

		FOR BHF USE				

LL1

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

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

I. IDPH Facility ID Number: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road Champaign 61821
 Number City Zip Code

County: Whiteside

Telephone Number: (217) 356-5164 **Fax #** (217) 356-7873

HFS ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 (c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) James R. Johnson

(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

(Signed) See Compilation Report (Date) _____

Paid Preparer (Print Name and Title) Robert A. Thomas Partner

(Firm Name & Address) Thomas Healthcare Consulting, P.C. 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038

(Telephone) (317) 577-0101 Fax # (317) 577-3389

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

Facility Name & ID Number Swann Special Care Center# 0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

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		Skilled (SNF)			1
2	<u>123</u>	Skilled Pediatric (SNF/PED)	<u>123</u>	<u>44,895</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF				8	
9	SNF/PED	<u>39,700</u>	<u>730</u>	<u>0</u>	<u>40,430</u>	9
10	ICF				10	
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>39,700</u>	<u>730</u>		<u>40,430</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.05%

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

1,405 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 08/15/89

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

YES Date 08/15/89 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 0 and days of care provided N/AMedicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	236,481	21,060	17,402	274,943	7,493	282,436	(66,011)	216,425			1
2	Food Purchase		251,230		251,230		251,230		251,230			2
3	Housekeeping		40,882	133,289	174,171		174,171		174,171			3
4	Laundry	34,083	17,215	99,064	150,362		150,362		150,362			4
5	Heat and Other Utilities			101,378	101,378		101,378		101,378			5
6	Maintenance	51,720	20,210	61,574	133,504		133,504		133,504			6
7	Other (specify):*											7
8	TOTAL General Services	322,284	350,597	412,707	1,085,588	7,493	1,093,081	(66,011)	1,027,070			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,569,246	217,473	198,338	2,985,057	(12,998)	2,972,059	(473)	2,971,586			10
10a	Therapy	43,304	2,821	117,000	163,125		163,125		163,125			10a
11	Activities	210,314	2,926	733	213,973		213,973		213,973			11
12	Social Services	3,330		2,399	5,729		5,729		5,729			12
13	CNA Training					16,763	16,763		16,763			13
14	Program Transportation	3,062	6,874	4,881	14,817		14,817		14,817			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,829,256	230,094	359,351	3,418,701	3,765	3,422,466	(473)	3,421,993			16
	C. General Administration											
17	Administrative	61,515		215,657	277,172	(205,513)	71,659	(10,144)	61,515			17
18	Directors Fees					7,918	7,918		7,918			18
19	Professional Services			656,345	656,345	75,369	731,714	(1,500)	730,214			19
20	Dues, Fees, Subscriptions & Promotions			49,747	49,747	139	49,886	(39,632)	10,254			20
21	Clerical & General Office Expenses	131,866	22,925	65,681	220,472	39,498	259,970	(48,893)	211,077			21
22	Employee Benefits & Payroll Taxes			650,643	650,643	3,214	653,857	(4,329)	649,528			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,278	18,278	1,073	19,351	(208)	19,143			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,902	48,902		48,902		48,902			26
27	Other (specify):* Bad Debt			(2,910)	(2,910)		(2,910)	2,910				27
28	TOTAL General Administration	193,381	22,925	1,702,343	1,918,649	(78,302)	1,840,347	(101,796)	1,738,551			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,344,921	603,616	2,474,401	6,422,938	(67,044)	6,355,894	(168,280)	6,187,614			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center #0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			161,676	161,676	39	161,715		161,715		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			410,076	410,076	67,989	478,065	(31,682)	446,383		32
33	Real Estate Taxes			40	40		40		40		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			12,199	12,199	(245)	11,954		11,954		35
36	Other (specify):* Amortization			38,760	38,760		38,760	(27,835)	10,925		36
37	TOTAL Ownership			622,751	622,751	67,783	690,534	(59,517)	631,017		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			415,436	415,436		415,436		415,436		42
43	Other (specify):* Edu/Day Training	1,261,626	20,145	302,382	1,584,153	(739)	1,583,414		1,583,414		43
44	TOTAL Special Cost Centers	1,261,626	20,145	717,818	1,999,589	(739)	1,998,850		1,998,850		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,606,547	623,761	3,814,970	9,045,278		9,045,278	(227,797)	8,817,481		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(31,682)	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				19
20	Contributions	(4,457)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,910	27		24
25	Fund Raising, Advertising and Promotional	(39,432)	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	(143,492)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (217,653)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,144)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (10,144)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (227,797)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Swann Special Care Center

ID# 0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(10,144)	0	0	0	0	0	0	0	0	0	(10,144)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	19
20	Fees, Subscriptions & Promotions	(39,432)	0	0	0	0	0	0	0	0	0	0	(39,432)	20
21	Clerical & General Office Expenses	(4,457)	0	0	0	0	0	0	0	0	0	0	(4,457)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	2,910	0	0	0	0	0	0	0	0	0	0	2,910	27
28	TOTAL General Administration	(42,479)	(10,144)	0	0	0	0	0	0	0	0	0	(52,623)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,479)	(10,144)	0	0	0	0	0	0	0	0	0	(52,623)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,682)	0	0	0	0	0	0	0	0	0	0	(31,682)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,682)	0	0	0	0	0	0	0	0	0	0	(31,682)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(74,161)	(10,144)	0	(84,305)	45								

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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
		Exceptional Care & Training Center	Sterling			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Corporate Expense	\$ 215,657	Hoosier Care, Inc.	100.00%	\$ 205,513	\$ (10,144)	1
2	V							2
3	V			Note: See Schedule VIII of allocation of cost per column 7.				3
4	V							4
5	V							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		\$ 215,657			\$ 205,513	\$ * (10,144)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	Bruce Hutson, M.D.	Director	Board Meetings	0.00	5,800			Director Fees	\$ 1,584	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	5,799			Director Fees	1,584	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	5,800			Director Fees	1,583	18.8	3
4	John Foos	Director	Board Meetings	0.00	5,799			Director Fees	1,584	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	5,800			Director Fees	1,583	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,918		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Hoosier Care, Inc.
 Street Address 535 West Second, Suite 105
 City / State / Zip Code Lexington, Kentucky 40508
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Revenue	43,523,659	8	\$ 34,932	\$ 0	9,335,583	\$ 7,493	1
2	10	Nursing / Medical Records	Revenue	43,523,659	8	14,059	0	9,335,583	3,016	2
3	18	Directors Fees	Revenue	43,523,659	8	36,916	0	9,335,583	7,918	3
4	19	Professional Services	Revenue	43,523,659	8	351,378	0	9,335,583	75,369	4
5	20	Dues, Subscriptions & Fees	Revenue	43,523,659	8	649	0	9,335,583	139	5
6	21	Clerical & General Office Exp.	Revenue	43,523,659	8	183,050	0	9,335,583	39,263	6
7	22	Emp. Benefits & Pyaroll Tax	Revenue	43,523,659	8	14,983	0	9,335,583	3,214	7
8	24	Travel & Seminar	Revenue	43,523,659	8	5,004	0	9,335,583	1,073	8
9	30	Depreciation	Revenue	43,523,659	8	182	0	9,335,583	39	9
10	32	Interest - Working Capital	Revenue	43,523,659	8	316,973	0	9,335,583	67,989	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					\$ 958,126	\$		\$ 205,513	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	Ill. Health Finance Authority		X	Purchase of Facility	Varies	7/8/99	\$ 5,710,000	\$ 5,375,000	6/1/2034	7.1250	\$ 386,216	1								
2	Ill. Health Finance Authority		X	Purchase of Facility	Varies	7/8/99	260,000	220,000	6/2/2019	10.5000	23,860	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Corporate Allocation										67,989	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 5,970,000	\$ 5,595,000			\$ 478,065	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 5,970,000	\$ 5,595,000			\$ 478,065	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning: 7/1/05

Ending: 6/30/06

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	<u>None</u>	8		
2002		9		
2003		10		
2004		11		
2005		12		
Note: The facility became exempt from property taxes starting 1/1/96				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

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

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 NO

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Swann Special Care Center

0035485 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,257 B. General Construction Type: Exterior Block & Brick Frame Wood 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).

None

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	<u>SNF/PED</u>	<u>89,603</u>	<u>1989</u>	<u>\$ 538,000</u>	1
2					2
3	TOTALS	89,603		\$ 538,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1989	1975	\$ 2,592,000	\$ 56,275	10-40	\$ 56,275		\$ 1,292,985	4
5	9			1993	319,955	10,665	30	10,665		161,186	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		30,270	7
8	11			2004	N/A		N/A				8
	Improvement Type**										
9	Paint & Panels			1989	1,308		3			1,308	9
10	Blinds			1990	384		3			384	10
11	Fire Doors			1990	2,751		10			2,751	11
12	Storm Windows			1991	4,224		10			4,224	12
13	Fire Doors			1991	3,675		10			3,675	13
14	Compressor			1991	1,035		10			1,035	14
15	Carpeting			1991	220		10			220	15
16	Sprinkler & Fire Alarm			1991	695		10			695	16
17	Sprinkler			1992	3,162		10			3,162	17
18	Damper			1992	674		10			674	18
19	Fire Alarm System			1992	1,945		10			1,945	19
20	Water Heater			1992	1,998		7			1,998	20
21	Roofing			1992	3,900		10			3,900	21
22	Voltage Relay			1993	1,875		10			1,875	22
23	Sprinkler System			1993	14,460		10			14,460	23
24	Wall Covering			1993	3,190		10			3,190	24
25	Wall Papering			1993	3,000		10			3,000	25
26	Blinds with Valance			1993	2,395		10			2,395	26
27	Carpet and Rubber Base			1993	2,848		10			2,848	27
28	Replace Siding			1993	575		10			575	28
29	Remodeling in Team Rooms			1993	9,405		10			9,405	29
30	Plexiglas for Doors & Walls			1993	714		10			714	30
31	Resurface Parking Lot			1993	19,115		10			19,115	31
32	Shed			1993	5,990		10			5,990	32
33	Stain New Shed			1993	1,248		10			1,248	33
34	Fire Doors, Closets, Tile			1993	5,225		10			5,225	34
35	Architectural Renovation			1993	855		10			855	35
36	Install Alarm & Nurse Call			1994	688		10			688	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Heat Pump	1994	\$ 2,017	\$	10	\$	\$	\$ 2,017	37
38	Paving for New Sign	1994	680		10			680	38
39	Labor for Laying Brick - Sign	1994	1,000		10			1,000	39
40	Sign for Dedication	1994	325		10			325	40
41	Sign and Granite Pieces	1994	1,300		10			1,300	41
42	Material for Leasehold Improvements	1995	7,858		3			7,858	42
43	Hoods, Fans, Ansul System	1995	2,500		10			2,500	43
44	Work for Exhaust Fan & Hood	1995	3,995		10			3,995	44
45	Day Room Addition	1995	3,337		10			3,337	45
46	Replace Water Heater	1995	3,750		10			3,750	46
47	Day Room Additional Supplies	1995	1,926		10			1,926	47
48	Walk-in-Cooler	1995	3,334	83	10	83		3,334	48
49	Nurse Call System	1996	1,198	80	10	80		1,198	49
50	Shed	1996	2,034	153	10	153		2,034	50
51	Air Conditioner Compressor	1996	1,208	111	10	111		1,208	51
52	Supplies for Leasehold Improvements	1996	3,091		3			3,091	52
53	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose								53
54	Activity Room & Bathroom Addition plus renovation								54
55	to the Dental Office	1996	180,928	9,046	20	9,046		92,725	55
56	Construct Screens, Wheelchairs	1996	1,420		3			1,420	56
57	Construct Shelving, Beds, Screen	1996	2,964		3			2,964	57
58	Install Nurse Call System	1996	1,530	153	10	153		1,530	58
59	Tile Flooring & Adhesive	1996	1,227	123	10	123		1,206	59
60	Linoleum Flooring	1996	686	69	10	69		664	60
61	Install New Drain Pipes	1996	2,190	219	10	219		2,117	61
62	Remove Concrete to Replace Drain Pipes	1996	575	58	10	58		556	62
63	Install Exit Door Hardware	1997	874	87	10	87		823	63
64	Day Training Improvement	1997	4,078		4			4,078	64
65	Install New Disposal	1997	1,069	107	10	107		936	65
66	Replace Four-Door Glass	1998	520	52	10	52		433	66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		3,536	67
68	Remodel Project 2410 Springfield	1998	33,764		4			33,764	68
69	Partition Wall Kitchen / Dining Area	1998	595	74	8	74		564	69
70	TOTAL (lines 4 thru 69)		\$ 3,448,638	\$ 83,080		\$ 83,080	\$	\$ 1,768,864	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,448,638	\$ 83,080		\$ 83,080	\$	\$ 1,768,864	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	1,765	10	1,765		13,384	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	74	10	74		561	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	1,526	10	1,526		11,571	4
5	Security Door and Hardware - Converted Rooms	1999	520	52	10	52		385	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	300	10	300		2,150	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	116	10	116		838	7
8	Electrical Service Move Switches	1999	141	18	8	18		131	8
9	Installation of Water Heaters	1999	595	60	10	60		427	9
10	Resurface Parking Lot	1999	2,350	157	15	157		1,084	10
11	14 Almond FRP Panel Dividers	1999	513		5			513	11
12	Install Alarm System	2000	2,000		5			2,000	12
13	Install Alarm System	2000	2,730		5			2,730	13
14	Replaced Compressor on Freezer	1999	635	63	10	63		434	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		271	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		1,878	16
17	Storage Barn	1999	120	5	25	5		32	17
18	Storage Barn	1999	1,045	42	25	42		282	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		1,029	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		409	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		1,399	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		4,779	22
23	Intstall Clinical Sink	2000	3,030		5			3,030	23
24	Stoneybrook Remodeling PR	2000	138,235	6,912	5	6,912		138,235	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		1,611	25
26	Replace Gate Valve	2000	6,005	400	15	400		2,335	26
27	Replace Ceiling Tile	2000	674	67	10	67		394	27
28	Materials to Tile Bathroom	2001	784	78	10	78		438	28
29	Install Booster Pump	2001	1,995	133	15	133		731	29
30	Install Tile in Bathroom	2001	825	55	15	55		302	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		1,166	31
32	Replace Reversing Valve	2001	599	60	10	60		309	32
33	Replacement Parts for Roof	2001	662	66	10	66		342	33
34	TOTAL (lines 1 thru 33)		\$ 3,679,880	\$ 97,014		\$ 97,014	\$	\$ 1,964,044	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,679,880	\$ 97,014		\$ 97,014	\$	\$ 1,964,044	1
2	Tile for Bathroom	2001	1,854	185	10	185		942	2
3	Stoneybrook Awning	2001	15,560	1,556	5	1,556		15,560	3
4	Stoneybrook Telephone System	2001	1,668	167	5	167		1,668	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431	243	5	243		2,431	5
6	Stoneybrook Shelves - Inst	2001	516	60	5	60		516	6
7	Remodeling	2001	8,351	1,670	5	1,670		8,073	7
8	Sprinkler System Renovation	2001	760	51	15	51		253	8
9	Install Shower Drains	2001	10,500	525	20	525		2,625	9
10	Tile to Replce Tubs	2001	1,278	85	15	85		426	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		690	11
12	Replace Laundry Panel	2001	1,179	79	15	79		373	12
13	Valve-Water Heater	2001	876	88	10	88		416	13
14	Internet Set-up Wiring Cable	2002	6,141	409	15	409		1,808	14
15	Thermostats with Locking Guards	2002	1,371	91	15	91		381	15
16	Classroom Remodel	2002	5,978	598	10	598		2,591	16
17	Replace Fencing Around Dumpster Area	2002	674	67	10	67		281	17
18	Replace Doors	2002	3,000	600	5	600		2,700	18
19	Security System	2002	3,165	633	5	633		2,796	19
20	Remodeling	2002	8,351	1,670	5	1,670		7,238	20
21	Electrical Labor-Remodeling	2002	1,425	285	5	285		1,235	21
22	Install Two Sinks	2002	3,561	712	5	712		2,968	22
23	Revise Sprinkler System	2002	501	100	5	100		426	23
24	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		1,124	24
25	Install New Phone System	2002	2,735	547	5	547		2,051	25
26	Install New Phone System / Day Training	2002	2,488	498	5	498		1,866	26
27	Carpet & Installation	2002	2,954	295	10	295		1,182	27
28	New Mother Board / Alarm System	2002	1,490	149	10	149		584	28
29	Install A/C Rooftop Unit	2002	8,237	549	15	549		2,151	29
30	New 2nd Rooftop Compressor	2002	762	51	15	51		195	30
31	Height Adjustment Supine Tub	2002	8,469	847	10	847		3,035	31
32	Relief Valves / Booster Heater	2003	555	56	10	56		194	32
33	Central Heat / Air Rooftop	2003	5,180	345	15	345		1,209	33
34	TOTAL (lines 1 thru 33)		\$ 3,796,104	\$ 110,646		\$ 110,646	\$	\$ 2,034,032	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,796,104	\$ 110,646		\$ 110,646	\$	\$ 2,034,032	1
2	New Tile and Base Floor	2003	847	85	10	85		296	2
3	New Hydrotherapy Tub	2003	1,900	190	10	190		665	3
4	Electric Water Heater	2003	5,600	560	10	560		1,867	4
5	Exhaust Fan	2003	525	53	10	53		162	5
6	Remodeling	2003	8,351	1,670	5	1,670		5,846	6
7	Install Dry Pendent Sprinkler in Freezer	2003	675	68	10	68		197	7
8	Rooftop Unit Installed / Heat Air Wing 3	2003	10,910	727	15	727		2,121	8
9	60 X 94 Lami Glass	2003	179,834	5,994	30	5,994		13,987	9
10	New Wing	2004	839	120	7	120		320	10
11	Installing Draining System in Courtyard	2004	9,268	1,324	7	1,324		3,200	11
12	5th Annual Payment on Remodeling	2004	8,351	1,670	5	1,670		4,176	12
13	Drainage System for Courtyard	2004	501	72	7	72		155	13
14	Lift Pump for Drinking Fountain	2004	1,040	208	5	208		433	14
15	AC Compressor Roof Top Main Building	2004	1,403	281	5	281		538	15
16	HVAC Compressor - Office	2004	1,079	216	5	216		414	16
17	New Roof	2004	28,855	1,443	20	1,443		2,765	17
18	Exhaust Fan Motor / Thermostat	2005	787	79	10	79		98	18
19	Roofing Project Wing 1,2,&4	2005	66,485	4,432	15	4,432		4,802	19
20	Replace 8 Vinyl Windows	2006	668	22	10	22		22	20
21	Re-Tile Shower Room	2006	10,714	119	15	119		119	21
22	Rounding		1	(1)		(1)		(1)	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,134,737	\$ 129,978		\$ 129,978	\$	\$ 2,076,214	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	\$ 135,966	\$ 22,219	\$ 22,219	\$		\$ 76,739	71
72	Current Year Purchases	18,845	1,489	1,489			1,489	72
73	Fully Depreciated Assets	558,792	2,506	2,506			558,792	73
74	Corporate Allocation		39	39				74
75	TOTALS	\$ 713,603	\$ 26,253	\$ 26,253	\$		\$ 637,020	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	Patient Transportation	1985 GMC Bus	1993	\$ 16,250	\$	\$	\$		\$ 16,250	76
77	Patient Transportation	1985 GMC Bus	N/A	4,041					4,041	77
78	Patient Transportation	1994 Ford Station Wagon	1999	7,020					7,020	78
79	See Attached			53,902	5,484	5,484			37,204	79
80	TOTALS			\$ 81,213	\$ 5,484	\$ 5,484	\$		\$ 64,515	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)	\$	5,467,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	161,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	161,715	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)	\$	2,777,749	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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

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								6
7	TOTAL				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 11,954 Description: See 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

* 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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/05 Ending: 6/30/06

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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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		10		10
3	Classroom Wages (a)		4,922		4,922
4	Clinical Wages (b)		9,844		9,844
5	In-House Trainer Wages (c)		1,987		1,987
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 16,763	\$	\$ 16,763
10	SUM OF line 9, col. 1 and 2 (e)	\$	16,763		

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	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/05

Ending:

6/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 25,930	\$	1
2	Cash-Patient Deposits	108,772		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 4,680)	1,564,276		3
4	Supply Inventory (priced at <u>Cost</u>)	47,611		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,288		6
7	Other Prepaid Expenses	19,267		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due to / from Corporate</u>	(3,836,203)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (2,027,059)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,134,737		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	794,816		16
17	Accumulated Depreciation (book methods)	(2,777,749)		17
18	Deferred Charges	305,880		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):	500,065		22
23	Other(specify): <u>Goodwill</u>	642,533		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,138,282	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,111,223	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 188,945	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	108,772		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,209		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,500		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	33,838		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 596,264	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,595,000		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)	\$ 5,595,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,191,264	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,080,041)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,111,223	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,479,213)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,479,213)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	399,172	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 399,172	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)	\$ (4,080,041)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	\$ 6,992,177	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,992,177	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	970,382	9
10	Other Government Grants	66,011	10
11	CNA Training Reimbursements	8,103	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,044,496	23
D. Non-Operating Revenue			
24	Contributions	45,254	24
25	Interest and Other Investment Income***	31,682	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 76,936	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,316,174	28
28a	<u>Miscellaneous Income</u>	14,667	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,330,841	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,444,450	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,085,588	31
32	Health Care	3,418,701	32
33	General Administration	1,918,649	33
B. Capital Expense			
34	Ownership	622,751	34
C. Ancillary Expense			
35	Special Cost Centers	1,584,153	35
36	Provider Participation Fee	415,436	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,045,278	40
41	Income before Income Taxes (line 30 minus line 40)**	399,172	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 399,172	43

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

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

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

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

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,967	2,187	\$ 57,018	\$ 26.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,966	31,583	792,165	25.08	3
4	Licensed Practical Nurses	12,761	13,904	254,662	18.32	4
5	CNAs & Orderlies	119,698	130,435	1,465,401	11.23	5
6	CNA Trainees					6
7	Licensed Therapist	4,560	4,973	43,304	8.71	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,994	2,154	33,000	15.32	9
10	Activity Assistants	22,308	24,235	177,314	7.32	10
11	Social Service Workers	74	74	3,330	45.00	11
12	Dietician					12
13	Food Service Supervisor	2,019	2,162	39,881	18.45	13
14	Head Cook	14,258	15,757	196,600	12.48	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,000	4,274	51,720	12.10	17
18	Housekeepers					18
19	Laundry	2,232	2,464	34,083	13.83	19
20	Administrator	1,853	2,080	61,515	29.57	20
21	Assistant Administrator					21
22	Other Administrative	264	264	3,062	11.60	22
23	Office Manager					23
24	Clerical	6,073	6,505	131,866	20.27	24
25	Vocational Instruction					25
26	Academic Instruction	38,627	42,834	585,501	13.67	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)					32
33	Other(specify)	54,072	57,926	676,125	11.67	33
34	TOTAL (lines 1 - 33)	316,726	343,811	\$ 4,606,547 *	\$ 13.40	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	441	\$ 17,011	1.3	35
36	Medical Director	N/A	36,000	09.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	71	17,306	10.3	38
39	Pharmacist Consultant	N/A	975	10.3	39
40	Physical Therapy Consultant	33	7,650	10A.3	40
41	Occupational Therapy Consultant	1,021	54,618	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	930	53,687	10A.3	43
44	Activity Consultant	4	190	11.3	44
45	Social Service Consultant	43	2,399	12.3	45
46	Other(specify) Dental Fees	N/A	6,381	10.3	46
47	Resident Transport	N/A	3,765	14.3	47
48	See Attached	N/A	352,574		48
49	TOTAL (lines 35 - 48)	2,543	\$ 552,556		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,568	\$ 148,144	10.3	50
51	Licensed Practical Nurses	632	22,121	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,200	\$ 170,265		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center

0035485

Report Period Beginning: 7/1/05

Ending: 6/30/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Lou Bedient	Administrator	0	\$ 61,515	Workers' Compensation Insurance	\$ 105,203	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(6,144)	Advertising: Employee Recruitment		
				FICA Taxes	348,789	Health Care Worker Background Check		
				Employee Health Insurance	174,047	(Indicate # of checks performed <u>96</u>)	1,545	
				Employee Meals		Illnois Health Care Assoc.	6,790	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	40,547	
				Employee Retirement Plan	7,505	Chamber of Commerce	200	
				Employee Benefits- Other	16,914	Corporate Allocation	139	
				Corporate Allocation	3,214	Other Fees	665	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 61,515	TOTAL (agree to Schedule V, line 22, col.8)		\$ 10,254		
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corporate Expense			\$ 215,657				Out-of-State Travel	\$ 170
							Non-Allowable	(170)
							In-State Travel	10,087
							Non-Allowable	(38)
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 215,657	TOTAL		\$	Seminar Expense	8,021
(Attach a copy of any management service agreement)							Corporate Allocation	1,073
C. Professional Services								
Vendor/Payee	Type	Amount						
Medical Rehabilitation Centers, Inc.	Management Fees	\$ 536,400					Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Thomas Healthcare Consulting	Accounting Fees	4,100						
Connie Rosen	Accounting Fees	2,103						
Erwin Martinkus and Cole	Legal Fees	12,105						
Sommer Barnard	Legal Fees	1,535						
Duane, Morris & Heckscher LLP	Legal Fees	96,640						
Stoll, Keenan & Ogden	Legal Fees	677						
Medical Rehabilitation Centers, Inc.	Legal Fees	2,785						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 656,345				TOTAL	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 19,143	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule XIX, Section F
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,309 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 415,436
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 66,011
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes - Offset
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? 100 %
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? Yes
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 42,650
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT