

Facility Name & ID Number Evergreen Health Care Center

0044560 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	242	Skilled (SNF)	242	88,330	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	242	TOTALS	242	88,330	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	21,337	12,337	31,396	65,070	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,337	12,337	31,396	65,070	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.67%

D. How many bed-hold days during this year were paid by the Department? None (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 11/30/1999

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/30/1999 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 242 and days of care provided 16,905

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Evergreen Health Care Center # 0044560 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	450,246	62,541	1,100	513,887		513,887		513,887		1
2	Food Purchase		434,339		434,339		434,339	(352)	433,987		2
3	Housekeeping		353,284		353,284		353,284		353,284		3
4	Laundry		208,218		208,218		208,218		208,218		4
5	Heat and Other Utilities			338,906	338,906		338,906		338,906		5
6	Maintenance	131,647	8,869	248,372	388,888		388,888		388,888		6
7	Other (specify):*										7
8	TOTAL General Services	581,893	1,067,251	588,378	2,237,523		2,237,523	(352)	2,237,171		8
	B. Health Care and Programs										
9	Medical Director			30,804	30,804		30,804		30,804		9
10	Nursing and Medical Records	5,718,134	186,458	43,798	5,948,390		5,948,390	77,478	6,025,868		10
10a	Therapy										10a
11	Activities	214,269		6,000	220,269		220,269		220,269		11
12	Social Services	265,270			265,270		265,270		265,270		12
13	CNA Training										13
14	Program Transportation			6,769	6,769		6,769		6,769		14
15	Other (specify):*							15,171	15,171		15
16	TOTAL Health Care and Programs	6,197,672	186,458	87,371	6,471,501		6,471,501	92,649	6,564,150		16
	C. General Administration										
17	Administrative	224,810		1,000,985	1,225,795		1,225,795	(412,156)	813,639		17
18	Directors Fees										18
19	Professional Services			123,817	123,817		123,817		123,817		19
20	Dues, Fees, Subscriptions & Promotions			62,036	62,036		62,036		62,036		20
21	Clerical & General Office Expenses	379,505	71,790	469,460	920,755		920,755	(355,106)	565,649		21
22	Employee Benefits & Payroll Taxes			1,371,823	1,371,823		1,371,823		1,371,823		22
23	Inservice Training & Education			386	386		386		386		23
24	Travel and Seminar			4,877	4,877		4,877		4,877		24
25	Other Admin. Staff Transportation			495	495		495		495		25
26	Insurance-Prop.Liab.Malpractice			702,873	702,873		702,873		702,873		26
27	Other (specify):*							82,194	82,194		27
28	TOTAL General Administration	604,315	71,790	3,736,752	4,412,856		4,412,856	(685,068)	3,727,788		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,383,880	1,325,499	4,412,501	13,121,880		13,121,880	(592,771)	12,529,109		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Health Care Center

#0044560

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			153,771	153,771		153,771	249,728	403,499			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							473,355	473,355			32
33	Real Estate Taxes			243,000	243,000		243,000		243,000			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(975,938)	62,062			34
35	Rent-Equipment & Vehicles			17,746	17,746		17,746	12,035	29,781			35
36	Other (specify):*											36
37	TOTAL Ownership			1,452,516	1,452,516		1,452,516	(240,820)	1,211,696			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,211,975	2,401,180	4,613,155		4,613,155	32,103	4,645,258			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,495	132,495		132,495		132,495			42
43	Other (specify):*	243,243		46,520	289,763		289,763	(289,763)	0			43
44	TOTAL Special Cost Centers	243,243	2,211,975	2,580,196	5,035,413		5,035,413	(257,660)	4,777,753			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,627,123	3,537,474	8,445,213	19,609,810		19,609,810	(1,091,251)	18,518,559			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	39,927	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(352)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(340,089)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,797)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(333,662)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (635,973)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(455,278)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (455,278)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,091,251)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Evergreen Health Care Center

ID# 0044560

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Wages	\$ (243,243)	43	1
2	Marketing Expenses	(46,520)	43	2
3	Non-Allowable Expenses	(13,220)	21	3
4	Building Company - Professional Fees	(309)	19	4
5	Building Company - Amortization	(30,370)	36	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	(333,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evergreen Health Care Center# 0044560

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(352)	0	0	0	0	0	0	0	0	0	0	(352)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(352)	0	0	0	0	0	0	0	0	0	0	(352)	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	77,478	0	0	0	0	0	0	0	0	77,478	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	15,171	0	0	0	0	0	0	0	0	15,171	15
16	TOTAL Health Care and Programs	0	0	92,649	0	92,649	16							
	C. General Administration													
17	Administrative	0	0	(412,156)	0	0	0	0	0	0	0	0	(412,156)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(309)	309	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(355,106)	0	0	0	0	0	0	0	0	0	0	(355,106)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	82,194	0	0	0	0	0	0	0	0	82,194	27
28	TOTAL General Administration	(355,415)	309	(329,962)	0	(685,068)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(355,767)	309	(237,313)	0	(592,771)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evergreen Health Care Center# 0044560

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	39,927	194,119	15,682	0	0	0	0	0	0	0	0	249,728	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	473,279	76	0	0	0	0	0	0	0	0	473,355	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,038,000)	62,062	0	0	0	0	0	0	0	0	(975,938)	34
35	Rent-Equipment & Vehicles	0	0	12,035	0	0	0	0	0	0	0	0	12,035	35
36	Other (specify):*	(30,370)	30,370	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,557	(340,232)	89,855	0	0	0	0	0	0	0	0	(240,820)	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	32,103	0	0	0	0	0	0	0	32,103	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):*	(289,763)	0	0	0	0	0	0	0	0	0	0	(289,763)	43
44	TOTAL Special Cost Centers	(289,763)	0	0	32,103	0	(257,660)	44						
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(635,973)	(339,923)	(147,458)	32,103	0	0	0	0	0	0	0	(1,091,251)	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
Evergreen Healthcare Realty	100	See Attached		See Attached		
See Attached List Of Evergreen HC Realty Owners				Evergreen Healthcare Realty, LLC		Bldg. Company

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,038,000	Evergreen Healthcare Realty, LLC	100.00%	\$	\$ (1,038,000)	1
2	V	32 Interest		Evergreen Healthcare Realty, LLC	100.00%	473,279	473,279	2
3	V	19 Professional Fees		Evergreen Healthcare Realty, LLC	100.00%	309	309	3
4	V	30 Depreciation		Evergreen Healthcare Realty, LLC	100.00%	194,119	194,119	4
5	V	36 Amortization		Evergreen Healthcare Realty, LLC	100.00%	30,370	30,370	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,038,000			\$ 698,077	\$ * (339,923)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 1,000,985	Boulevard Healthcare Mangement, LLC		\$	\$ (1,000,985)
16	V	10 Nursing & Rehabilitation		Boulevard Healthcare Mangement, LLC		77,478	77,478
17	V	15 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		15,171	15,171
18	V	17 Administrative & General		Boulevard Healthcare Mangement, LLC		588,829	588,829
19	V	27 Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Mangement, LLC		82,194	82,194
20	V	30 Depreciation		Boulevard Healthcare Mangement, LLC		15,682	15,682
21	V	34 Building Rent		Boulevard Healthcare Mangement, LLC		62,062	62,062
22	V	35 Equipment Rent		Boulevard Healthcare Mangement, LLC		12,035	12,035
23	V	32 Interest Expense		Boulevard Healthcare Mangement, LLC		76	76
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,000,985			\$ 853,527	\$ * (147,458)

* 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	39 <u>ANCILLARY REHAB</u>	\$ <u>2,401,180</u>	<u>ADVANCED THERAPY & REHAB, LLC</u>		\$ <u>2,433,283</u>	\$ <u>32,103</u>	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,401,180			\$ 2,433,283	\$ * 32,103	39

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

Facility Name & ID Number Evergreen Health Care Center # 0044560 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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

Name of Related Organization Boulevard Healthcare Management, LLC
 Street Address 6400 Shafer Ct., Suite 600
 City / State / Zip Code Rosemont, IL 60018-4914
 Phone Number (847) 720-8700
 Fax Number ()

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

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	10	Nursing & Rehabilitation	Patient Days/Direct	195,885	4	\$ 233,239	\$ 268,857	65,070	\$ 77,478	1
2	15	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	195,885	4	45,672		65,070	15,172	2
3	17	Administrative & General	Patient Days/Direct	195,885	4	1,772,594	1,263,621	65,070	588,829	3
4	27	Payroll Taxes, Fringes, Staff Dev.	Patient Days/Direct	195,885	4	247,436		65,070	82,194	4
5	30	Depreciation	Patient Days/Direct	195,885	4	47,209		65,070	15,682	5
6	34	Building Rent	Patient Days/Direct	195,885	4	186,831		65,070	62,062	6
7	35	Equipment Rent	Patient Days/Direct	195,885	4	36,229		65,070	12,035	7
8	32	Interest Expense	Patient Days/Direct	195,885	4	228		65,070	76	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					\$ 2,569,438	\$ 1,532,478		\$ 853,528	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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	39	ANCILLARY REHAB	DIRECT ALLOCATION		\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	Bank of America - Mortgage		X	Mortgage				\$	10,312,318			\$	466,785	1						
2														2						
3														3						
4														4						
5														5						
Working Capital																				
6	FIC		X	Line of Credit					528,992				6,494	6						
7														7						
8														8						
9	TOTAL Facility Related							\$	10,841,310			\$	473,279	9						
B. Non-Facility Related*																				
10	Allocated From Boulevard	X											76	10						
11														11						
12														12						
13														13						
14	TOTAL Non-Facility Related							\$				\$	76	14						
15	TOTALS (line 9+line14)							\$	10,841,310			\$	473,355	15						

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	2,366,514	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.)		\$	2,308,750	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(57,764)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	300,764	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.		\$	243,000	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	280,688	8	
	2005	271,451	9	
	2006	275,263	10	
	2007	277,063	11	
	2008	274,720	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212 B. General Construction Type: Exterior Brick Frame Basement Foundation 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).

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. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1999</u>	<u>\$ 1,627,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 1,627,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	Various		1999	3,440		20	172	172	1,548
10	Various		2000	18,650		20	934	934	8,399
11	Various		2001	34,993		20	1,751	1,751	15,011
12	Various		2002	95,778		20	9,558	9,558	72,815
13	Various		2003	239,209		20	26,791	26,791	176,802
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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		7,967,115	194,118		238,498	44,380	2,348,040	67
68		7,129	186		356	170	5,414	68
69			153,771			(153,771)		69
70		\$ 8,366,314	\$ 348,075		\$ 278,060	\$ (70,015)	\$ 2,628,028	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,366,314	\$ 348,075		\$ 278,060	\$ (70,015)	\$ 2,628,028	1
2	Bwd Roof/Evg Wall Cove	2004	27,500		20	2,750	2,750	14,208	2
3	Replace Door	2004	1,495		20	150	150	898	3
4	Hot Water System Thermal Control	2004	2,613		20	523	523	2,657	4
5	Hot Water System Valve	2004	819		20	164	164	833	5
6	Painting	2004	900		20	45	45	270	6
7	Heating / Cooling	2004	878		20	44	44	260	7
8	Heating / Cooling	2004	866		20	43	43	252	8
9	Drain Rebuilding Kit	2004	545		20	27	27	159	9
10	Handrails	2004	1,175		20	59	59	343	10
11	Gas Valve Repair	2004	691		20	35	35	200	11
12	Heating / Cooling	2004	876		20	44	44	252	12
13	Relay Base - Dampers	2004	532		20	27	27	154	13
14	Heating / Cooling	2004	1,745		20	87	87	501	14
15	Repair Garage Door	2004	513		20	26	26	146	15
16	Fire Alarm Panel Repair	2004	550		20	28	28	150	16
17	Replace Parking Lot Light	2004	1,685		20	84	84	449	17
18	Matv System Service	2004	685		20	34	34	182	18
19	Heating Unit Repair	2004	900		20	45	45	229	19
20	Carpet Entryway	2005	1,675		20	84	84	363	20
21	Fire Door	2005	1,315		20	66	66	291	21
22	Generator	2005	6,043		20	302	302	1,510	22
23	Interior & Exterior Signs	2005	3,433		20	172	172	830	23
24	Circulation Pump	2005	2,620		20	131	131	655	24
25	Heat Exchanger	2005	1,509		20	151	151	742	25
26	Wiring	2005	1,390		20	139	139	637	26
27	2 Pull Door Trims	2005	2,024		20	202	202	876	27
28	Repair On Generator	2005	1,775		20	178	178	726	28
29	4 Rooftop Compressors	2006	20,307		20	4,061	4,061	13,537	29
30	Wiring For Off Network Circuit	2006	3,108		20	622	622	2,332	30
31	Dish Room Wall Panels	2006	6,135		20	1,227	1,227	4,806	31
32	Asphalt Removal & Replacement	2006	16,739		20	3,348	3,348	11,439	32
33	Dumpster Corral	2006	5,500		20	367	367	1,467	33
34	TOTAL (lines 1 thru 33)		\$ 8,484,855	\$ 348,075		\$ 293,325	\$ (54,750)	\$ 2,690,382	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,484,855	\$ 348,075		\$ 293,325	\$ (54,750)	\$ 2,690,382	1
2	Pump, Valves & Fittings	2006	7,040		20	352	352	3,755	2
3	2 Submersible Pumps	2006	5,886		20	294	294	2,453	3
4	Install New Compressor	2007	4,753		20	238	238	614	4
5	Co Detectors & Program For Fan & Doors	2007	7,375		20	369	369	953	5
6	Asphalt	2007	27,046		20	1,352	1,352	3,381	6
7	3 Ge Star 115V	2007	1,785		20	89	89	216	7
8	Landscape Renovation	2007	72,166		20	3,608	3,608	8,420	8
9	Three Boilers	2007	77,284		20	3,864	3,864	8,372	9
10	Repair Main Water	2007	3,741		20	187	187	561	10
11	Sewer Repair	2007	4,160		20	208	208	624	11
12	Physicians Office Remodel	2008	14,156		20	708	708	1,239	12
13	Lobby Renovation	2008	80,877		20	4,044	4,044	6,740	13
14	Sprinkler System	2008	74,375		20	3,719	3,719	5,268	14
15	Smoke Detectors	2008	1,874		20	94	94	133	15
16	Bldg Drainage Improvements	2008	50,365		20	2,518	2,518	2,728	16
17	Flood Damage Repair & Improv	2008	10,000		20	500	500	542	17
18	Rebuild Pump	2009	2,295		20	77	77	77	18
19	Install New Fitting & Valves For Boiler	2009	9,425		20	236	236	236	19
20	Rebuild 100 Unit Showers	2009	23,440		20	488	488	488	20
21	Repair Parking Lot	2009	15,009		20	250	250	250	21
22	Installation Of Egress Lighting	2009	6,153		20	77	77	77	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,984,060	\$ 348,075		\$ 316,597	\$ (31,478)	\$ 2,737,507	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Healthcare Center

#

0044560

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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 OHF USE O	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	242		1999	1963	\$ 7,052,500	\$ 180,833	35	\$ 201,500	\$ 20,667	\$ 2,031,792	4
5			1999	1963	303,741		35	8,678	8,678	87,504	5
6			2000	1963	103,836		35	2,967	2,967	29,669	6
7											7
8											8
	Improvement Type**										
9	Duct Work		2000		90,000		20	4,500	4,500	36,375	9
10	Masonry Restorater		2000		131,234		20	6,562	6,562	53,590	10
11	Permit Fees		2000		5,165		20	258	258	2,107	11
12	Parking Lot		2000		108,000		20	5,400	5,400	44,100	12
13	Parking Lot - Engineer		2000		2,500		20	125	125	1,031	13
14	Architect Fees		2000		11,619		20	581	581	4,842	14
15	Survey Fees		2000		2,000		20	100	100	817	15
16	General Contract Fees		2000		25,356		20	1,268	1,268	10,248	16
17	General Contract Fees		2001		3,538		20	177	177	1,092	17
18	Architect Fees		2001		3,097		20	155	155	1,162	18
19	Landscaping		2001		27,435		20	1,372	1,372	10,290	19
20	Parking Lot		2001		50,000		20	2,500	2,500	18,334	20
21	Curb Replacement		2001		2,200		20	110	110	826	21
22	Roof Repair		2001		2,200		20	110	110	806	22
23	Bathroom		2001		2,250		20	113	113	828	23
24	Tile Work		2001		500		20	25	25	180	24
25	Kitchen Work		2001		3,900		20	195	195	1,398	25
26	Vending Area Work		2001		1,900		20	95	95	680	26
27	Kitchen Work		2001		1,084		20	54	54	388	27
28	A/C Units		2001		4,884		20	244	244	1,748	28
29	Sheet Metal System		2001		9,540		20	477	477	3,340	29
30	Architect Fees		2001		4,579		20	229	229	1,488	30
31	Architect Fees		2002		6,480		20	324	324	2,268	31
32	Ductless System		2005		5,582		20	279	279	837	32
33	Fire Suppression System		2005		1,995		20	100	100	300	33
34						13,285			(13,285)		34
35									0		35
36									0		36

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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)	\$ 7,967,115	\$ 194,118		\$ 238,498	\$ 44,380	\$ 2,348,040	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	0	\$	4
5									0		5
6									0		6
7									0		7
8									0		8
	Improvement Type**										
9	Boulevard Healthcare Management		2002		6,131	160	20	307	147	5,414	9
10									0		10
11									0		11
12									0		12
13									0		13
14									0		14
15									0		15
16									0		16
17									0		17
18									0		18
19									0		19
20									0		20
21									0		21
22									0		22
23									0		23
24									0		24
25									0		25
26									0		26
27									0		27
28									0		28
29									0		29
30									0		30
31									0		31
32									0		32
33									0		33
34									0		34
35									0		35
36									0		36

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Evergreen Healthcare Center

0044560

Report Period Beginning:

1/1/2008

Ending:

Page 12A-REP

12/31/2008

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)	\$ 6,131	\$ 160		\$ 307	\$ 147	\$ 5,414	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 828,385	\$ 15,332	\$ 84,209	\$ 68,877	10	\$ 623,471	71
72	Current Year Purchases	26,433	164	2,692	2,528	10	2,692	72
73	Fully Depreciated Assets	407,034					407,034	73
74								74
75	TOTALS	\$ 1,261,852	\$ 15,496	\$ 86,901	\$ 71,405		\$ 1,033,197	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,873,412	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 363,571	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 403,498	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,927	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,770,704	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:				\$			3
4	Additions							4
5	Allocated From Boulevard				62,062			5
6								6
7	TOTAL				\$ 62,062			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: \$ 29,781 Description: _____

(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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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>
--	---	--

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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$		\$ 977,342	\$		\$ 977,342	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			376,603			376,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			1,079,338			1,079,338	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				1,314,956		1,314,956	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						897,019		897,019	13
14	TOTAL			\$		\$ 2,433,283	\$ 2,211,975		\$ 4,645,258	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center# 0044560Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 78,857	\$ 169,424	1
2	Cash-Patient Deposits	69,390	69,390	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,015,169	2,015,169	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,741	62,741	6
7	Other Prepaid Expenses	23,063	19,541	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	896,557	896,557	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,145,777	\$ 3,232,822	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,627,500	13
14	Buildings, at Historical Cost		7,052,500	14
15	Leasehold Improvements, at Historical Cost	842,065	1,756,680	15
16	Equipment, at Historical Cost	955,545	955,545	16
17	Accumulated Depreciation (book methods)	(1,042,566)	(3,088,716)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	197,601	36,024	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 952,645	\$ 8,339,533	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,098,422	\$ 11,572,355	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 611,056	\$ 822,992	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,390	69,390	28
29	Short-Term Notes Payable		1,136,000	29
30	Accrued Salaries Payable	359,331	359,331	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	300,764	300,764	32
33	Accrued Interest Payable	528,992	578,994	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,327	5,327	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	836,665	835,985	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,711,525	\$ 4,108,783	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,312,318	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)	\$	\$ 10,312,318	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,711,525	\$ 14,421,101	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,386,897	\$ (2,848,746)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,098,422	\$ 11,572,355	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,031,652	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,031,652	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	361,142	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	(5,897)	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)	\$ 355,245	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,386,897	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 19,454,100	1
2	Discounts and Allowances for all Levels	(10,293,273)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,160,826	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,675,283	6
7	Oxygen	33,724	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 8,709,007	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	884,679	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	602,790	19
20	Radiology and X-Ray	151,793	20
21	Other Medical Services	461,857	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,101,119	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		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)	\$ 19,970,952	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,237,523	31
32	Health Care	6,471,501	32
33	General Administration	4,412,856	33
B. Capital Expense			
34	Ownership	1,452,516	34
C. Ancillary Expense			
35	Special Cost Centers	4,902,918	35
36	Provider Participation Fee	132,495	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,609,810	40
41	Income before Income Taxes (line 30 minus line 40)**	361,142	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 361,142	43

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

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

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

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

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	3,880	4,271	\$ 144,102	\$ 33.74	1
2	Assistant Director of Nursing	22,953	25,284	871,661	34.47	2
3	Registered Nurses	23,025	25,158	789,540	31.38	3
4	Licensed Practical Nurses	55,707	62,561	1,738,201	27.78	4
5	CNAs & Orderlies	144,399	163,646	2,105,756	12.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,907	4,401	80,051	18.19	9
10	Activity Assistants	9,548	10,979	134,218	12.22	10
11	Social Service Workers	9,201	10,119	265,270	26.22	11
12	Dietician					12
13	Food Service Supervisor	1,789	2,010	58,186	28.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,507	34,133	392,060	11.49	15
16	Dishwashers					16
17	Maintenance Workers	5,182	5,984	131,647	22.00	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,749	1,883	145,441	77.24	20
21	Assistant Administrator	1,615	1,685	79,369	47.10	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,357	20,313	379,505	18.68	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	2,772	3,199	68,875	21.53	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	6,384	7,094	243,243	34.29	33
34	TOTAL (lines 1 - 33)	340,975	382,720	\$ 7,627,125 *	\$ 19.93	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	22	\$ 1,100	01-03	35
36	Medical Director	Monthly	30,804	09-03	36
37	Medical Records Consultant	Monthly	1,920	10-03	37
38	Nurse Consultant	Monthly	4,528	10-03	38
39	Pharmacist Consultant	133	7,932	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	29,419	10-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	6,000	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	155	\$ 81,703		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joanne Graf	Administrator		\$ 145,441	Workers' Compensation Insurance	\$ 133,881	IDPH License Fee	\$	
Mary Rose Stucker	Assistant Administrator		79,369	Unemployment Compensation Insurance	82,629	Advertising: Employee Recruitment	16,292	
				FICA Taxes	613,837	Health Care Worker Background Check		
				Employee Health Insurance	471,185	(Indicate # of checks performed <u>111</u>)	1,110	
				Employee Meals		Patient Background Checks <u>1802</u>	18,020	
				Illinois Municipal Retirement Fund (IMRF)*		Patient Background Checks	7,007	
				Employee Welfare	9,488	Licenses	19,607	
				Holiday Party	2,402	Administrative Subscriptions		
				Employee Disability Insurance	33,942			
				401k Expense	18,901	Less: Public Relations Expense	()	
				Employee Life Insurance	5,557	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 224,810	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,371,823		\$ 62,036		
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
Management Fees - Boulevard Healthcare Management			\$ 1,000,985				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,000,985				Seminar Expense	4,877
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Ruby Harris Total	Legal		\$ 153	\$				
Barclay Dixon & Smith, PC Total	Legal		1,000					
Burmila & Murphy Total	Legal		825					
Chicago Legal Clinic Total	Legal		829					
Gould & Ratner Total	Legal		2,356					
Pretzel & Stouffer, Chartered Total	Legal		7,013					
Smith Amundsen Total	Legal		156					
Stone, McGuire & Siegel Total	Legal		3,301					
Weltman, Weinberg & Reis Co. Total	Legal		50					
Plant & Moran	Accounting		59,990					
ADP/AT&T	Data Processing		46,101					
Surequest System	Software Maintenance		2,042					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 123,817				TOTAL	
							\$ 4,877	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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? No
If YES, give association name and amount. _____
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 105,363 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 132,495
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Plante & Moran, PLLC
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT