

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CTR

0046417 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 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	699	518	5,348	6,565	8
9	SNF/PED					9
10	ICF	16,437	7,343		23,780	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,136	7,861	5,348	30,345	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.09%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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 5,348

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **EVERGREEN NURSING & REHABILITATION** # **0046417** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	169,735	16,198	8,374	194,307		194,307		194,307		1
2	Food Purchase		151,449		151,449		151,449		151,449		2
3	Housekeeping	84,015	15,465		99,480		99,480		99,480		3
4	Laundry	46,309	10,122	4,196	60,627		60,627		60,627		4
5	Heat and Other Utilities			157,352	157,352		157,352	1,543	158,895		5
6	Maintenance	45,137	7,704	20,117	72,958		72,958	7,688	80,646		6
7	Other (specify):*			12,830	12,830		12,830	265	13,095		7
8	TOTAL General Services	345,196	200,938	202,869	749,003		749,003	9,496	758,499		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,236,474	105,243	32,879	1,374,596		1,374,596		1,374,596		10
10a	Therapy	46,973		375	47,348		47,348		47,348		10a
11	Activities	41,902	1,660		43,562		43,562		43,562		11
12	Social Services	30,039		3,554	33,593		33,593		33,593		12
13	CNA Training										13
14	Program Transportation			4,850	4,850		4,850		4,850		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,355,388	106,903	47,658	1,509,949		1,509,949		1,509,949		16
	C. General Administration										
17	Administrative	81,608		193,298	274,906		274,906	(89,855)	185,051		17
18	Directors Fees										18
19	Professional Services			81,373	81,373		81,373	(29,894)	51,479		19
20	Dues, Fees, Subscriptions & Promotions			44,088	44,088		44,088	(27,272)	16,816		20
21	Clerical & General Office Expenses	88,584	13,513	77,311	179,408		179,408	(43,028)	136,380		21
22	Employee Benefits & Payroll Taxes			266,358	266,358		266,358		266,358		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,804	3,804		3,804	980	4,784		24
25	Other Admin. Staff Transportation			10,710	10,710		10,710	(331)	10,379		25
26	Insurance-Prop.Liab.Malpractice			70,648	70,648		70,648	2,417	73,065		26
27	Other (specify):*			24,606	24,606		24,606	(30)	24,576		27
28	TOTAL General Administration	170,192	13,513	772,196	955,901		955,901	(187,013)	768,888		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,870,776	321,354	1,022,723	3,214,853		3,214,853	(177,517)	3,037,336		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	8,374
	REPAIRS & MAINTENANCE	0
		0
		8,374
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,196
		0
		4,196
5	HEAT & OTHER UTILITIES	
	GAS HEAT	1,450
	ELECTRICITY	106,662
	WATER	40,539
	CABLE TV - LOBBY	8,701
		0
		157,352
6	MAINTENANCE	
	GROUNDS MAINTENANCE	3,360
	PAINTING & DECORATING	1,190
	BUILDING REPAIRS	2,793
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,368
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,664
	FIRE SERVICE	1,742
		0
		0
		0
		0
		20,117
7	OTHER	
	SCAVENGER	12,830
	SECURITY SERVICE	0
		0
		0
		12,830
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	17,721
	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	2,234
	PHARMACY CONSULTANT XVIII B 39-2	5,664
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	7,260
		0
		0
		32,879
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	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	375
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		375
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
		0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,554
		0
		3,554
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	4,850
		4,850
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	193,298
		193,298
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,894
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	73,479
		0
		81,373
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	23,461
	EMPLOYEE WANT ADS XIX F	2,753
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	8,383
	LICENSES & PERMITS XIX F	1,569
	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	4,318
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,272
	PATIENT BACKGROUND CHECKS XIX F	1,332
		44,088
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,307
	EQUIPMENT REPAIR & MAINTENANCE	1,062
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	500
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,442
	MESSENGER SERVICE	0
		0
		77,311

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	141,937
	UNEMPLOYMENT COMPENSATION XIX D	33,758
	WORKERS COMPENSATION INSURANC XIX D	67,768
	HOSPITALIZATION INSURANCE XIX D	9,689
	EMPLOYEE BENEFITS - OTHER XIX D	7,383
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,823
	CHICAGO HEAD TAX XIX D	0
		0
		266,358
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,804
	TRAVEL XIX G	
		3,804
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,710
		10,710
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	70,648
		70,648
27	OTHER	
	BAD DEBTS VI 24	24,606
		24,606

GRAND TOTAL COLUMN 3 OTHER

1,022,723

EVERGREEN NURSING & REHABILITATION CTR
SCHEDULES
12/31/2008

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	151,449
LESS SALES TAX	<u>0</u>
NET FOOD	151,449

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

TOTAL PATIENT CENSUS	30,345
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	91,035

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	91,035
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	91,035

NET FOOD	151,449
DIVIDE TOTAL MEALS/YEAR	<u>91,035</u>

COST PER MEAL	1.66
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			34,662	34,662		34,662	(13,380)	21,282			30
31	Amortization of Pre-Op. & Org.			299	299		299		299			31
32	Interest			32,350	32,350		32,350	1,371	33,721			32
33	Real Estate Taxes			33,626	33,626		33,626	1,439	35,065			33
34	Rent-Facility & Grounds			388,692	388,692		388,692		388,692			34
35	Rent-Equipment & Vehicles			29,380	29,380		29,380		29,380			35
36	Other (specify):*											36
37	TOTAL Ownership			519,009	519,009		519,009	(10,570)	508,439			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,288	481,249	654,537		654,537		654,537			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		173,288	547,129	720,417		720,417		720,417			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,870,776	494,642	2,088,861	4,454,279		4,454,279	(188,087)	4,266,192			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	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,646)	30		9
10	Interest and Other Investment Income	(1,797)	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		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(500)	21		18
19	Entertainment		20		19
20	Contributions	(4,318)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,606)	27		24
25	Fund Raising, Advertising and Promotional	(23,461)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(52,395)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,723)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(66,364)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (66,364)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (188,087)		37

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

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

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

STATE OF ILLINOIS
 EVERGREEN NURSING & REHABILITATION CTR

ID# 0046417

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2			21	2
3	MARKETING SALARY	(16,447)	21	3
4	MARKETING TRAVEL	(2,948)	25	4
5	PROF FEES. - HEALTHCARE HORIZONS	(33,000)	19	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	(52,395)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	1,543	0	0	0	0	0	0	0	0	0	1,543	5
6	Maintenance	0	7,688	0	0	0	0	0	0	0	0	0	7,688	6
7	Other (specify):*	0	265	0	0	0	0	0	0	0	0	0	265	7
8	TOTAL General Services	0	9,496	0	9,496	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	(89,855)	0	0	0	0	0	0	0	0	0	(89,855)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,000)	3,106	0	0	0	0	0	0	0	0	0	(29,894)	19
20	Fees, Subscriptions & Promotions	(27,779)	507	0	0	0	0	0	0	0	0	0	(27,272)	20
21	Clerical & General Office Expenses	(16,947)	(26,081)	0	0	0	0	0	0	0	0	0	(43,028)	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	980	0	0	0	0	0	0	0	0	0	980	24
25	Other Admin. Staff Transportation	(2,948)	2,617	0	0	0	0	0	0	0	0	0	(331)	25
26	Insurance-Prop.Liab.Malpractice	0	2,417	0	0	0	0	0	0	0	0	0	2,417	26
27	Other (specify):*	(24,606)	24,576	0	0	0	0	0	0	0	0	0	(30)	27
28	TOTAL General Administration	(105,280)	(81,733)	0	(187,013)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,280)	(72,237)	0	(177,517)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CTR

0046417

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(14,646)	0	1,266	0	0	0	0	0	0	0	0	(13,380)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,797)	0	3,168	0	0	0	0	0	0	0	0	1,371	32
33	Real Estate Taxes	0	0	1,439	0	0	0	0	0	0	0	0	1,439	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	(16,443)	0	5,873	0	(10,570)	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)	(121,723)	(72,237)	5,873	0	(188,087)	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
ROBERT HEDGES	50					
WILLIAM IRVINE	50			HI CARE		
				MANAGEMENT	SPRINGFIELD	MANAGEMENT
		SEE ATTACHED SCHEDULE		HEALTHCARE	SPRINGFIELD	NURSE
				HORIZONS		CONSULTING
				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	\$ 193,298	HI CARE MANAGEMENT		\$	\$ (193,298)	1
2	V	21 HOME OFFICE EXPENSE	60,000	" " "			(60,000)	2
3	V	5 UTILITIES		" " "		1,543	1,543	3
4	V	6 MAINTENANCE		" " "		7,688	7,688	4
5	V	7 SCAVENGER & EXTERM		" " "		265	265	5
6	V	17 ADMINISTRATIVE		" " "		103,443	103,443	6
7	V	19 PROFESSIONAL FEES		" " "		3,106	3,106	7
8	V	20 DUES & SUBSCRIPTION		" " "		507	507	8
9	V	21 OFFICE EXPENSE		" " "		33,919	33,919	9
10	V	24 TRAVEL & SEMINARS		" " "		980	980	10
11	V	25 TRANSPORTATION		" " "		2,617	2,617	11
12	V	26 INSURANCE		" " "		2,417	2,417	12
13	V	27 PAYROLL TAXES & GRP INS		" " "		24,576	24,576	13
14	Total		\$ 253,298			\$ 181,061	\$ * (72,237)	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		" " " "		3,168	3,168	16
17	V	33 REAL ESTATE		" " " "		1,439	1,439	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		\$			\$ 5,873	\$ * 5,873	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: 01/01/2008 Ending: 12/31/2008

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.	50.00				SALARY	\$ 32,440	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	32,440	17-7	4
5						SEE					5
6						ATTACHED					6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	2,403	17-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	12,707	17-7	10
11											11
12											12
13								TOTAL	\$ 79,990		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 CTR # 0046417 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 1625 S SIXTH 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 DAY	182,408	7	\$ 9,275	30,345	\$ 1,543	1
2	6	MAINTENANCE	PER RESIDENT DAY	182,408	7	46,214	30,345	7,688	2
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	182,408	7	1,592	30,345	265	3
4	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	30,345	32,440	4
5	17	OFFICER SALARY	PER RESIDENT DAY	182,408	7	195,000	30,345	32,440	5
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	182,408	7	71,673	30,345	11,923	6
7	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	182,408	7	83,756	30,345	13,933	7
8	17	SPECIAL PROJ MNGR	PER RESIDENT DAY	182,408	7	76,385	30,345	12,707	8
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	182,408	7	18,671	30,345	3,106	9
10	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	182,408	7	3,048	30,345	507	10
11	21	OFFICE EXPENSE	PER RESIDENT DAY	182,408	7	203,894	30,345	33,919	11
12	24	TRAVEL & SEMINARS	PER RESIDENT DAY	182,408	7	5,891	30,345	980	12
13	25	TRANSPORTATION	PER RESIDENT DAY	182,408	7	15,730	30,345	2,617	13
14	26	INSURANCE	PER RESIDENT DAY	182,408	7	14,528	30,345	2,417	14
15	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	182,408	7	147,729	30,345	24,576	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,088,386	\$ 806,417	\$ 181,061	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CTR # 0046417 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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	PER LICENSED BED	639	7	\$ 6,741	120	\$ 1,266	1
2	32	INTEREST	PER LICENSED BED	639	7	16,870	120	3,168	2
3	33	REAL ESTATE	PER LICENSED BED	639	7	7,664	120	1,439	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					\$ 31,275		\$ 5,873	25

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			48,306	6/29/12	0.0635										
4																				
5																				
Working Capital																				
6	COLE TAYLOR	X	WORKING CAPITAL	INTEREST	REVOLV			450,144	REVOLV	PRIME+										
7																				
8																				
9	TOTAL Facility Related							\$ 498,450		\$ 35,518										
B. Non-Facility Related*																				
10	IRS, IDR, ETC	X	LATE FEES																	
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)							\$ 498,450		\$ 35,518										

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EVERGREEN NURSING & REHABILITATION CTR 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 2007 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 2007.

(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>31,835.00</u>	\$ <u>31,835.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>31,835.00</u>	\$ <u>31,835.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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: 299 4. Dates Incurred: 9/01/03

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	CARPETING		2004	27,697	1,595	5	5,539	3,944	27,695	9
10	WATER HEATER		2005	2,785	101	27.5	101		366	10
11	REPLACE WALKS		2006	11,500	767	15	767		1,917	11
12	WATER HEATERS		2006	5,820	212	27.5	212		521	12
13	REHAB THERAPY WING ADDITION (PAID BY LANDLORD)		2008	320,555		27.5				13
14	REHAB THERAPY WING -SIGN		2008	1,744	58	15	58		58	14
15	REHAB THERAPY WING- ARCHITECT FEES		2008	16,693	430	27.5	430		430	15
16	REHAB WING- RUNNING PHONE & COMPUTER CABLE		2008	2,303	60	27.5	60		60	16
17	REHAB THERAPY- VERTICAL BLINDS		2008	3,972	2,383	5	794	(1,589)	794	17
18	PATIENT WANDERING SYSTEM		2008	2,852	74	27.5	74		74	18
19	PATIENT WANDERING SYSTEM (PAID BY LANDLORD)		2008	4,380						19
20	ROOF (POST 6/30/08 CAP COST REPORT STARTS HERE)		2008	47,900	218	27.5	218		218	20
21										21
22										22
23										23
24										24
25										25
26	H & I OFFICE BUILDING		2005	49,376	1,266	39	1,266		4,779	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

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)	\$ 497,577	\$ 7,164		\$ 9,519	\$ 2,355	\$ 36,912	70

**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	\$ 40,849	\$ 8,480	\$ 4,086	\$ (4,394)		\$ 10,487	71
72	Current Year Purchases	29,539	17,724	1,477	(16,247)		1,477	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 70,388	\$ 26,204	\$ 5,563	\$ (20,641)		\$ 11,964	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		2001 15 passemg. Chev van	2007	\$ 8,000	\$ 2,560	\$ 1,600	\$ (960)	5 yrs	\$ 3,200	76
77	Facility	USED BUS	2004	23,000		4,600	4,600	5 yrs	23,000	77
78										78
79										79
80	TOTALS			\$ 31,000	\$ 2,560	\$ 6,200	\$ 3,640		\$ 26,200	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)	\$ 609,869	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,928	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,282	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,646)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 75,076	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, L.L.C.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	09/04/04	\$ 388,692	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 388,692			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: \$ 29,380 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 _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$ 147,636	\$		\$ 147,636	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			57,292			57,292	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			276,321			276,321	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				173,288		173,288	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 481,249	\$ 173,288		\$ 654,537	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 CTR # 0046417

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 117,967	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (70,000))	1,271,135		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	6,000		5
6	Prepaid Insurance	67,908		6
7	Other Prepaid Expenses	49,737		7
8	Accounts Receivable (owners or related parties)	1,001		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	30,186		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,543,934	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	5,000		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	91,597		15
16	Equipment, at Historical Cost	137,884		16
17	Accumulated Depreciation (book methods)	(111,446)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,258		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,258)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,000		22
23	Other(specify): <u>security deposit</u>	56,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 182,702	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,726,636	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 785,550	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	450,144		29
30	Accrued Salaries Payable	73,194		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,467		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,835		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,375,190	\$	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	<u>Members' Loan Payable</u>	24,100		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 24,100	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,399,290	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 327,346	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,726,636	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (33,265)	1
2	Restatements (describe):		2
3		(9,999)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (43,264)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,610	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 370,610	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)	\$ 327,346	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	\$ 4,702,031	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,702,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,581	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 170,581	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	480	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)	\$ 480	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,797	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,797	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,874,889	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	749,003	31
32	Health Care	1,509,949	32
33	General Administration	955,901	33
	B. Capital Expense		
34	Ownership	519,009	34
	C. Ancillary Expense		
35	Special Cost Centers	654,537	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,454,279	40
41	Income before Income Taxes (line 30 minus line 40)**	420,610	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 420,610	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 CTR**

0046417

Report Period Beginning: **01/01/2008**

Ending:

12/31/2008

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	2,052	2,080	\$ 56,662	\$ 27.24	1
2	Assistant Director of Nursing	1,899	2,022	39,560	19.56	2
3	Registered Nurses	5,805	6,580	139,450	21.19	3
4	Licensed Practical Nurses	16,479	18,856	330,899	17.55	4
5	CNAs & Orderlies	51,842	57,258	544,457	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,293	4,623	46,973	10.16	8
9	Activity Director	1,806	2,105	27,015	12.83	9
10	Activity Assistants	1,530	1,598	14,887	9.32	10
11	Social Service Workers	2,891	3,097	30,039	9.70	11
12	Dietician					12
13	Food Service Supervisor	1,988	2,120	31,893	15.04	13
14	Head Cook	8,326	8,978	66,738	7.43	14
15	Cook Helpers/Assistants	6,624	7,282	71,104	9.76	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,167	45,137	20.83	17
18	Housekeepers	9,034	10,091	84,015	8.33	18
19	Laundry	5,643	6,067	46,309	7.63	19
20	Administrator	2,056	2,480	81,608	32.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,835	2,124	30,366	14.30	23
24	Clerical	3,963	4,279	58,218	13.61	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	1,762	1,975	22,788	11.54	31
32	Other Health C: MDS & Wrd Clk	5,176	5,510	102,658	18.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,928	151,292	\$ 1,870,776 *	\$ 12.37	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	613	\$ 8,374	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant	961	2,234	10-3	37
38	Nurse Consultant	Monthly	7,260	10-3	38
39	Pharmacist Consultant	Monthly	5,664	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	8	375	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	1,727	3,554	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,309	\$ 33,461		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

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. \$7176
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,196 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES 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. \$ 65,880
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 \$5,000, 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