

		FOR BHF USE					

LL1

**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0046417</u></p> <p><b>Facility Name:</b> <u>EVERGREEN NURSING &amp; REHABILITATION CENTER</u></p> <p><b>Address:</b> <u>1115 NORTH WENTHE</u> <u>EFFINGHAM</u> <u>62401</u>          Number City Zip Code</p> <p><b>County:</b> <u>EFFINGHAM</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 528-0044</u> <b>Fax #</b> <u>( 217 ) 528-3412</u></p> <p><b>HFS ID Number:</b> <u>200089842001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>09/01/2003</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u></td> </tr> <tr> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u>	(Title) <u>MEMBER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input type="checkbox"/> "Sub-S" Corp.																																		
	<input checked="" type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
<b>Officer or Administrator of Provider</b>	(Signed) _____																																		
	(Type or Print Name) <u>ROBERT HEDGES</u>																																		
	(Title) <u>MEMBER</u>																																		
<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>																																		
	(Date) _____																																		
	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>																																		
	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>																																		
	(Telephone) <u>( 847 ) 675-3585</u> <b>Fax #</b> <u>( 847 ) 675-5777</u>																																		

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER

# 0046417 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,143	501	5,096	6,740	8	
9	SNF/PED					9	
10	ICF	19,196	6,371		25,567	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	20,339	6,872	5,096	32,307	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.76%

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 5,096

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: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION # 0046417 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				Reclassification 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
	<b>A. General Services</b>										
1	Dietary	178,267	12,406	9,040	199,713		199,713		199,713		1
2	Food Purchase		154,768		154,768		154,768		154,768		2
3	Housekeeping	94,851	10,965		105,816		105,816		105,816		3
4	Laundry	52,942	9,969	1,067	63,978		63,978		63,978		4
5	Heat and Other Utilities			155,558	155,558		155,558	1,726	157,284		5
6	Maintenance	59,583	9,258	21,092	89,933		89,933	10,243	100,176		6
7	Other (specify):*			10,018	10,018		10,018	269	10,287		7
8	<b>TOTAL General Services</b>	<b>385,643</b>	<b>197,366</b>	<b>196,775</b>	<b>779,784</b>		<b>779,784</b>	<b>12,238</b>	<b>792,022</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,444,907	121,088	32,502	1,598,497		1,598,497	(7,920)	1,590,577		10
10a	Therapy	64,938	47	1,275	66,260		66,260		66,260		10a
11	Activities	44,958	2,750		47,708		47,708		47,708		11
12	Social Services	37,728		3,897	41,625		41,625		41,625		12
13	CNA Training										13
14	Program Transportation			1,289	1,289		1,289		1,289		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,592,531</b>	<b>123,885</b>	<b>44,963</b>	<b>1,761,379</b>		<b>1,761,379</b>	<b>(7,920)</b>	<b>1,753,459</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	80,400		373,266	453,666		453,666	(241,133)	212,533		17
18	Directors Fees										18
19	Professional Services			90,197	90,197		90,197	(28,469)	61,728		19
20	Dues, Fees, Subscriptions & Promotions			38,969	38,969		38,969	(25,604)	13,365		20
21	Clerical & General Office Expenses	87,855	15,967	83,291	187,113		187,113	(8,977)	178,136		21
22	Employee Benefits & Payroll Taxes			287,921	287,921		287,921		287,921		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,411	3,411		3,411	1,249	4,660		24
25	Other Admin. Staff Transportation			11,237	11,237		11,237	1,243	12,480		25
26	Insurance-Prop.Liab.Malpractice			68,423	68,423		68,423	4,348	72,771		26
27	Other (specify):*			22,542	22,542		22,542	14,431	36,973		27
28	<b>TOTAL General Administration</b>	<b>168,255</b>	<b>15,967</b>	<b>979,257</b>	<b>1,163,479</b>		<b>1,163,479</b>	<b>(282,912)</b>	<b>880,567</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,146,429</b>	<b>337,218</b>	<b>1,220,995</b>	<b>3,704,642</b>		<b>3,704,642</b>	<b>(278,594)</b>	<b>3,426,048</b>		<b>29</b>

\*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
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,289
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	373,266
18	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	10,330
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	79,867
		0
		90,197
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	23,491
	EMPLOYEE WANT ADS XIX F	441
	CONTRIBUTIONS VI 20 XIX F	250
	DUES & SUBSCRIPTIONS XIX F	6,429
	LICENSES & PERMITS XIX F	2,375
	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	3,568
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,088
	PATIENT BACKGROUND CHECKS XIX F	1,327
		38,969
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	9,733
	EQUIPMENT REPAIR & MAINTENANCE	652
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	60,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,554
	MESSENGER SERVICE	0
	CREDIT CARD PROCESSING FEE	352
		83,291

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	162,962
	UNEMPLOYMENT COMPENSATION XIX D	34,337
	WORKERS COMPENSATION INSURANC XIX D	72,497
	HOSPITALIZATION INSURANCE XIX D	8,237
	EMPLOYEE BENEFITS - OTHER XIX D	5,140
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	4,748
	CHICAGO HEAD TAX XIX D	0
		0
		287,921
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	3,411
	TRAVEL XIX G	0
		3,411
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	11,237
		11,237
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	68,423
		68,423
27	<b>OTHER</b>	
	BAD DEBTS VI 24	22,542
		22,542

GRAND TOTAL COLUMN 3 OTHER **1,220,995**

**EVERGREEN NURSING & REHABILITATION CENTER  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	154,768	
LESS SALES TAX	<u>0</u>	<b>HAVE YOU FORGOTTEN TO EN</b>
NET FOOD	154,768	
TOTAL PATIENT CENSUS	32,307	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	96,921	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	96,921	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	96,921	
NET FOOD	154,768	
DIVIDE TOTAL MEALS/YEAR	<u>96,921</u>	
COST PER MEAL	1.60	
TIME EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>	
	=====	

**INTER SALES TAX ON PAGE 5??**

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

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

## 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	
	<b>D. Ownership</b>											
30	Depreciation			35,103	35,103		35,103	(17,961)	17,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,857	13,857		13,857	(159)	13,698			32
33	Real Estate Taxes			48,283	48,283		48,283	2,084	50,367			33
34	Rent-Facility & Grounds			525,311	525,311		525,311		525,311			34
35	Rent-Equipment & Vehicles			24,619	24,619		24,619		24,619			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			647,173	647,173		647,173	(16,036)	631,137			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		180,078	484,905	664,983		664,983		664,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		180,078	550,605	730,683		730,683		730,683			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,146,429	517,296	2,418,773	5,082,498		5,082,498	(294,630)	4,787,868			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(19,716)	30		9
10	Interest and Other Investment Income	(4,400)	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		21		18
19	Entertainment		20		19
20	Contributions	(3,818)	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	(22,542)	27		24
25	Fund Raising, Advertising and Promotional	(23,491)	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	(59,037)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (133,004)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(161,626)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (161,626)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (294,630)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

EVERGREEN NURSING & REHABILITATION CENTER

ID# 0046417

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2	HEALTHCARE HORIZONS	(7,920)	10	2
3	MARKETING SALARY	(15,809)	21	3
4	CREDIT CARD PROCESS FEE	(352)	21	4
5	MARKETING TRAVEL	(1,956)	25	5
6	PROF FEES - HEALTHCARE HORIZONS	(33,000)	19	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	<b>Total</b>	(59,037)		49

## STATE OF ILLINOIS

Summary A

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

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	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	1,726	0	0	0	0	0	0	0	0	0	1,726	5
6	Maintenance	0	10,243	0	0	0	0	0	0	0	0	0	10,243	6
7	Other (specify):*	0	269	0	0	0	0	0	0	0	0	0	269	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>12,238</b>	<b>0</b>	<b>12,238</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7,920)	0	0	0	0	0	0	0	0	0	0	(7,920)	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	<b>TOTAL Health Care and Programs</b>	<b>(7,920)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,920)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(241,133)	0	0	0	0	0	0	0	0	0	(241,133)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,000)	4,531	0	0	0	0	0	0	0	0	0	(28,469)	19
20	Fees, Subscriptions & Promotions	(27,309)	1,705	0	0	0	0	0	0	0	0	0	(25,604)	20
21	Clerical & General Office Expenses	(16,161)	7,184	0	0	0	0	0	0	0	0	0	(8,977)	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	1,249	0	0	0	0	0	0	0	0	0	1,249	24
25	Other Admin. Staff Transportation	(1,956)	3,199	0	0	0	0	0	0	0	0	0	1,243	25
26	Insurance-Prop.Liab.Malpractice	0	4,348	0	0	0	0	0	0	0	0	0	4,348	26
27	Other (specify):*	(22,542)	36,973	0	0	0	0	0	0	0	0	0	14,431	27
28	<b>TOTAL General Administration</b>	<b>(100,968)</b>	<b>(181,944)</b>	<b>0</b>	<b>(282,912)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(108,888)</b>	<b>(169,706)</b>	<b>0</b>	<b>(278,594)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

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

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)	
	<b>D. Ownership</b>													
30	Depreciation	(19,716)	0	1,755	0	0	0	0	0	0	0	0	(17,961)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,400)	0	4,241	0	0	0	0	0	0	0	0	(159)	32
33	Real Estate Taxes	0	0	2,084	0	0	0	0	0	0	0	0	2,084	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	<b>TOTAL Ownership</b>	<b>(24,116)</b>	<b>0</b>	<b>8,080</b>	<b>0</b>	<b>(16,036)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(133,004)	(169,706)	8,080	0	0	0	0	0	0	0	0	(294,630)	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
<b>ROBERT HEDGES</b>	<b>50</b>			<b>HI CARE</b>		
<b>WILLIAM IRVINE</b>	<b>50</b>			<b>MANAGEMENT</b>	<b>SPRINGFIELD</b>	<b>MANAGEMENT</b>
		<b>SEE ATTACHED SCHEDULE</b>		<b>H-I PROPERTIES</b>	<b>SPRINGFIELD</b>	<b>REAL ESTATE</b>
				<b>HEALTHCARE</b>	<b>SPRINGFIELD</b>	<b>NURSE</b>
				<b>HORIZONS</b>		<b>CONSULTING</b>

**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	<b>MANAGEMENT FEES</b>	\$ 373,266	<b>HI CARE MANAGEMENT</b>		\$	(373,266)	1
2	V	21	<b>HOME OFFICE EXPENSE</b>	60,000	" " "			(60,000)	2
3	V	5	<b>UTILITIES</b>		" " "			1,726	3
4	V	6	<b>MAINTENANCE</b>		" " "			10,243	4
5	V	7	<b>SCAVENGER &amp; EXTERM</b>		" " "			269	5
6	V	17	<b>ADMINISTRATIVE</b>		" " "			132,133	6
7	V	19	<b>PROFESSIONAL FEES</b>		" " "			4,531	7
8	V	20	<b>DUES &amp; SUBSCRIPTION</b>		" " "			1,705	8
9	V	21	<b>OFFICE EXPENSE</b>		" " "			67,184	9
10	V	24	<b>TRAVEL &amp; SEMINARS</b>		" " "			1,249	10
11	V	25	<b>TRANSPORTATION</b>		" " "			3,199	11
12	V	26	<b>INSURANCE</b>		" " "			4,348	12
13	V	27	<b>PAYROLL TAXES &amp; GRP INS</b>		" " "			36,973	13
14	Total		\$ 433,266				\$	263,560	\$ * (169,706) 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)		\$ 1,755	\$ 1,755	15
16	V	32 INTEREST		" " " "		4,241	4,241	16
17	V	33 REAL ESTATE		" " " "		2,084	2,084	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	<b>Total</b>		\$			\$ 8,080	\$ * 8,080	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: 01/01/2009 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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 48,644	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	48,644	17-7	4
5							SEE				5
6							ATTACHED				6
7	MARTHA IRVINE	BOOKKEEPING					SCHEDULE	SALARY	3,585	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	14,750	17-7	10
11											11
12											12
13								TOTAL	\$ 115,623		13

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

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 Report Period Beginning: 01/01/2009 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 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	130,175	7	\$ 6,954	\$ 32,307	\$ 1,726	1
2	6	MAINTENANCE	PER RESIDENT DAY	130,175	7	41,271	39,501	10,243	2
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	130,175	7	1,082	32,307	269	3
4	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	130,175	7	196,000	196,000	48,644	4
5	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	130,175	7	196,000	196,000	48,644	5
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	130,175	7	59,432	59,432	14,750	6
7	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	130,175	7	80,970	80,970	20,095	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	130,175	7	18,255	32,307	4,531	8
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	130,175	7	6,868	32,307	1,705	9
10	21	OFFICE EXPENSE	PER RESIDENT DAY	130,175	7	270,705	223,239	67,184	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	130,175	7	5,032	32,307	1,249	11
12	25	TRANSPORTATION	PER RESIDENT DAY	130,175	7	12,888	32,307	3,199	12
13	26	INSURANCE	PER RESIDENT DAY	130,175	7	17,518	32,307	4,348	13
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	130,175	7	148,977	32,307	36,973	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,061,952	\$ 795,142	\$ 263,560	25

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTE # 0046417 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 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	461	7	\$ 6,741	\$ 120	\$ 1,755	1
2	32	INTEREST	PER LICENSED BED	461	7	16,292	120	4,241	2
3	33	REAL ESTATE	PER LICENSED BED	461	7	8,006	120	2,084	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					\$ 31,039	\$	\$ 8,080	25

Facility Name & ID Number

EVERGREEN NURSING & REHABILITAT

# 0046417

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		8	9	10						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$	1					
2												2					
3												3					
4	US BANK (HI PROP)		X	MORTGAGE ( office)		6/29/05		64,594	6/29/12	0.0635	4,241	4					
5												5					
	<b>Working Capital</b>																
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST	REVOLV		200,000	REVOLV	PRIME +	13,857	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	264,594			\$	18,098	9				
	<b>B. Non-Facility Related*</b>																
10	IRS, IDR, ETC		X	LATE FEES								10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$				\$		14				
15	TOTALS (line 9+line14)						\$	264,594			\$	18,098	15				

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>31,835</b>	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.)		\$	<b>40,059</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>8,224</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>40,059</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>48,283</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>30,378</b>	8	
	2005	<b>29,534</b>	9	
	2006	<b>30,044</b>	10	
	2007	<b>31,835</b>	11	
	2008	<b>40,059</b>	12	
	<b>FOR BHF USE ONLY</b>			
	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.**



Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER

# 0046417

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				\$	1
2	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>15,080</u>	2
3	<b>TOTALS</b>			\$ <b>15,080</b>	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6	<b>H &amp; I</b>								
7	<b>Properties</b>								
8	<b>Office</b>	<b>2005</b>		<b>68,353</b>	<b>1,755</b>	<b>39</b>	<b>1,755</b>		<b>6,534</b>
	<b>Improvement Type**</b>								
9	<b>CARPETING</b>		<b>2004</b>	<b>27,697</b>	<b>798</b>	<b>5</b>	<b>2</b>	<b>(796)</b>	<b>27,697</b>
10	<b>WATER HEATER</b>		<b>2005</b>	<b>2,785</b>	<b>101</b>	<b>27.5</b>	<b>101</b>		<b>467</b>
11	<b>REPLACE WALKS</b>		<b>2006</b>	<b>11,500</b>	<b>767</b>	<b>15</b>	<b>767</b>		<b>2,684</b>
12	<b>WATER HEATERS</b>		<b>2006</b>	<b>5,820</b>	<b>212</b>	<b>27.5</b>	<b>212</b>		<b>733</b>
13	<b>REHAB THERAPY WING ADDITION (PAID BY LANDLORD)</b>		<b>2008</b>	<b>320,555</b>		<b>27.5</b>			
14	<b>REHAB THERAPY WING -SIGN</b>		<b>2008</b>	<b>1,744</b>	<b>116</b>	<b>15</b>	<b>116</b>		<b>174</b>
15	<b>REHAB THERAPY WING- ARCHITECT FEES</b>		<b>2008</b>	<b>16,693</b>	<b>607</b>	<b>27.5</b>	<b>607</b>		<b>1,037</b>
16	<b>REHAB WING- RUNNING PHONE &amp; COMPUTER CABLE</b>		<b>2008</b>	<b>2,303</b>	<b>84</b>	<b>27.5</b>	<b>84</b>		<b>144</b>
17	<b>REHAB THERAPY- VERTICAL BLINDS</b>		<b>2008</b>	<b>3,972</b>	<b>636</b>	<b>5</b>	<b>794</b>	<b>158</b>	<b>1,588</b>
18	<b>PATIENT WANDERING SYSTEM</b>		<b>2008</b>	<b>2,852</b>	<b>104</b>	<b>27.5</b>	<b>104</b>		<b>178</b>
19	<b>PATIENT WANDERING SYSTEM (PAID BY LANDLORD)</b>		<b>2008</b>	<b>4,380</b>					
20	<b>ROOF (POST 6/30/08 CAP COST REPORT STARTS HERE)</b>		<b>2008</b>	<b>47,900</b>	<b>1,742</b>	<b>27.5</b>	<b>1,742</b>		<b>1,960</b>
21	<b>LANDSCAPING AND PATIO</b>		<b>2009</b>	<b>10,740</b>	<b>358</b>	<b>15</b>	<b>716</b>	<b>358</b>	<b>716</b>
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 527,294	\$ 7,280		\$ 7,000	\$ (280)	\$ 43,912	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	\$ 70,388	\$ 10,020	\$ 7,040	\$ (2,980)	10 YRS	\$ 17,527	71
72	Current Year Purchases	30,036	18,022	1,502	(16,520)	10 YRS	1,502	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 100,424	\$ 28,042	\$ 8,542	\$ (19,500)		\$ 19,029	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 PASS CHEV VAN	2007	\$ 8,000	\$ 1,536	\$ 1,600	\$ 64	5 YRS	\$ 4,800	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 8,000	\$ 1,536	\$ 1,600	\$ 64		\$ 4,800	80

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 650,798	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,858	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,142	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,716)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 67,741	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	<b>TOTALS</b>	\$	\$	\$	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	\$ 525,311	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 525,311			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: \$ 24,619 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>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$		\$ 146,640	\$		\$ 146,640	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			61,360			61,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			276,905			276,905	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				180,078		180,078	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	<b>TOTAL</b>			\$		\$ 484,905	\$ 180,078		\$ 664,983	14

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

Facility Name & ID Number EVERGREEN NURSING & REHABILITATION CENTER # 0046417 Report Period Beginning: 01/01/2009 Ending: 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 353,896	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (70,000) )	716,410		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,955		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,510		8
9	Other(specify): <u>Real Estate Escrow Deposit</u>	33,941		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,175,712	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	102,337		15
16	Equipment, at Historical Cost	140,093		16
17	Accumulated Depreciation (book methods)	(118,722)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	56,667		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 180,375	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,356,087	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 474,571	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	76,238		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,295		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,059		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 823,163	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 823,163	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 532,924	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,356,087	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>327,346</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>(2)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>327,344</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>205,580</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>205,580</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>532,924</b>	<b>24</b> *

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

Facility Name &amp; ID Number EVERGREEN NURSING &amp; REHABILITATION ( # 0046417 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,066,754	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,066,754	3
<b>B. Ancillary Revenue</b>			
4	Day Care	2,043	4
5	Other Care for Outpatients		5
6	Therapy	214,748	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 216,791	8
<b>C. Other Operating Revenue</b>			
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	545	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 545	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,400	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,400	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,288,490	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	779,784	31
32	Health Care	1,761,379	32
33	General Administration	1,163,479	33
<b>B. Capital Expense</b>			
34	Ownership	647,173	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	664,983	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,082,498	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	205,992	41
42	<b>Income Taxes</b>	(412)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 205,580	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.

**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	2,016	2,080	\$ 57,795	\$ 27.79	1
2	Assistant Director of Nursing	1,988	2,060	41,202	20.00	2
3	Registered Nurses	5,853	6,315	141,036	22.33	3
4	Licensed Practical Nurses	20,732	22,606	418,069	18.49	4
5	CNAs & Orderlies	63,211	68,112	639,515	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,564	6,342	64,938	10.24	8
9	Activity Director	1,801	2,113	27,630	13.08	9
10	Activity Assistants	1,710	1,846	17,328	9.39	10
11	Social Service Workers	3,500	3,927	37,728	9.61	11
12	Dietician					12
13	Food Service Supervisor	1,935	1,982	30,328	15.30	13
14	Head Cook	7,210	7,829	72,106	9.21	14
15	Cook Helpers/Assistants	8,640	9,326	75,833	8.13	15
16	Dishwashers					16
17	Maintenance Workers	3,161	3,425	59,583	17.40	17
18	Housekeepers	9,475	10,476	94,851	9.05	18
19	Laundry	5,796	6,685	52,942	7.92	19
20	Administrator	2,040	2,080	80,400	38.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,832	2,346	30,270	12.90	23
24	Clerical	3,673	4,167	57,585	13.82	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					31
32	Other Health Care(specify)	7,783	8,349	147,290	17.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,920	172,066	\$ 2,146,429 *	\$ 12.47	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	231	\$ 9,040	1-3	35
36	Medical Director	65	6,000	9-3	36
37	Medical Records Consultant	44	2,190	10-3	37
38	Nurse Consultant		7,920	10-3	38
39	Pharmacist Consultant		3,234	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	26	1,275	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	64	3,539	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	430	\$ 33,198		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





Facility Name &amp; ID Number EVERGREEN NURSING &amp; REHABILITATION CENTER

# 0046417

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? YES  
If YES, give association name and amount. IL HEALTHCARE ASSOC \$6072
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,837 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. \$ 65,700  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (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.