

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0044560

Facility Name: Evergreen Health Care Center

Address: 10124 South Kedzie Evergreen Park 60805
Number City Zip Code

County: Cook

Telephone Number: (708) 907 - 7000 Fax #: (708) 907 - 7003

HFS ID Number:

Date of Initial License for Current Owners: 11/30/99

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

X

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Boris Kushnir Telephone Number: (614) 849-3000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed)

(Date)

(Print Name and Title)

(Firm Name & Address) Plante & Moran, PLLC 65 E. State Street, Suite 600 Columbus, Ohio 43215

(Telephone) (614) 849-3000 Fax #: (614) 221-3535

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

SEE ACCOUNTANTS' COMPILATION REPORT

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Evergreen Health Care Center

0044560 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	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	<u>242</u>	Skilled (SNF)	<u>242</u>	<u>88,330</u>	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	<u>242</u>	TOTALS	<u>242</u>	<u>88,330</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,205</u>	<u>9,956</u>	<u>24,775</u>	<u>51,936</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,205</u>	<u>9,956</u>	<u>24,775</u>	<u>51,936</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.80%

SEE ACCOUNTANTS' COMPILATION REPORT

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)
N/A

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 11/30/99

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/30/99 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 22,970

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number

Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
1	A. General Services										
1	Dietary		1,183	853,998	855,181		855,181		855,181		1
2	Food Purchase		21,295		21,295		21,295	(590)	20,705		2
3	Housekeeping		5,758	340,832	346,590		346,590		346,590		3
4	Laundry		145	182,563	182,708		182,708		182,708		4
5	Heat and Other Utilities			295,572	295,572		295,572		295,572		5
6	Maintenance	118,998	32,451	191,499	342,948		342,948	1,764	344,712		6
7	Other (specify):*										7
8	TOTAL General Services	118,998	60,832	1,864,464	2,044,294		2,044,294	1,174	2,045,468		8
	B. Health Care and Programs										
9	Medical Director			50,004	50,004		50,004		50,004		9
10	Nursing and Medical Records	4,365,639	161,392	48,910	4,575,941		4,575,941	19,811	4,595,752		10
10a	Therapy	111,068			111,068		111,068		111,068		10a
11	Activities	169,449	7,605	400	177,454		177,454		177,454		11
12	Social Services	118,267			118,267		118,267		118,267		12
13	CNA Training										13
14	Program Transportation			32,918	32,918		32,918		32,918		14
15	Other (specify):* See Supplemental							4,941	4,941		15
16	TOTAL Health Care and Programs	4,764,423	168,997	132,232	5,065,652		5,065,652	24,752	5,090,404		16
	C. General Administration										
17	Administrative	280,940		901,866	1,182,806		1,182,806	(17,102)	1,165,704		17
18	Directors Fees										18
19	Professional Services			188,399	188,399		188,399	(10,256)	178,143		19
20	Dues, Fees, Subscriptions & Promotions			98,149	98,149		98,149	(46,814)	51,335		20
21	Clerical & General Office Expenses	195,197	54,187	274,443	523,827		523,827	(230,107)	293,720		21
22	Employee Benefits & Payroll Taxes			1,074,599	1,074,599		1,074,599	(2,164)	1,072,435		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,140	15,140		15,140		15,140		24
25	Other Admin. Staff Transportation			1,607	1,607		1,607		1,607		25
26	Insurance-Prop.Liab.Malpractice			433,117	433,117		433,117		433,117		26
27	Other (specify):* See Supplemental							28,408	28,408		27
28	TOTAL General Administration	476,137	54,187	2,987,320	3,517,644		3,517,644	(278,035)	3,239,609		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,359,558	284,016	4,984,016	10,627,590		10,627,590	(252,109)	10,375,481		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.

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 7 Detailed			
Total	-	-	-
Line 15 Detailed			
Alloc. - Boulevard Healthcare Management, LLC			4,941
Total	-	-	4,941
Line 27 Detailed			
Alloc. - Boulevard Healthcare Management, LLC			28,408
Total	-	-	28,408

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			146,341	146,341		146,341	197,519	343,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,953	2,953		2,953	850,918	853,871			32
33	Real Estate Taxes			95,324	95,324		95,324		95,324			33
34	Rent-Facility & Grounds			1,062,543	1,062,543		1,062,543	(993,661)	68,882			34
35	Rent-Equipment & Vehicles			26,117	26,117		26,117	5,250	31,367			35
36	Other (specify):*											36
37	TOTAL Ownership			1,333,278	1,333,278		1,333,278	60,026	1,393,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,129,423	2,301,753	3,431,176		3,431,176	195,319	3,626,495			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):* Supplemental	215,970		2,217	218,187		218,187	(218,187)				43
44	TOTAL Special Cost Centers	215,970	1,129,423	2,436,465	3,781,858		3,781,858	(22,868)	3,758,990			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,575,528	1,413,439	8,753,759	15,742,726		15,742,726	(214,951)	15,527,775			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

Page 4 Supplemental Schedule

IL478-2471

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(590)	02		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				9
10	Interest and Other Investment Income	(2,555)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,164)	22		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	(203,884)	21		24
25	Fund Raising, Advertising and Promotional	(46,814)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(305,924)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (561,931)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	346,980		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 346,980		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (214,951)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (2,048)	21	1
2	Bank Fees	(12,294)	21	2
3	Miscellaneous Expenses	(11,873)	21	3
4	Taxes - Sale	(8)	21	4
5	Marketing Salary	(215,970)	43	5
6	Marketing Other	(2,217)	43	6
7	Non-Allowable Legal Fees	(10,256)	19	7
8				8
9				9
10				10
11	Evergreen Realty			11
12	Amortzation	(51,258)	31	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	(305,924)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evergreen Health Care Center

0044560

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(590)	0	0	0	0	0	0	0	0	0	0	(590)	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	1,764	0	0	0	0	0	0	0	0	1,764	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(590)	0	1,764	0	0	0	0	0	0	0	0	1,174	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	19,811	0	0	0	0	0	0	0	0	19,811	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	4,941	0	0	0	0	0	0	0	0	4,941	15
16	TOTAL Health Care and Programs	0	0	24,752	0	0	0	0	0	0	0	0	24,752	16
	C. General Administration													
17	Administrative	0	0	(17,102)	0	0	0	0	0	0	0	0	(17,102)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,256)	0	0	0	0	0	0	0	0	0	0	(10,256)	19
20	Fees, Subscriptions & Promotions	(46,814)	0	0	0	0	0	0	0	0	0	0	(46,814)	20
21	Clerical & General Office Expenses	(230,107)	0	0	0	0	0	0	0	0	0	0	(230,107)	21
22	Employee Benefits & Payroll Taxes	(2,164)	0	0	0	0	0	0	0	0	0	0	(2,164)	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	28,408	0	0	0	0	0	0	0	0	28,408	27
28	TOTAL General Administration	(289,341)	0	11,306	0	0	0	0	0	0	0	0	(278,035)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(289,931)	0	37,822	0	0	0	0	0	0	0	0	(252,109)	29

Summary B

12/31/11

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

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Pg. 6 Supp 1 and Page P6. Supp 2		Ridgewood Health Care Center, LLC		Evergreen Realty	Chicago, IL	Building Co.
		Westlake Health Care Center, LLC		Boulevard Mgmt.	Rosemont, IL	Mgmt. Co.
		Warren Barr Pavilion, LLC	Chicago, IL	Advanced Therapy	Rosemont, IL	Therapy Co.

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	34	Rent	\$ 1,038,000	Evergreen Healthcare Realty, LLC	100.00%	\$	\$ (1,038,000)	1
2	V	21	Office		Evergreen Healthcare Realty, LLC	100.00%			2
3	V	30	Depreciation		Evergreen Healthcare Realty, LLC	100.00%	194,119	194,119	3
4	V	31	Amortization		Evergreen Healthcare Realty, LLC	100.00%	51,258	51,258	4
5	V	32	Interest		Evergreen Healthcare Realty, LLC	100.00%	853,473	853,473	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			\$ 1,098,850	\$ * 60,850	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	George P. Bauer Revocable Trust	6%						1
2	Carol B. Bauer Revocable Trust	6%						2
3	Margot M. Brinley	2%						3
4	Growth Partners	2%						4
5	Jerold A. Hecktman F. Partnership	1%						5
6	Amy Heinrich	1%						6
7	Thomas Hunter III	10%						7
8	Thomas Hunter IV	0.6%						8
9	Willard Hunter	0.4%						9
10	Leisure Investments, LLC	0.5%						10
11	Frank Locallo	1%						11
12	Mark Madigan	0.2%						12
13	McKay Trading Partnership	1%						13
14	Adeline S. Morrison	6%						14
15	Helen Morrison	2%						15
16	Lois L. Morrison	2%						16
17	Lisa Nemeroff Revocable Trust	1%						17
18	Joe Perillo	1%						18
19	Theodore Pecora	1%						19
20	Ray Rusnak	1%						20
21	Jennifer Steans	4%						21
22	Steans Family Foundation	4%						22
23	Robin Steans	4%						23
24	Harrison I. Steans	19.5%						24
25	Neele Stearns	5.8%						25
26	Tower Investors	1%						26
27	WHI Ventures Fund I, LLC	4%						27
28	Thomas E. Wood Revocable Trust	1%						28
29	Marlene Elowe	1%						29
30	Sidney Freedland	2%						30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Strategic Management Advisors	1%						1
2	Michael G. Hara Revocable Trust	1%						2
3	Gene Jacobs	1%						3
4	Jeff Elowe - Spousal Trust	1.0605%						4
5	Randi J. Elowe	1.0605%						5
6	Brian Cloch	2.12075%						6
7	Fred Benjamin	0.7485%						7
8	CBE III, LLC	0.01%						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

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 Fee	\$ 217,034	Boulevard Healthcare Management, LLC	100.00%	\$	\$ (217,034)	15
16	V	6	Maintenance & Minor Equipment		Boulevard Healthcare Management, LLC	100.00%	1,764	1,764	16
17	V	10	Nursing & Rehabilitation		Boulevard Healthcare Management, LLC	100.00%	19,811	19,811	17
18	V	15	Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	4,941	4,941	18
19	V	17	Administrative and General		Boulevard Healthcare Management, LLC	100.00%	199,932	199,932	19
20	V	27	Payroll Taxes, Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	28,408	28,408	20
21	V	30	Depreciation		Boulevard Healthcare Management, LLC	100.00%	3,400	3,400	21
22	V	34	Building Rent		Boulevard Healthcare Management, LLC	100.00%	44,339	44,339	22
23	V	35	Equipment Rent		Boulevard Healthcare Management, LLC	100.00%	5,250	5,250	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			\$ 217,034			\$ 307,845	\$ * 90,811	39

* 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.

☒ X

 YES

☐

 NO

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

1		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	Ancillary Services - Therapy	\$ 1,979,369	Advanced Therapy & Rehab, LLC	100.00%	\$ 2,174,688	\$ 195,319	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			\$ 1,979,369			\$ 2,174,688	\$ * 195,319	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Health Care Center # 0044560 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 - No Compensation								\$		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

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

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

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

(847) 720 - 8701

	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	6	Maintenance & Minor Equip.	Patient Days	181,795	4	\$ 6,176	\$	51,936	\$ 1,764	1
2	10	Nursing & Rehabilitation	Patient Days	181,795	4	69,347	69,347	51,936	19,811	2
3	15	Payroll Taxes, Fringes, Staff	Patient Days	181,795	4	17,296		51,936	4,941	3
4	17	Administrative and General	Patient Days	181,795	4	699,834	643,366	51,936	199,932	4
5	27	Payroll Taxes, Fringes, Staff	Patient Days	181,795	4	99,437		51,936	28,408	5
6	30	Depreciation	Patient Days	181,795	4	11,901		51,936	3,400	6
7	34	Building Rent	Patient Days	181,795	4	155,203		51,936	44,339	7
8	35	Equipment Rent	Patient Days	181,795	4	18,377		51,936	5,250	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					\$ 1,077,572	\$ 712,713		\$ 307,845	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

Advanced Therapy and Rehab, LLC

Street Address

6400 Shafer Ct., Suite 600

City / State / Zip Code

Rosemont, IL 60018-4914

Phone Number

(847) 720 - 8700

Fax Number

(847) 720 - 8701

	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 Services - Therapy	Billing	4,809,603	4	\$ 5,284,200	\$ 3,523,291	1,979,369	\$ 2,174,688	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					\$ 5,284,200	\$ 3,523,291		\$ 2,174,688	25

SEE ACCOUNTANTS' COMPILATION REPORT

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		X	Mortgage			\$	8,976,318			\$ 814,930	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Insurance Financing		X								2,953	6
7	FIC	X						2,900,001			38,543	7
8												8
9	TOTAL Facility Related						\$	11,876,319			\$ 856,426	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income		X								(2,555)	13
14	TOTAL Non-Facility Related						\$				\$ (2,555)	14
15	TOTALS (line 9+line14)						\$	11,876,319			\$ 853,871	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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 bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	326,730		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.)		\$	200,978		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(125,752)		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	221,076		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.		\$	95,324		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	275,263	8	
		2007	277,603	9	
		2008	274,720	10	
		2009	311,231	11	
		2010	200,978	12	
2011 Real Estate Tax Accrual = 2010 Tax Bill of \$200,978 * 1.10 = \$221,076					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044560

CONTACT PERSON REGARDING THIS REPORT Boris Kushnir

TELEPHONE (614) 849 - 3000 FAX #: (614) 221 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>24-11-411-014-0000</u>	<u>Nursing Home</u>	\$ <u>200,977.78</u>	\$ <u>200,977.78</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>200,977.78</u>	\$ <u>200,977.78</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212

B. General Construction Type: Exterior Brick Frame

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1999	\$ 1,627,500	1
2					2
3	TOTALS			\$ 1,627,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	39	\$ 180,833	\$	\$ 2,185,069	4
5			1999	1963	303,742		39				5
6			2000	1963	103,836		39				6
7											7
8											8
	Improvement Type**										
9	The building costs above and leasehold improvements listed										9
10	below are captured on Evergreen Healthcare Realty, LLC										10
11											11
12	Various										12
13	Various			2000	375,874	9,047	39	9,047		107,430	13
14	Various			2001	117,107	3,594	39	3,594		31,931	14
15	Various			2002	6,479	166	39	166		1,633	15
16				2005	7,577	479	10 - 20	479		3,168	16
17	The following leasehold improvement cost listed below are										17
18	captured on Boulevard Healthcare Magement, LLC.										18
19											19
20	Various			2002	6,131	53		53			20
21											21
22	The leasehold improvements listed below are captured on										22
23	the books of Evergreen Health Care Center:										23
24											24
25	Various			1999	3,440						25
26	Various			2000	18,650						26
27	Various			2001	34,993						27
28	Various			2002	95,778						28
29	Various			2003	239,209						29
30	Various			2004	44,968						30
31	Various			2005	21,784						31
32	Various			2006	64,715						32
33	Various			2007	198,310						33
34	Physicians Office Remodel			2008	14,156						34
35	Lobby Renovation			2008	80,877						35
36	Sprinkler System			2008	74,375						36

*Total beds on this schedule must agree with page 2.
 See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Smoke Detectors	2008	\$ 1,874	\$		\$	\$	\$	37
38 Building Drainage Improvement	2008	50,365						38
39 Flood Damage Repair and Improvement	2008	10,000						39
40 Rebuilding Pump	2009	2,295						40
41 Install New Fitting & Valves for Boiler	2009	9,425						41
42 Rebuild 100 Unit Showers	2009	23,440						42
43 Repair Parking Lot	2009	15,009						43
44 Installation of Egree Lighting	2009	6,153						44
45 New Screen Door	2010	2,865						45
46 Double Egres Doors and Nurse Station	2011	19,900						46
47 Double Egres Doors and Nurse Station	2011	19,528						47
48 Boiler Return Piping	2011	7,780						48
49 Sump Pump	2011	6,916						49
50 Solarium Windows	2011	4,159						50
51 Solarium Windows Installation	2011	2,160						51
52 Concrete Sidewalk	2011	4,950						52
53 Central Butterfly Valves	2011	6,040						53
54								54
55 Financial Statement Depreciation			80,924	5 - 10	80,924		445,906	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)		\$ 9,057,360	\$ 275,096		\$ 275,096	\$	\$ 2,775,137	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 Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 808,314	\$ 60,462	\$ 60,462	\$	5 - 10	\$ 885,415	71
72	Current Year Purchases	59,306	4,955	4,955		5 - 10	4,955	72
73	Fully Depreciated Assets							73
74	See Supplemental	2,429,822	3,347	3,347			2,159,202	74
75	TOTALS	\$ 3,297,442	\$ 68,764	\$ 68,764	\$		\$ 3,049,572	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 13,982,302	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 343,860	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 343,860	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,824,709	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

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 13 Supplemental Schedule

Description	Cost	Depreciation	Accumulated Depreciation
Evergreen Real Estate, LLC			
Prior	2,159,202	-	2,159,202
Current			
Total	2,159,202	-	2,159,202
Boulevard Healthcare Management, LLC			
Prior	270,620	3,347	-
Current			
Total	270,620	3,347	-
Total	2,429,822	3,347	2,159,202

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								5
6	See Supp.				68,882			6
7	TOTAL				\$ 68,882			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: \$ 31,367 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 14 Supplemental Schedule - Building Rental

Page 14 Supplemental Schedule - Equipment Rental

IL478-2471

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

- (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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 849,724	\$		\$ 849,724	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			202,135			202,135	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			930,425			930,425	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				844,329		844,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					285,094		285,094	12
13	Other (specify): See Supplemental	39 - 03				319,469			319,469	13
14	TOTAL			\$		\$ 2,301,753	\$ 1,129,423		\$ 3,431,176	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

Page 16 Supplemental Schedule

IL478-2471

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	\$ 288,248	\$ 355,314	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 417,747)	3,774,000	3,774,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,150	88,150	6
7	Other Prepaid Expenses	89,604	89,604	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	1,302,342	15,962	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,542,344	\$ 4,323,030	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	924,578	1,431,615	15
16	Equipment, at Historical Cost	1,027,156	1,027,156	16
17	Accumulated Depreciation (book methods)	(1,336,276)	(3,665,507)	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): See Supplemental	393,183	734,705	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,008,641	\$ 8,207,969	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,550,985	\$ 12,530,999	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,542,616	\$ 2,542,616	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,900,001	2,900,001	29
30	Accrued Salaries Payable	312,678	312,678	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,455	10,455	31
32	Accrued Real Estate Taxes(Sch.IX-B)	221,076	221,076	32
33	Accrued Interest Payable		38,648	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	404,868	1,153,378	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,391,694	\$ 7,178,852	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,976,318	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)	\$	\$ 8,976,318	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,391,694	\$ 16,155,170	46
47	TOTAL EQUITY(page 18, line 24)	\$ 159,291	\$ (3,624,171)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,550,985	\$ 12,530,999	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Page 17 Supplemental Schedule

Line 43 - Other Long Term Liabilities

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (386,807)	1
2	Restatements (describe):		2
3	Prior Year Financial Statement Audit Adjustments	(504,452)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (891,259)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,056,446	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	(5,896)	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)	\$ 1,050,550	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)	\$ 159,291	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 15,602,474	1
2	Discounts and Allowances for all Levels	(6,887,863)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,714,611	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,918,471	6
7	Oxygen	7,412	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,925,883	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	1,555	13
14	Non-Patient Meals	590	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	737,183	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	170,164	19
20	Radiology and X-Ray	28,599	20
21	Other Medical Services	215,759	21
22	Laundry	229	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,154,079	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,555	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,555	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,044	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,044	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,799,172	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,044,294	31
32	Health Care	5,065,652	32
33	General Administration	3,517,644	33
B. Capital Expense			
34	Ownership	1,333,278	34
C. Ancillary Expense			
35	Special Cost Centers	3,649,363	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)*	\$ 15,742,726	40
41	Income before Income Taxes (line 30 minus line 40)**	1,056,446	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,056,446	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

Page 19 Supplemental Schedule

IL478-2471

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	3,872	4,064	\$ 170,408	\$ 41.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	49,383	53,236	1,589,755	29.86	3
4	Licensed Practical Nurses	44,853	49,076	1,193,127	24.31	4
5	CNAs & Orderlies	102,835	113,492	1,269,257	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,982	6,069	111,068	18.30	8
9	Activity Director	3,216	3,376	73,285	21.71	9
10	Activity Assistants	7,040	7,907	96,164	12.16	10
11	Social Service Workers	4,670	4,966	118,267	23.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,602	5,014	118,998	23.73	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,088	2,288	193,440	84.55	20
21	Assistant Administrator	1,840	2,080	87,500	42.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,750	10,756	195,197	18.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,822	2,121	44,924	21.18	31
32	Other Health Care(specify)					32
33	Other(specify) Supplemental	11,663	12,937	314,138	24.28	33
34	TOTAL (lines 1 - 33)	253,616	277,382	\$ 5,575,528 *	\$ 20.10	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		\$		35
36	Medical Director		50,004	09 - 03	36
37	Medical Records Consultant		3,486	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,812	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		17,563	10 - 03	42
43	Speech Therapy Consultant				43
44	Activity Consultant		400	11 - 03	44
45	Social Service Consultant				45
46	Other(specify)		18,050	10 - 03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 99,315		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

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Marketing	5,918	6,435	215,970
Central Services and Supply	1,945	2,123	36,680
Unit Secretary	3,800	4,379	61,488
Total	11,663	12,937	314,138

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership	
Name	Function	%	Amount		
Gred Kennedy	Administrator	0	\$ 129,897		
JoMarie Silver	Administrator	0	63,543		
Megan Mulherin	Asst. Admin.	0	87,500		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 280,940		
B. Administrative - Other					
Description			Amount		
Management Fees - Boulevard Healthcare, LLC			\$ 217,034		
Management Fees - Transitional Care			684,832		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 901,866		
C. Professional Services					
Vendor/Payee	Type		Amount		
Plant Moran, PLLC	Accounting / Auditing		\$ 41,598		
Paycom	Payroll Processing		21,699		
MDI	Data Processing		8,299		
AT&T Data	Data Processing		16,772		
Nebo Systems	Data Processing		3,270		
Ellen E. Douglas	Legal		860		
Gould & Ratner	Legal		5,160		
Klafter & Burkert	Legal		4,999		
Much, Shelist	Legal		22,088		
Pretzel & Stouffer, Chartered	Legal		4,802		
Stone, McGuire & Siegal	Legal		(1,477)		
See Supplemental Schedule	See Supplemental Schedule		60,328		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 188,399		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 149,580		
Unemployment Compensation Insurance			130,899		
FICA Taxes			413,732		
Employee Health Insurance			325,585		
Employee Meals			2,322		
Illinois Municipal Retirement Fund (IMRF)*					
Insurance - Disability, Dental, Life, Vision			18,662		
Employee Welfare			1,298		
401K Expense			13,692		
Other Employee Benefits			16,665		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,072,435		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description	Line #		Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$		
Advertising: Employee Recruitment			4,283		
Health Care Worker Background Check (Indicate # of checks performed)			7,846		
Patient Background Checks					
Dues and Subscriptions			24,738		
Licenses			14,468		
Marketing and Advertising			46,814		
Less: Public Relations Expense			()		
Non-allowable advertising			(46,814)		
Yellow page advertising			()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 51,335		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			15,140		
Entertainment Expense			()		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 15,140		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Law Office of Wolfe and Wolfe	Legal	420
Weltman, Weinberg & Reis	Legal	700
FR&R	Consulting	10,000
Accurate Electric	Energy	6,300
Getzler, Henrich & Associates, LLC	Management Consultants	26,326
Michigan Peer Review	Healthcare Consulting	1,300
Security Insurance	Healthcare Broker Fee	2,000
Personnel Planners	Unemployment Consultants	(180)
Life Safety Resourcs	Life Safety Consulting	960
Mary Kemp	CHF Program Development	1,193
Barb Larimore	Medicaid Consulting	5,850
VCIP	IT Consulting	5,450
Other Consultants	Other	9
Total		60,328

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Legal Schedule

Vendor	Invoice Date	Amount	Allowable
Weltman, Weinberg & Reis Co.	10/13/11	400	
Weltman, Weinberg & Reis Co.	11/07/11	300	
The Law Offices Of Wolf & Wolfe, Ltd	07/01/11	420	420
Pretzel & Stouffer, Chartered	01/01/11	1,538	
Pretzel & Stouffer, Chartered	03/29/11	100	100
Pretzel & Stouffer, Chartered	04/21/11	188	
Pretzel & Stouffer, Chartered	06/01/11	468	
Pretzel & Stouffer, Chartered	07/27/11	315	
Pretzel & Stouffer, Chartered	07/27/11	75	
Pretzel & Stouffer, Chartered	08/17/11	326	326
Pretzel & Stouffer, Chartered	11/01/11	68	
Pretzel & Stouffer, Chartered	11/16/11	390	
Pretzel & Stouffer, Chartered	11/16/11	115	
Pretzel & Stouffer, Chartered	12/14/11	840	840
Pretzel & Stouffer	12/31/11	381	
Much Shelist	01/01/11	6,081	6,081
Much Shelist	03/01/11	558	558
Much Shelist	03/01/11	1,349	1,349
Much Shelist	04/01/11	2,271	2,271
Much Shelist	05/01/11	512	512
Much Shelist	05/01/11	1,170	1,170
Much Shelist	07/01/11	1,674	1,674
Much Shelist	07/01/11	698	698
Much Shelist	07/01/11	1,674	1,674
Much Shelist	07/01/11	847	847
Much Shelist	07/01/11	2,511	2,511
Much Shelist	08/01/11	140	140
Much Shelist	08/01/11	372	372
Much Shelist	11/01/11	93	93
Much Shelist	11/01/11	93	93
Much Shelist	12/01/11	465	465
Much Shelist	12/01/11	1,581	1,581
Klafter and Burke	02/25/11	4,999	4,999
Gould & Ratner, LLP	10/18/11	3,164	
Gould & Ratner, LLP	11/07/11	1,997	
Ellen E. Douglas	07/01/11	860	
Stone, McGuire & Siegel, P.C.	03/31/11	(2,143)	(2,143)
Stone, McGuire & Siegel, P.C.	11/30/11	400	400
Stone, McGuire & Siegel, P.C.	12/31/11	266	266
Total		37,552	27,296
Page 5 Non-Allowable Legal Fees			10,256

Evergreen Health Care Center
Medicaid Cost Report
01/01/11 - 12/31/11

Page 21 Supplemental Schedule - Seminar Schedule

Vendor	Invoice Date	Description	Amount	Allowable
Ominicare	01/31/11	Purchasing Nursing Handbook	215	215
Paula Stanislaw	06/28/11	Expense Report	105	105
Paula Stanislaw	07/31/11	Education Service Hours for the Week ending 7/09/11 & 7/16/11	2,440	2,440
Mulherin, Megan	08/09/11	Expense Report	129	129
Mulherin, Megan	08/09/11	Expense Report	129	129
Illinois Council on Long Term Car	08/26/11	MDS 3.0 After A Year Seminar	875	875
Michelle Epps	08/26/11	Wound Certification Course	2,897	2,897
Catrina Mitchell-Smith	09/26/11	Registration fee for wound certification course	30	30
G. Kennedy	09/30/11	TRAINING AND RECRUITMENT	169	169
Sarah Frigo	09/30/11	The 2011 Seminar Series for Nursing Home Professionals	210	210
Sarah Frigo	09/30/11	The 2011 Seminar Series for Nursing Home Professionals	105	105
Paula Stanislaw	10/01/11	Education Service Hours for the Week ending 9/16/2011	240	240
Mulherin, Megan	10/18/11	AANAC MDS CERTIFICATION COURSE	2,200	2,200
Paula Stanislaw	10/31/11	Education Service Hours for the Week ending 10/27/2011	200	200
Kelly O'Leary, Tighe	11/03/11	Suddenly Senior Conference	139	139
PICC ME Vascular Solutions	11/30/11	Midline/PICC Line Insertion	3,600	3,600
Joan A. Bornack	12/11/11	Orthopedic Nursing Education	1,150	1,150
Old Mountain	12/31/11	To record 5 years old mountain storage fee	67	67
Paula Stanislaw	12/31/11	Education Service Hours for the Week ending 12/9/11 & 12/13/11 & 12/16/11	240	240
				-
				-
				-
Total			15,140	15,140

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 01/01/11

Ending: 12/31/11

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. IHCA - \$13,206
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 - 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 84,603 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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. \$ 2,322 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 590
- (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? Ln 14
d. Have vehicle usage logs been maintained? Yes
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.