling Lights		2018	20,753	173	10	173		173
10	Sewer Line in Kitchen		2018	13,157		20			
11									
12									
13									
14	Related Party Allocation - Bridgemark								
15	New Office Build Out		2011	6,224		20	330	330	2,457
16	Conference Rm Chair Rail & Paint		2012	70		5			70
17	AC Unit in Server Room		2018	483		20	12	12	12
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		40,687	173		515	342	2,712	

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,456	\$	\$ 557	\$ 557	3-15	\$ 2,330	71
72	Current Year Purchases	8,883	812	897	85	3-15	897	72
73	Fully Depreciated Assets	5,308					5,308	73
74								74
75	TOTALS	\$ 17,647	\$ 812	\$ 1,454	\$ 642		\$ 8,535	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	Related Party Allocation - Bridgemark			\$ 609	\$	\$	\$	4	\$ 609	76
77										77
78										78
79										79
80	TOTALS			\$ 609	\$	\$	\$		\$ 609	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)	\$ 58,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 985	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,969	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 984	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,856	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	Section N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning: 05/07/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: OMG Effingham Property, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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	5/7/18	\$ 126,405			3
4	Additions							4
5	Storage Rental				469			5
6	Related Party Allocation - Bridgemark				5,049			6
7	TOTAL		120		\$ 131,923			7

10. Effective dates of current rental agreement:

Beginning 5/7/18

Ending 4/30/38

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u>/2019</u>	\$ _____
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A

N/A

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 25,281

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	<u>Section N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Helia Healthcare of Effingham
Attachment to Schedule XII B
Equipment Rental
12/31/2018

Description		
16A	Specialty Beds	16,837
16B	Respiratory Equipment	4,015
16C	Copier Lease	3,968
16E	Related Party Allocation - Bridgemark	461
		<u>25,281</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				88,241		88,241	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Wound, Oxy, Enterals</u>	39,2					26,625		26,625	12
13	Other (specify): <u>X-Rays, Labs, Therapy</u>	39,3				439,414			439,414	13
14	TOTAL			\$		\$ 439,414	\$ 114,866		\$ 554,280	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	175		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,100</u>)	1,058,973		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	400		6
7	Other Prepaid Expenses	1,609		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,061,157	\$	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	33,910		15
16	Equipment, at Historical Cost	8,157		16
17	Accumulated Depreciation (book methods)	(985)		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)	\$ 41,082	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,102,239	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 495,222	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	409		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,743		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,514		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	93,917		36
37	<u>Accrued Assessment Tax</u>	11,145		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 702,950	\$	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)	\$ 702,950	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 399,289	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,102,239	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	399,289	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 399,289	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)	\$ 399,289	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning: 05/07/2018

Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,615,134	1
2	Discounts and Allowances for all Levels	(39,375)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,575,759	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	175,035	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 175,035	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	1,113	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,113	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,751,907	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	606,267	31
32	Health Care	1,246,037	32
33	General Administration	572,847	33
B. Capital Expense			
34	Ownership	242,585	34
C. Ancillary Expense			
35	Special Cost Centers	554,280	35
36	Provider Participation Fee	130,602	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,352,618	40
41	Income before Income Taxes (line 30 minus line 40)**	399,289	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 399,289	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,392,455	44
45	Private Pay - Net Inpatient Revenue	715,304	45
46	Medicare - Net Inpatient Revenue	1,410,822	46
47	Other-(specify) <u>Insurance</u>	57,178	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,575,759	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning: 05/07/2018

Ending: 12/31/2018

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	1,443	\$ 71,257	\$ 49.38	1
2	Assistant Director of Nursing	1,390	39,385	27.31	2
3	Registered Nurses	2,084	56,187	26.26	3
4	Licensed Practical Nurses	16,624	364,475	21.10	4
5	CNAs & Orderlies	29,560	388,302	12.82	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	4,246	57,601	13.05	8
9	Activity Director				9
10	Activity Assistants	2,704	30,835	11.37	10
11	Social Service Workers	2,331	37,221	13.36	11
12	Dietician				12
13	Food Service Supervisor	1,828	43,064	23.20	13
14	Head Cook				14
15	Cook Helpers/Assistants	8,320	95,630	11.09	15
16	Dishwashers				16
17	Maintenance Workers	1,478	39,169	25.47	17
18	Housekeepers	6,614	78,745	11.45	18
19	Laundry	2,380	23,769	9.64	19
20	Administrator	1,288	52,434	37.75	20
21	Assistant Administrator				21
22	Other Administrative	254	2,767	9.99	22
23	Office Manager	1,479	29,066	18.96	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	141	3,163	22.43	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	84,164	\$ 1,413,070 *	\$ 16.21	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	\$ 5,426	1,3	35
36	Medical Director	8,000	9,3	36
37	Medical Records Consultant	1,779	10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,486	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	1,056	11,3	44
45	Social Service Consultant	1,236	12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,983		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	3,385	101,498	10,3	52
53	TOTAL (lines 50 - 52)	3,385	\$ 101,498		53

SEE ACCOUNTANTS' PREPARATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Adra Baldwin</u>	<u>Administrator</u>	<u>0</u>	\$ <u>52,434</u>	<u>Workers' Compensation Insurance</u>	\$ <u>51,521</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>26,452</u>	<u>Advertising: Employee Recruitment</u>	<u>2,000</u>	
				<u>FICA Taxes</u>	<u>103,011</u>	<u>Health Care Worker Background Check</u>	<u>3,106</u>	
				<u>Employee Health Insurance</u>	<u>12,805</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>4,620</u>	
				<u>401(k) Match</u>	<u>1,370</u>	<u>Late Fees</u>	<u>4,749</u>	
				<u>Employee Benefits</u>	<u>2,584</u>	<u>Advertising</u>	<u>16,076</u>	
				<u>Other Employee Insurance</u>	<u>4,439</u>	<u>Miscellaneous Licenses & Fees</u>	<u>277</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>52,434</u>			<u>Related Party Allocation</u>	<u>814</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	(_____)	
B. Administrative - Other						<u>Non-allowable advertising</u>	<u>(16,076)</u>	
				<u>Related Party Allocation - Bridgemark</u>	<u>11,708</u>	<u>Yellow page advertising</u>	(_____)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>213,890</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>17,556</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>110,828</u>	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)								
C. Professional Services								
<u>Vendor/Payee</u>	<u>Type</u>		<u>Amount</u>	<u>Description</u>	<u>Line #</u>	<u>Amount</u>	<u>Description</u>	<u>Amount</u>
<u>Stein Law Offices</u>	<u>Legal Fees</u>		\$ <u>242</u>	<u>Section N/A</u>			<u>Out-of-State Travel</u>	\$ _____
<u>Paycom Payroll</u>	<u>Payroll Processing</u>		<u>8,438</u>					
							<u>In-State Travel</u>	<u>738</u>
							<u>Seminar Expense</u>	<u>1,811</u>
							<u>Related Party Allocation - Bridgemark</u>	<u>3,429</u>
							<u>Entertainment Expense</u>	(_____)
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>8,680</u>	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>5,978</u>
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number Evergreen Nursing & Rehab Ctr

0054932

Report Period Beginning: 05/07/2018

Ending: 12/31/2018

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 \$2,248
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-15 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,728 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,602
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ None 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT