

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: <u>0046417</u></p> <p>Facility Name: <u>EVERGREEN NURSING & REHABILITATION CENTER</u></p> <p>Address: <u>1115 NORTH WENTHE</u> <u>EFFINGHAM</u> <u>62401</u> Number City Zip Code</p> <p>County: <u>EFFINGHAM</u></p> <p>Telephone Number: <u>(217) 528-0044</u> Fax # <u>(217) 528-3412</u></p> <p>HFS ID Number: <u>###</u></p> <p>Date of Initial License for Current Owners: <u>9/1/2003</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u> </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u> </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<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>01/01/2006</u> to <u>12/31/2006</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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> <td></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> <td></td> </tr> </table> <p 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) _____	(Date) _____	(Type or Print Name) <u>ROBERT HEDGES</u>			(Title) <u>MEMBER</u>		Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>		(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	
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Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER

0046417 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,212	529	4,236	6,977	8
9	SNF/PED					9
10	ICF	14,400	8,500		22,900	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,612	9,029	4,236	29,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.21%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/03

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/03 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 4,236

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION** # **0046417** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	158,059	11,639	8,106	177,804		177,804	0	177,804		1
2	Food Purchase		133,519		133,519	0	133,519	0	133,519		2
3	Housekeeping	71,406	9,520	0	80,926		80,926	0	80,926		3
4	Laundry	46,102	9,776	1,862	57,740	0	57,740	0	57,740		4
5	Heat and Other Utilities			114,196	114,196		114,196	1,284	115,480		5
6	Maintenance	42,199	4,507	15,588	62,294	7,435	69,729	6,912	76,641		6
7	Other (specify):*			10,035	10,035		10,035	0	10,035		7
8	TOTAL General Services	317,766	168,961	149,787	636,514	7,435	643,949	8,196	652,145		8
	B. Health Care and Programs										
9	Medical Director	0		6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	1,254,057	83,330	33,138	1,370,525		1,370,525	0	1,370,525		10
10a	Therapy	885		175	1,060		1,060	0	1,060		10a
11	Activities	41,970	1,234	0	43,204		43,204	0	43,204		11
12	Social Services	38,266		3,279	41,545		41,545	0	41,545		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			6,276	6,276		6,276	0	6,276		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,335,178	84,564	48,868	1,468,610	0	1,468,610	0	1,468,610		16
	C. General Administration										
17	Administrative	62,288		245,310	307,598		307,598	(162,497)	145,101		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			125,851	125,851		125,851	(30,633)	95,218		19
20	Dues, Fees, Subscriptions & Promotions			27,268	27,268		27,268	(7,898)	19,370		20
21	Clerical & General Office Expenses	105,452	12,913	84,263	202,628		202,628	(69,580)	133,048		21
22	Employee Benefits & Payroll Taxes			259,959	259,959	0	259,959	0	259,959		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			1,428	1,428		1,428	669	2,097		24
25	Other Admin. Staff Transportation			15,519	15,519	(7,435)	8,084	(853)	7,231		25
26	Insurance-Prop.Liab.Malpractice			69,656	69,656		69,656	2,459	72,115		26
27	Other (specify):*			40,293	40,293		40,293	(20,258)	20,035		27
28	TOTAL General Administration	167,740	12,913	869,547	1,050,200	(7,435)	1,042,765	(288,591)	754,174		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,820,684	266,438	1,068,202	3,155,324	0	3,155,324	(280,395)	2,874,929		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,106
	REPAIRS & MAINTENANCE	0
		0
		8,106
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,862
		0
		1,862
5	HEAT & OTHER UTILITIES	
	GAS HEAT	949
	ELECTRICITY	67,739
	WATER	38,602
	CABLE TV - LOBBY	6,906
		0
		114,196
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,403
	PAINTING & DECORATING	699
	BUILDING REPAIRS	3,404
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,976
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,567
	FIRE SERVICE	1,539
		0
		0
		0
		0
		15,588
7	OTHER	
	SCAVENGER	10,035
	SECURITY SERVICE	0
		0
		0
		10,035
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	23,481
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,669
	PHARMACY CONSULTANT XVIII B 39-2	7,200
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	788
		0
		0
		33,138
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	175
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		175
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,279
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,279
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	6,276
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	245,310
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	8,446
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	117,405
		0
		125,851
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	8,170
	EMPLOYEE WANT ADS XIX F	1,040
	CONTRIBUTIONS VI 20 XIX F	60
	DUES & SUBSCRIPTIONS XIX F	11,496
	LICENSES & PERMITS XIX F	2,517
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,545
	PATIENT BACKGROUND CHECKS XIX F	1,440
		27,268
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,432
	EQUIPMENT REPAIR & MAINTENANCE	298
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	828
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	14,705
	MESSENGER SERVICE	0
	ADMINISTRATIVE & MEETING FEES	60,000
		84,263

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	138,189
	UNEMPLOYMENT COMPENSATION XIX D	38,988
	WORKERS COMPENSATION INSURANC XIX D	56,388
	HOSPITALIZATION INSURANCE XIX D	15,918
	EMPLOYEE BENEFITS - OTHER XIX D	4,754
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,722
	CHICAGO HEAD TAX XIX D	0
		0
		259,959
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,428
	TRAVEL XIX G	0
		1,428
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	15,519
		15,519
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	69,656
		69,656
27	OTHER	
	BAD DEBTS VI 24	40,293
		40,293

GRAND TOTAL COLUMN 3 OTHER 1,068,202

EVERGREEN NURSING & REHABILITATION CENTER
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	133,519	PATIENT MEALS	89631
LESS SALES TAX	0	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	133,519	TOTAL MEALS/YEAR	89631
TOTAL PATIENT CENSUS	29,877	NET FOOD	133519
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	89631

TOTAL PATIENT MEALS	89631	COST PER MEAL	1.49
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,365	14,365		14,365	(421)	13,944			30
31	Amortization of Pre-Op. & Org.			452	452		452	0	452			31
32	Interest			18,477	18,477		18,477	20	18,497			32
33	Real Estate Taxes			28,690	28,690		28,690	811	29,501			33
34	Rent-Facility & Grounds			374,508	374,508		374,508	0	374,508			34
35	Rent-Equipment & Vehicles			32,621	32,621		32,621	0	32,621			35
36	Other (specify):* amort software			1,374	1,374		1,374	0	1,374			36
37	TOTAL Ownership			470,487	470,487	0	470,487	410	470,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		215,704	364,369	580,073		580,073	0	580,073			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	215,704	430,069	645,773	0	645,773	0	645,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,820,684	482,142	1,968,758	4,271,584	0	4,271,584	(279,985)	3,991,599			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,687)	30		9
10	Interest and Other Investment Income	(3,319)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(828)	21		18
19	Entertainment	0	20		19
20	Contributions	(60)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,293)	27		24
25	Fund Raising, Advertising and Promotional	(8,170)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	(69,451)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (123,808)		\$ 0	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	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)	(156,177)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (156,177)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (279,985)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 EVERGREEN NURSING & REHABILITATION CENTER

ID# 0046417

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3	MARKETING SALARIES	(24,565)	21	3
4	BANK CHARGES	(8,432)	21	4
5	NONALLOWABLE TRAVEL	(2,510)	25	5
6	HEALTHCARE HORIZONS	(33,000)	19	6
7	THE COMPUTER SHOP	(944)	19	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	(69,451)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER# 0046417

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	1,284	0	0	0	0	0	0	0	0	0	1,284	5
6	Maintenance	0	6,912	0	0	0	0	0	0	0	0	0	6,912	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	8,196	0	0	0	0	0	0	0	0	0	8,196	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(162,497)	0	0	0	0	0	0	0	0	0	(162,497)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,944)	3,311	0	0	0	0	0	0	0	0	0	(30,633)	19
20	Fees, Subscriptions & Promotions	(8,230)	332	0	0	0	0	0	0	0	0	0	(7,898)	20
21	Clerical & General Office Expenses	(33,825)	(35,755)	0	0	0	0	0	0	0	0	0	(69,580)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	669	0	0	0	0	0	0	0	0	0	669	24
25	Other Admin. Staff Transportation	(2,510)	1,657	0	0	0	0	0	0	0	0	0	(853)	25
26	Insurance-Prop.Liab.Malpractice	0	2,459	0	0	0	0	0	0	0	0	0	2,459	26
27	Other (specify):*	(40,293)	20,035	0	0	0	0	0	0	0	0	0	(20,258)	27
28	TOTAL General Administration	(118,802)	(169,789)	0	0	0	0	0	0	0	0	0	(288,591)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,802)	(161,593)	0	0	0	0	0	0	0	0	0	(280,395)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,687)	0	1,266	0	0	0	0	0	0	0	0	(421)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,319)	0	3,339	0	0	0	0	0	0	0	0	20	32
33	Real Estate Taxes	0	0	811	0	0	0	0	0	0	0	0	811	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,006)	0	5,416	0	410	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)	(123,808)	(161,593)	5,416	0	(279,985)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				HI CARE MANAGEMENT	SPRINGFIELD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				
				H-I PROPERTIES	SPRINGFIELD	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 MANAGEMENT FEES	\$ 245,310	HI CARE MANAGEMENT		\$	\$ (245,310)	1
2	V	21 HOME OFFICE EXPENSE	60,000				(60,000)	2
3	V	5 UTILITIES				1,284	1,284	3
4	V	6 MAINTENANCE				6,912	6,912	4
5	V	17 ADMINISTRATIVE				82,813	82,813	5
6	V	19 PROFESSIONAL FEES				3,311	3,311	6
7	V	20 DUES & SUBSCRIPTION				332	332	7
8	V	21 OFFICE EXPENSE				24,245	24,245	8
9	V	24 TRAVEL & SEMINARS				669	669	9
10	V	25 TRANSPORTATION				1,657	1,657	10
11	V	26 INSURANCE				2,459	2,459	11
12	V	27 PAYROLL TAXES & GRP INS				20,035	20,035	12
13	V							13
14	Total		\$ 305,310			\$ 143,717	\$ * (161,593)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 1,266	\$ 1,266	15
16	V	32 INTEREST				3,339	3,339	16
17	V	33 REAL ESTATE				811	811	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		\$			\$ 5,416	\$ * 5,416	39

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITA' # 0046417 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT					SALARY	\$ 27,469	17-7	1
2	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT					SALARY	27,469	17-7	4
5	TOTAL ALLOWABLE SALARY RECEIVED FROM HI CARE \$170,000										5
6											6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,392	21-7	7
8	TOTAL SALARY RECEIVED FROM HI CARE \$8,615										8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	4,363	17-7	10
11	TOAL SALARY RECEIVED FROM HI CARE \$27,000										11
12											12
13								TOTAL	\$ 60,693		13

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

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 HI CARE MANAGEMENT
 Street Address 827 S FIFTH STREET
 City / State / Zip Code SPRINGFIELD,IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0044

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	PER RESIDENT DAYS	184,904	7	\$ 7,946	29,877	\$ 1,284	1
2	6	MAINTENANCE	PER RESIDENT DAYS	184,904	7	42,775	36,113	29,877	6,912
3	17	OFFICER SALARY	PER RESIDENT DAYS	184,904	7	340,000	340,000	29,877	54,938
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAYS	184,904	7	68,050	68,050	29,877	10,996
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAYS	184,904	7	77,460	77,460	29,877	12,516
6	17	SPECIAL PROJECTS MNGR	PER RESIDENT DAYS	184,904	7	27,000	27,000	29,877	4,363
7	19	PROFESSIONAL FEES	PER RESIDENT DAYS	184,904	7	20,492	29,877	29,877	3,311
8	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAYS	184,904	7	2,057	29,877	29,877	332
9	21	OFFICE EXPENSE	PER RESIDENT DAYS	184,904	7	150,049	112,536	29,877	24,245
10	24	TRAVEL & SEMINARS	PER RESIDENT DAYS	184,904	7	4,140	29,877	29,877	669
11	25	TRANSPORTATION	PER RESIDENT DAYS	184,904	7	10,252	29,877	29,877	1,657
12	26	INSURANCE	PER RESIDENT DAYS	184,904	7	15,218	29,877	29,877	2,459
13	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAYS	184,904	7	123,996	29,877	29,877	20,035
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 889,435	\$ 661,159	\$ 143,717	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 H & I PROPERTIES-OFFICE BUILDING
 Street Address 1625 S SIXTH STREET
 City / State / Zip Code SPRINGFIELD IL 62703
 Phone Number (217)528-0044
 Fax Number (217)528-0412

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	639	7	\$ 6,741	\$ 0	120	\$ 1,266	1
2	32	INTEREST	639	7	17,780	0	120	3,339	2
3	33	REAL ESTATE	639	7	4,317	0	120	811	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	TOTALS				\$ 28,838	\$		\$ 5,416	25

Facility Name & ID Number

EVERGREEN NURSING & REHABILITA1

0046417

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3	US BANK (HI PROP)	X	MORTGAGE (OFFICE)		6/29/05		6/29/12	0.0635	3,339											
4																				
5																				
Working Capital																				
6	MARINE BANK	X	LINE OF CREDIT	INTEREST	009/17/03	50,000	322,384	REVOLV	0.0650	18,082										
7	MARINE BANK	X	BUS LOAN	\$593.23	05/19/04	19,500	2,914	06/19/07	0.0600	395										
8																				
9	TOTAL Facility Related			\$593.23		\$ 69,500	\$ 325,298			\$ 21,816										
B. Non-Facility Related*																				
10	IRS, IDR, ETC	X	LATE FEES																	
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0										
15	TOTALS (line 9+line14)					\$ 69,500	\$ 325,298			\$ 21,816										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

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

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

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

B. Real Estate Taxes

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 2005 report.	\$	30,378	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.)	\$	29,534	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(844)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	29,534	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.	\$	28,690	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001		8
	2002		9
	2003	28,605	10
	2004	30,378	11
	2005	29,534	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN NURSING & REHABILITATION CENTER COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0046417

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-11-017-031</u>	<u>NURSING HOME</u>	\$ <u>29,534.12</u>	\$ <u>29,534.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>29,534.12</u>	\$ <u>29,534.12</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 & REHABILITATION CENTER

0046417

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,754 B. General Construction Type: Exterior BRICK Frame _____ 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).

N/A

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

1. Total Amount Incurred: 2,258 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 452 4. Dates Incurred: 09/01/03

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	<u>HOME OFFICE</u>		<u>2005</u>	<u>\$ 10,904</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 10,904	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	CARPETING		2004	27,697	2,659	5	5,539	2,880	16,617
10	WATER HEATER		2005	2,785	101	27.5	101		164
11	REPLACE WALKS		2006	11,500	671	15	383	(288)	383
12	WATER HEATERS		2006	5,820	97	27.5	97		97
13									
14									
15									
16									
17	H & I OFFICE BUILDING		2005	49,376	1,266	39	1,266		2,247
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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
			97,178		4,794		7,386	2,592	19,508

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 9,694	\$ 2,469	\$ 970	\$ (1,499)	10 YRS	\$ 1,897	71
72	Current Year Purchases	19,758	3,952	988	(2,964)	10 YRS	988	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$ 29,452	\$ 6,421	\$ 1,958	\$ (4,463)		\$ 2,885	75

D. Vehicle Depreciation (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	FACILITY	USED BUS	2004	\$ 23,000	\$ 4,416	\$ 4,600	\$ 184	5 YRS	\$ 13,800	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 23,000	\$ 4,416	\$ 4,600	\$ 184		\$ 13,800	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)	\$ 160,534	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,944	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,687)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 36,193	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: EFFINGHAM ASSOCIATES 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	09/01/04	\$ 374,508	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 374,508			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 32,621 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 09/01/03

Ending 08/31/13

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

Fiscal Year Ending Annual Rent

12. /2007 \$ 385,743

13. /2008 \$ 397,315

14. /2009 \$ _____

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

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

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

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

<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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 116,070	\$		\$ 116,070	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			58,076			58,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			190,223			190,223	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				215,704		215,704	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 364,369	\$ 215,704		\$ 580,073	14

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

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION CENTER** # **0046417** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2006** (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	\$ 78,037	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (60,000))	690,896		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,069		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,001		8
9	Other(specify): <u>R.E. ESCROW DEPOSIT</u>	35,905		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 872,908	\$ 0	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	20,105		15
16	Equipment, at Historical Cost	107,976		16
17	Accumulated Depreciation (book methods)	(78,785)		17
18	Deferred Charges	14,698		18
19	Organization & Pre-Operating Costs	2,258		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,507)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>security deposit</u>	56,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 121,412	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 994,320	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 534,629	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	325,298		29
30	Accrued Salaries Payable	63,235		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,388		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,534		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 983,084	\$ 0	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)	\$ 0	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 983,084	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,236	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 994,320	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 178,891	1
2	Restatements (describe):		2
3			3
4	POSTCLOSING ENTRIES	(306)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 178,585	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(167,349)	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)	\$ (167,349)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,236	24 *

* This must agree with page 17, line 47.

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

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,101,228	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,101,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,119	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,104,347	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	636,514	31
32	Health Care	1,468,610	32
33	General Administration	1,050,200	33
	B. Capital Expense		
34	Ownership	470,487	34
	C. Ancillary Expense		
35	Special Cost Centers	580,073	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,271,584	40
41	Income before Income Taxes (line 30 minus line 40)**	(167,237)	41
42	Income Taxes	(112)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (167,349)	43

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

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

TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION CENTER**

0046417

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

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	1,961	2,089	\$ 55,514	\$ 26.57	1
2	Assistant Director of Nursing	1,062	1,225	27,938	22.81	2
3	Registered Nurses	3,430	3,698	72,238	19.53	3
4	Licensed Practical Nurses	20,768	22,680	393,268	17.34	4
5	CNAs & Orderlies	59,176	63,719	608,895	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	80	88	885	10.06	8
9	Activity Director	1,851	2,088	25,752	12.33	9
10	Activity Assistants	1,584	1,739	16,218	9.33	10
11	Social Service Workers	3,468	3,859	38,266	9.92	11
12	Dietician					12
13	Food Service Supervisor	1,459	1,633	26,102	15.98	13
14	Head Cook	7,829	8,534	75,508	8.85	14
15	Cook Helpers/Assistants	6,849	7,544	56,449	7.48	15
16	Dishwashers					16
17	Maintenance Workers	1,797	2,065	42,199	20.44	17
18	Housekeepers	8,552	9,351	71,406	7.64	18
19	Laundry	5,935	6,412	46,102	7.19	19
20	Administrator	1,904	2,080	62,288	29.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,864	2,147	29,683	13.83	23
24	Clerical	3,833	4,194	75,769	18.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,833	2,084	23,056	11.06	31
32	Other Health C: MDS	2,038	2,320	51,342	22.13	32
33	Other(specify) <u>central supply</u>	1,833	2,087	21,806	10.45	33
34	TOTAL (lines 1 - 33)	139,106	151,636	\$ 1,820,684 *	\$ 12.01	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	M	\$ 8,106	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,669	10-3	37
38	Nurse Consultant	T	788	10-3	38
39	Pharmacist Consultant	H	7,200	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		175	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,279	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,217		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount	
SHIRLEY DUNN	ADMINISTRATOR	0.00%	\$ 62,288	Workers' Compensation Insurance		\$ 56,388		IDPH License Fee		\$ 1,990	
			0	Unemployment Compensation Insurance		38,988		Advertising: Employee Recruitment		1,040	
				FICA Taxes		138,189		Health Care Worker Background Check		2,545	
				Employee Health Insurance		15,918		(Indicate # of checks performed <u>159</u>)			
				Employee Meals		0		Patient Background Checks	<u>90</u>	1,440	
				Illinois Municipal Retirement Fund (IMRF)*				TRUST/FRANCHISE/CONTRIB/ETC		60	
				EMPLOYEE BENEFITS - OTHER		4,754		MARKETING/ADV/PROMO		8,170	
				EMPLOYEE PHYSICAL EXAMS		0		LICENSES/DUES/SUBSCRIPTIONS		12,023	
				PENSION/PROFIT SHARING PLANS		5,722		MGMT CO ALLOC		332	
				CHICAGO HEAD TAX		0		TRUST/FRANCHISE/CONTRIB/ETC		(60)	
				INSURANCE - EXECUTIVE LIFE		0		Less: Public Relations Expense	(0)
				INSURANCE - EXECUTIVE LIFE VI 21		0		Non-allowable advertising		(8,170)	
								Yellow page advertising	(0)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,288	TOTAL (agree to Schedule V, line 22, col.8)		\$ 259,959		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,370	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount		Description		Amount	
HI-CARE MANAGEMENT			\$ 245,310			\$		Out-of-State Travel		\$	
								In-State Travel		0	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 245,310					Seminar Expense		1,428	
C. Professional Services								MGMT ALLOC		669	
Vendor/Payee	Type		Amount								
ACHIEVE HEALTHCARE	DATA PROCESSING		\$ 7,353					Entertainment Expense	()
IVANS	DATA PROCESSING		1,093					(agree to Sch. V, line 24, col. 8)			
KBKB	ACCOUNTING		21,550					TOTAL		\$ 2,097	
STRATTON GIGANTI	LEGAL FEES		121								
DUANE MORRIS	LEGAL FEES		43,604								
HEALTHCARE HORIZONS	MEDICAID / MEDICARE		33,000								
SYSTEMATIC MANGEMENT	MED B BILLING		14,711								
IL DEPT OF HEALTH	REVIEW FEE REHAB EXPN		2,976								
ACCENT HEALTHCARE	IN SERVICE		400								
BRENDA MATHENY	MDS WORK		99								
THE COMPUTER SHOP	WEB DESIGN		944								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 125,851	TOTAL		\$					

* Attach copy of IMRF notifications

**See instructions.

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. IL HEALTHCARE ASSOC. \$6,624
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ 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. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees