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.

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

I. IDPH License ID Number: 0054932

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: 05/07/18

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: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jason Mills
(Title) Chief Financial Officer

Paid Preparer

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 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	12,018	4,916	3,830	20,764	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,018	4,916	3,830	20,764	14

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

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 05/07/2018

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

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,901)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(161)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,402)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,925)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,356)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,896)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(55,948)	Var.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (55,948)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,844)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Evergreen Nursing Rehab Ctr

ID# 0054932

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Eliminate Gifts & Flowers	$ (1,787)	20	1
2	To Eliminate PAC Dues & Lobbying Expense	(2,950)	20	2
3	To Record Full Year IDPH License Fee	1,447	20	3
4	To Eliminate Chamber of Commerce Fees	(66)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,356)		49

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100	Helia Healthcare of Benton	Benton, IL	Bridgemark Healthcar	St. Ann, MO	Management Co
		Hillside Rehab & Care Center	Yorkville, IL	Helia Healthcare Servi	Benton, IL	Laundry Maint.
		Helia Healthcare of Energy	Energy, IL	Bridgemark Employer	St. Ann, MO	Human Resources
		Helia Healthcare of Olney	Olney, IL	Palladian Managemen	O'Fallon, IL	Management Co
		Palladian Senior Care of Poplar Bluff, LLC	Poplar Bluff, MO	Palladian Taylorville A	Taylorville, IL	Assisted Living
		Frankfort Healthcare & Rehab Center	West Frankfort, IL	Palladian Mt. Vernon A	Mt. Vernon, IL	Assisted Living
		Helia Southbelt Healthcare	Belleville, IL			

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	35	Equipment Rental	$	Bridgemark Healthcare, LLC	100.00%	$ 813	$ 813	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 813	$ * 813	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Healthcare of Hillsboro	Hillsboro, IL				1
2			Helia Healthcare of Jerseyville	Jerseyville, IL				2
3			Helia Healthcare of Florissant	Florissant, MO				3
4			Helia Healthcare of Poplar Bluff	Poplar Bluff, MO				4
5			Helia Healthcare of Belleville	Belleville, IL				5
6			Helia Healthcare of Salem	Salem, IL				6
7			Helia Richland Healthcare, LLC	Olney, IL				7
8			Palladian Aviston SNF, LLC	Aviston, IL				8
9			Palladian Mt. Vernon SNF, LLC	Mt. Vernon, IL				9
10			Palladian Taylorville SNF, LLC	Taylorville, IL				10
11			Helia Healthcare of Newton	Newton, IL				11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evergreen Nursing Rehab Ctr # 0054932 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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: Bridgemark Healthcare LLC
Street Address: 500 NW Plaza Dr., Suite 712
City / State / Zip Code: Saint Ann MO, 63074
Phone Number: ((314) 431-0511
Fax Number: ((314) 754-9176

	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	5	Utilities	Resident Days	405,225	17	$ 8,060	$	20,764	$ 413	1
2	10	Nursing & Med	Resident Days	405,225	17	450,909	450,909	20,764	23,105	2
3	17	Owners Compensation	Resident Days	405,225	17	406,428		20,764	20,826	3
4	19	Professional Services	Resident Days	405,225	17	131,963		20,764	6,762	4
5	20	Dues & Subscriptions	Resident Days	405,225	17	21,510		20,764	1,102	5
6	21	Salaries - Other	Resident Days	405,225	17	1,662,655	1,662,655	20,764	85,196	6
7	21	Clerical & Office Supplies	Resident Days	405,225	17	433,562		20,764	22,216	7
8	22	Employee Benefits	Resident Days	405,225	17	235,995		20,764	12,093	8
9	24	Travel & Seminar	Resident Days	405,225	17	35,584		20,764	1,823	9
10	25	Other Admin Transp	Resident Days	405,225	17	50,795		20,764	2,603	10
11	26	Insurance	Resident Days	405,225	17	342,172		20,764	17,533	11
12	30	Depreciation	Resident Days	405,225	17	57,762		20,764	2,960	12
13	33	Real Estate Taxes	Resident Days	405,225	17	629		20,764	32	13
14	34	Building Rent	Resident Days	405,225	17	97,672		20,764	5,005	14
15	34	Rental - Storage Unit	Resident Days	405,225	17	9,163		20,764	470	15
16	35	Equipment Rental	Resident Days	405,225	17	15,876		20,764	813	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,735	$ 2,113,564		$ 202,952	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding IV Trust		X	Line of Credit						Var.	8,123	6
7	Medline		X	Vendor Note						8.0000	615	7
8												8
9	TOTAL Facility Related						$	$			$ 8,738	9
	B. Non-Facility Related*											
10	Interest Income Offset										(151)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (151)	14
15	TOTALS (line 9+line14)						$	$			$ 8,587	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	$	39,600	2
3. Under or (over) accrual (line 2 minus line 1).	$	39,600	3
4. Real Estate Tax accrual used for 2020 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.	$	39,600	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	39,861	8
2016	40,754	9
2017	37,977	10
2018	38,636	11
2019	39,930	12

39,600 Line 7, Portion of Lease Payments Allocated to Real Estate Taxes
32 Related Party Allocation - Bridgemark
39,632 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Nursing Rehab Ctr COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0054932

CONTACT PERSON REGARDING THIS REPORT Jason Mills

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-11-017-031	Nursing Home	$ 39,929.94	$ 39,929.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,929.94	$ 39,929.94

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

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

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? [X] (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).

None

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	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

*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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 118,807	$ 8,963		$ 9,358	$ 395	$ 18,706	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 24,025	$ 2,714	$ 4,937	$ 2,223	3-15 Yrs	$ 10,513	71
72	Current Year Purchases	9,007	590	932	342	3-15 Yrs	932	72
73	Fully Depreciated Assets	2,462					2,462	73
74								74
75	TOTALS	$ 35,494	$ 3,304	$ 5,869	$ 2,565		$ 13,907	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	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)	$ 154,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,267	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,227	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 32,613	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: 01/01/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120		$ 196,301			3
4	Additions							4
5	Storage Rental				840			5
6	Related Party Allocation - Bridgemark				5,475			6
7	TOTAL		120		$ 202,616 **			7

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

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

10. Effective dates of current rental agreement:
Beginning 05/07/18
Ending 04/30/38

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 37,310 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	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				94,137		94,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Oxy, Enterals	39, 2					32,151		32,151	12
13	Other (specify): X-Rays, Labs, Therapy	39, 3				558,505			558,505	13
14	TOTAL			$		$ 558,505	$ 126,288		$ 684,793	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (50,000))	235,469		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,248		7
8	Accounts Receivable (owners or related parties)	2,682,220		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,921,937	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	111,229		15
16	Equipment, at Historical Cost	23,068		16
17	Accumulated Depreciation (book methods)	(21,558)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 112,739	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,034,676	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 472,698	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,498		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Assessment Tax	8,990		36
37	Deferred CARES Funds	696,787		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,305,137	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,305,137	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,729,539	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,034,676	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 984,260	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 984,260	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	745,279	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 745,279	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,729,539	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,947,269	1
2	Discounts and Allowances for all Levels	(187,432)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,759,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,193	6
7	Oxygen	16,135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 238,328	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 151	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	62	28
28a	CARES Funds	128,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 128,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,126,378	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	736,018	31
32	Health Care	1,608,358	32
33	General Administration	883,519	33
	B. Capital Expense		
34	Ownership	294,243	34
	C. Ancillary Expense		
35	Special Cost Centers	684,792	35
36	Provider Participation Fee	174,169	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,381,099	40
41	**Income before Income Taxes (line 30 minus line 40)****	745,279	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 745,279	43

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	2,394	2,394	$ 84,294	$ 35.21	1
2	Assistant Director of Nursing	2,358	2,571	87,417	34.00	2
3	Registered Nurses	1,905	2,148	77,860	36.25	3
4	Licensed Practical Nurses	17,249	18,744	490,452	26.17	4
5	CNAs & Orderlies	32,016	34,230	530,304	15.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,129	3,254	42,413	13.03	10
11	Social Service Workers	2,150	2,305	36,451	15.81	11
12	Dietician					12
13	Food Service Supervisor	2,315	2,315	58,298	25.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,666	9,152	120,017	13.11	15
16	Dishwashers					16
17	Maintenance Workers	1,910	2,100	55,599	26.48	17
18	Housekeepers	6,802	7,307	105,917	14.50	18
19	Laundry	3,239	3,538	40,312	11.39	19
20	Administrator	2,137	2,219	87,870	39.60	20
21	Assistant Administrator					21
22	Other Administrative	1,798	1,990	36,117	18.15	22
23	Office Manager	2,039	2,267	45,223	19.95	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	355	355	8,279	23.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,462	96,889	$ 1,906,823 *	$ 19.68	34

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		$ 7,392	1, 3	35
36	Medical Director		12,000	9, 3	36
37	Medical Records Consultant		3,694	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,285	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,792	11, 3	44
45	Social Service Consultant		2,131	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,294		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	4,518	137,260	10, 3	52
53	TOTAL (lines 50 - 52)	4,518	$ 137,260		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Brishke	Administrator	0	$ 87,870
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,870

B. Administrative - Other

Description	Amount
Bridgemark Healthcare, LLC - Management Fee	$ 258,900
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 258,900

C. Professional Services

Vendor/Payee	Type	Amount
Paycom Payroll	Payroll Processing	$ 15,567
Personnel Planners, Inc.	Unemployment Consulting	2,238
C.J. Schlosser & Company, LLC	Accounting Services	4,000
Hamlin & Burton Liability Managem	Legal Fees	611
Nationwide Trust	401k Admin	978
Pantegra	401k Admin	3,100
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 26,494

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,231
Unemployment Compensation Insurance	10,621
FICA Taxes	144,017
Employee Health Insurance	18,138
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Match	5,113
Employee Benefits	275
Related Party Allocation - Bridgemark	12,093
TOTAL (agree to Schedule V, line 22, col.8)	$ 204,488

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,330
Health Care Worker Background Check	4,133
(Indicate # of checks performed)	
Patient Background Checks	
Advertising	27,925
IHCA Dues	6,266
Dues & Subscriptions	4,718
Miscellaneous Licenses & Fees	2,859
Related Party Allocation - Bridgemark	1,102
Less: Public Relations Expense	( )
Non-allowable advertising	(27,925)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,398

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	94
Seminar Expense	1,250
Related Party Allocation - Bridgemark	1,823
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,167

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA Dues $6,266**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,317** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **174,169**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.