



Facility Name & ID Number Swann Special Care Center

# 0035485 Report Period Beginning: 7/1/07 Ending: 6/30/08

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>45,018</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>45,018</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>41,415</u>	<u>377</u>	<u>0</u>	<u>41,792</u>	9
10	ICF				10	
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>41,415</u>	<u>377</u>		<u>41,792</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.83%

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

408 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 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/A

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/07 Ending: 6/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	228,986	20,648	17,750	267,384	12,681	280,065	(67,802)	212,263			1
2	Food Purchase		238,677		238,677		238,677		238,677			2
3	Housekeeping		34,869	139,540	174,409		174,409		174,409			3
4	Laundry	36,494	12,769	98,143	147,406		147,406		147,406			4
5	Heat and Other Utilities			95,047	95,047	713	95,760		95,760			5
6	Maintenance	59,389	16,678	46,471	122,538	1,384	123,922		123,922			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>324,869</b>	<b>323,641</b>	<b>396,951</b>	<b>1,045,461</b>	<b>14,778</b>	<b>1,060,239</b>	<b>(67,802)</b>	<b>992,437</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,523,144	220,044	198,125	2,941,313	(24,412)	2,916,901		2,916,901			10
10a	Therapy	71,673	2,074	149,034	222,781		222,781		222,781			10a
11	Activities	218,098	1,557	363	220,018		220,018		220,018			11
12	Social Services	1,035	137	884	2,056		2,056		2,056			12
13	CNA Training					43,082	43,082		43,082			13
14	Program Transportation	61,962	14,391	24,852	101,205		101,205		101,205			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,875,912</b>	<b>238,203</b>	<b>409,258</b>	<b>3,523,373</b>	<b>18,670</b>	<b>3,542,043</b>		<b>3,542,043</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	81,028		328,593	409,621	(256,253)	153,368	(72,340)	81,028			17
18	Directors Fees					14,771	14,771		14,771			18
19	Professional Services			608,676	608,676	76,245	684,921	(2,361)	682,560			19
20	Dues, Fees, Subscriptions & Promotions			21,334	21,334	100	21,434	(9,947)	11,487			20
21	Clerical & General Office Expenses	102,439	13,517	49,901	165,857	78,989	244,846	(832)	244,014			21
22	Employee Benefits & Payroll Taxes			681,739	681,739	12,035	693,774	2,901	696,675			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,855	16,855	(1,059)	15,796	(565)	15,231			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,532	72,532		72,532		72,532			26
27	Other (specify):* <b>Bad Debt</b>			38,505	38,505		38,505	(38,505)				27
28	<b>TOTAL General Administration</b>	<b>183,467</b>	<b>13,517</b>	<b>1,818,135</b>	<b>2,015,119</b>	<b>(75,172)</b>	<b>1,939,947</b>	<b>(121,649)</b>	<b>1,818,298</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,384,248</b>	<b>575,361</b>	<b>2,624,344</b>	<b>6,583,953</b>	<b>(41,724)</b>	<b>6,542,229</b>	<b>(189,451)</b>	<b>6,352,778</b>			<b>29</b>

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

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: 7/1/07 Ending: 6/30/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			177,951	177,951	135	178,086		178,086		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			488,678	488,678	40,872	529,550	(123,905)	405,645		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds					2,414	2,414		2,414		34
35	Rent-Equipment & Vehicles			10,098	10,098	(310)	9,788		9,788		35
36	Other (specify):* <b>Amortization</b>			41,239	41,239		41,239	(30,315)	10,924		36
37	<b>TOTAL Ownership</b>			717,966	717,966	43,111	761,077	(154,220)	606,857		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			401,119	401,119		401,119		401,119		42
43	Other (specify):* <b>Edu/Day Training</b>	1,174,748	14,201	318,164	1,507,113	(1,387)	1,505,726		1,505,726		43
44	<b>TOTAL Special Cost Centers</b>	1,174,748	14,201	719,283	1,908,232	(1,387)	1,906,845		1,906,845		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,558,996	589,562	4,061,593	9,210,151		9,210,151	(343,671)	8,866,480		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: 7/1/07

Ending: 6/30/08

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(34,064)	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	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,361)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,505)	27		24
25	Fund Raising, Advertising and Promotional	(9,662)	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	(186,589)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (271,331)		\$	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)	(72,340)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (72,340)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (343,671)		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.

		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			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Swann Special Care Center

ID# 0035485

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	(72,340)	0	0	0	0	0	0	0	0	0	(72,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,361)	0	0	0	0	0	0	0	0	0	0	(2,361)	19
20	Fees, Subscriptions & Promotions	(9,662)	0	0	0	0	0	0	0	0	0	0	(9,662)	20
21	Clerical & General Office Expenses	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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):*	(38,505)	0	0	0	0	0	0	0	0	0	0	(38,505)	27
28	<b>TOTAL General Administration</b>	(50,678)	(72,340)	0	0	0	0	0	0	0	0	0	(123,018)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(50,678)	(72,340)	0	0	0	0	0	0	0	0	0	(123,018)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	(34,064)	0	0	0	0	0	0	0	0	0	0	(34,064)	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	<b>TOTAL Ownership</b>	<b>(34,064)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(34,064)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(84,742)</b>	<b>(72,340)</b>	<b>0</b>	<b>(157,082)</b>	<b>45</b>								

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/07 Ending: 6/30/08

**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			
		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	\$ 328,593	Hoosier Care, Inc.	100.00%	\$ 256,253	\$ (72,340)	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		\$ 328,593			\$ 256,253	\$ * (72,340)	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: 7/1/07 Ending: 6/30/08

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	10,433			Director Fees	\$ 3,234	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	18,036			Director Fees	5,591	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	9,588			Director Fees	2,973	18.8	3
4	John Foos	Director	Board Meetings	0.00	9,588			Director Fees	2,973	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,771		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:

7/1/07

Ending: 6/30/08

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 Street, 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	41,556,567	7	\$ 53,586	\$ 0	9,834,600	\$ 12,681	1
2	5	Heat & Other Utilities	Revenue	41,556,567	7	3,012	0	9,834,600	713	2
3	6	Maintenance	Revenue	41,556,567	7	5,850	0	9,834,600	1,384	3
4	10	Nursing / Medical Records	Revenue	41,556,567	7	65,268	0	9,834,600	15,446	4
5	18	Directors Fees	Revenue	41,556,567	7	62,416	0	9,834,600	14,771	5
6	19	Professional Services	Revenue	41,556,567	7	322,175	0	9,834,600	76,245	6
7	20	Dues, Subscriptions & Fees	Revenue	41,556,567	7	423	0	9,834,600	100	7
8	21	Clerical & General Office Exp.	Revenue	41,556,567	7	332,808	0	9,834,600	78,761	8
9	22	Emp. Benefits & Payroll Tax	Revenue	41,556,567	7	50,853	0	9,834,600	12,035	9
10	24	Travel & Seminar	Revenue	41,556,567	7	2,795	0	9,834,600	661	10
11	30	Depreciation	Revenue	41,556,567	7	571	0	9,834,600	135	11
12	32	Interest - Working Capital	Revenue	41,556,567	7	172,705	0	9,834,600	40,872	12
13	34	Rent- Facility	Revenue	41,556,567	7	10,200	0	9,834,600	2,414	13
14	35	Rent - Equipment	Revenue	41,556,567	7	150	0	9,834,600	35	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,082,812	\$		\$ 256,253	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Ill. Health Finance Authority		X	Purchase of Facility	Varies	7/8/99	\$ 5,710,000	\$ 5,240,000	6/1/2034	7.1250	\$ 376,874	1					
2	Ill. Health Finance Authority		X	Purchase of Facility	Varies	7/8/99	260,000	200,000	6/2/2019	10.5000	21,963	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Corporate Allocation										40,872	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 5,970,000	\$ 5,440,000			\$ 439,709	9					
<b>B. Non-Facility Related*</b>																	
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,225,799	Varies	Varies	89,841	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	1,225,799			\$ 89,841	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 5,970,000	\$ 6,665,799			\$ 529,550	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: 7/1/07

Ending: 6/30/08

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , 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 2008 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	<u>None</u>	8		
2004		9		
2005		10		
2006		11		
2007		12		
<b>Note: The facility became exempt from property taxes starting 1/1/96</b>				
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

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

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	<b>TOTALS</b>	<b>89,603</b>		<b>\$ 538,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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		\$ 1,405,535	4
5	9			1993	319,955	10,665	30	10,665		182,517	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		40,799	7
8	11			2004	N/A		N/A				8
<b>Improvement Type**</b>											
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 &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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		10			3,334	48
49	Nurse Call System	1996	1,198		10			1,198	49
50	Shed	1996	2,034		10			2,034	50
51	Air Conditioner Compressor	1996	1,208		10			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 to the Dental Office								54
55		1996	180,928	9,046	20	9,046		110,818	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		10			1,530	58
59	Tile Flooring & Adhesive	1996	1,227		10			1,227	59
60	Linoleum Flooring	1996	686		10			686	60
61	Install New Drain Pipes	1996	2,190		10			2,190	61
62	Remove Concrete to Replace Drain Pipes	1996	575		10			575	62
63	Install Exit Door Hardware	1997	874		10			874	63
64	Day Training Improvement	1997	4,078		4			4,078	64
65	Install New Disposal	1997	1,069	27	10	27		1,069	65
66	Replace Four-Door Glass	1998	520	35	10	35		520	66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		4,458	67
68	Remodel Project 2410 Springfield	1998	33,764		4			33,764	68
69	Partition Wall Kitchen / Dining Area	1998	595		8			595	69
70	TOTAL (lines 4 thru 69)		\$ 3,448,638	\$ 81,773		\$ 81,773	\$	\$ 1,932,726	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,448,638	\$ 81,773		\$ 81,773	\$	\$ 1,932,726	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	1,765	10	1,765		16,914	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	74	10	74		709	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	1,526	10	1,526		14,622	4
5	Security Door and Hardware - Converted Rooms	1999	520	52	10	52		489	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	300	10	300		2,750	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	116	10	116		1,069	7
8	Electrical Service Move Switches	1999	141		8			141	8
9	Installation of Water Heaters	1999	595	60	10	60		546	9
10	Resurface Parking Lot	1999	2,350	157	15	157		1,397	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		561	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		350	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		2,435	16
17	Storage Barn	1999	120	5	25	5		42	17
18	Storage Barn	1999	1,045	42	25	42		366	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		1,334	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		534	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		1,830	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		6,288	22
23	Intstall Clinical Sink	2000	3,030		5			3,030	23
24	Stoneybrook Remodeling PR	2000	138,235		5			138,235	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		2,148	25
26	Replace Gate Valve	2000	6,005	400	15	400		3,136	26
27	Replace Ceiling Tile	2000	674	67	10	67		528	27
28	Materials to Tile Bathroom	2001	784	78	10	78		594	28
29	Install Booster Pump	2001	1,995	133	15	133		997	29
30	Install Tile in Bathroom	2001	825	55	15	55		412	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		1,590	31
32	Replace Reversing Valve	2001	599	60	10	60		429	32
33	Replacement Parts for Roof	2001	662	66	10	66		474	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,679,880	\$ 88,777		\$ 88,777	\$	\$ 2,141,919	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,679,880	\$ 88,777		\$ 88,777	\$	\$ 2,141,919	1
2	Tile for Bathroom	2001	1,854	185	10	185		1,313	2
3	Stoneybrook Awning	2001	15,560		5			15,560	3
4	Stoneybrook Telephone System	2001	1,668		5			1,668	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431		5			2,431	5
6	Stoneybrook Shelves - Inst	2001	516		5			516	6
7	Remodeling	2001	8,351		5			8,351	7
8	Sprinkler System Renovation	2001	760	51	15	51		355	8
9	Install Shower Drains	2001	10,500	525	20	525		3,675	9
10	Tile to Replce Tubs	2001	1,278	85	15	85		596	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		971	11
12	Replace Laundry Panel	2001	1,179	79	15	79		531	12
13	Valve-Water Heater	2001	876	88	10	88		591	13
14	Internet Set-up Wiring Cable	2002	6,141	409	15	409		2,627	14
15	Thermostats with Locking Guards	2002	1,371	91	15	91		564	15
16	Classroom Remodel	2002	5,978	598	10	598		3,786	16
17	Replace Fencing Around Dumpster Area	2002	674	67	10	67		415	17
18	Replace Doors	2002	3,000		5			3,000	18
19	Security System	2002	3,165		5			3,165	19
20	Remodeling	2002	8,351		5			8,351	20
21	Electrical Labor-Remodeling	2002	1,425		5			1,425	21
22	Install Two Sinks	2002	3,561		5			3,561	22
23	Revise Sprinkler System	2002	501		5			501	23
24	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		1,686	24
25	Install New Phone System	2002	2,735	137	5	137		2,735	25
26	Install New Phone System / Day Training	2002	2,488	124	5	124		2,488	26
27	Carpet & Installation	2002	2,954	295	10	295		1,772	27
28	New Mother Board / Alarm System	2002	1,490	149	10	149		882	28
29	Install A/C Rooftop Unit	2002	8,237	549	15	549		3,249	29
30	New 2nd Rooftop Compressor	2002	762	51	15	51		297	30
31	Height Adjustment Supine Tub	2002	8,469	847	10	847		4,729	31
32	Relief Valves / Booster Heater	2003	555	56	10	56		305	32
33	Central Heat / Air Rooftop	2003	5,180	345	15	345		1,899	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,796,104	\$ 93,929		\$ 93,929	\$	\$ 2,225,914	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Swann Special Care Center

# 0035485

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,796,104	\$ 93,929		\$ 93,929	\$	\$ 2,225,914	1
2	New Tile and Base Floor	2003	847	85	10	85		466	2
3	New Hydrotherapy Tub	2003	1,900	190	10	190		1,045	3
4	Electric Water Heater	2003	5,600	560	10	560		2,987	4
5	Exhaust Fan	2003	525	53	10	53		267	5
6	Remodeling	2003	8,351	835	5	835		8,351	6
7	Install Dry Pendent Sprinkler in Freezer	2003	675	68	10	68		332	7
8	Rooftop Unit Installed / Heat Air Wing 3	2003	10,910	727	15	727		3,576	8
9	60 X 94 Lami Glass	2003	179,834	5,994	30	5,994		25,976	9
10	New Wing	2004	839	120	7	120		559	10
11	Installing Draining System in Courtyard	2004	9,268	1,324	7	1,324		5,847	11
12	5th Annual Payment on Remodeling	2004	8,351	1,670	5	1,670		7,516	12
13	Drainage System for Courtyard	2004	501	72	7	72		298	13
14	Lift Pump for Drinking Fountain	2004	1,040	208	5	208		849	14
15	AC Compressor Roof Top Main Building	2004	1,403	281	5	281		1,099	15
16	HVAC Compressor - Office	2004	1,079	216	5	216		845	16
17	New Roof	2004	28,855	1,443	20	1,443		5,651	17
18	Exhaust Fan Motor / Thermostat	2005	787	79	10	79		256	18
19	Roofing Project Wing 1,2,&4	2005	66,485	4,432	15	4,432		13,666	19
20	Replace 8 Vinyl Windows	2006	668	67	10	67		156	20
21	Re-Tile Shower Room	2006	10,714	714	15	714		1,548	21
22	Deposit for Duro Last Roof	2006	10,000	667	15	667		1,333	22
23	Compressor for A/C Unit Wing 2	2006	1,506	151	10	151		289	23
24	Duro Last Roof - Payment # 2	2006	4,384	292	15	292		585	24
25	100 Amp Sub Panel	2006	2,650	177	15	177		309	25
26	Laundry Room Walls Replaced	2006	2,323	155	15	155		284	26
27	Re-Tile Shower Room # 10	2006	11,642	776	15	776		1,358	27
28	Re-Tile Shower Room # 3	2006	11,642	776	15	776		1,229	28
29	Re-Tile Shower Room # 4	2006	11,642	776	15	776		1,164	29
30	Replace Walls in Dishwasher Area	2006	7,477	498	15	498		789	30
31	Dedicated Ground Circuit & Four Outlets	2006	1,513	101	15	101		151	31
32	Replace Kitchen Ceiling Tiles	2006	552	37	15	37		68	32
33	Parking Lot / Dumpster Pad Repaved	2006	8,073	807	10	807		1,346	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,208,140	\$ 118,280		\$ 118,280	\$	\$ 2,316,109	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:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 4,208,140	\$ 118,280		\$ 118,280	\$	\$ 2,316,109	1
2	Fence / Dumpster Enclosure	2006	2,750	275	10	275		413	2
3	Re-Tile Shower Room #s 5,6,7	2007	12,746	850	15	850		1,133	3
4	Curb & Guardrail Around Dumpster Area	2007	2,400	240	15	240		280	4
5	Metal Panels for School Windows	2007	2,158	144	15	144		168	5
6	15 Amp Receptacles	2007	780	52	15	52		61	6
7	Dedicated Ground Circuit for Server	2007	2,400	160	15	160		200	7
8	Electrical Outlets in Family Room	2007	1,222	81	15	81		95	8
9	Re-Tile Team 6 Bathroom	2007	7,561	420	15	420		420	9
10	Replace Motors on Roof Exhaust Fans (7)	2007	2,667	244	10	244		244	10
11	Upgrade Lighting System in Education	2007	6,501	361	15	361		361	11
12	Remodel Employee Breakroom	2007	2,478	186	10	186		186	12
13	Wire Breakroom & Outlets for Nurses Station	2007	2,574	100	15	100		100	13
14	Window on East Side of Education Building	2008	640	21	15	21		21	14
15	Air Curtain for Laundry Room	2008	1,195	40	10	40		40	15
16	Rooftop Heat Exchange Replaced	2008	2,463	103	10	103		103	16
17	South & Northwest Heat Exchangers	2008	2,421	81	10	81		81	17
18	Replace 2 Doors in Laundry Area	2008	4,187	93	15	93		93	18
19	Plexiglass Window Pane Replaced	2008	527	9	10	9		9	19
20	Rounding		1	(1)		(1)		3	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,265,811	\$ 121,739		\$ 121,739	\$	\$ 2,320,120	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: 7/1/07 Ending: 6/30/08

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	\$ 185,389	\$ 32,237	\$ 32,237	\$		\$ 96,256	71
72	Current Year Purchases	126,280	8,767	8,767			8,767	72
73	Fully Depreciated Assets	607,050	1,727	1,727			607,050	73
74	Corporate Allocation		135	135				74
75	TOTALS	\$ 918,719	\$ 42,866	\$ 42,866	\$		\$ 712,073	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	\$ 5,450	\$	\$	\$		\$ 5,450	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			161,921	13,481	13,481			62,026	79
80	TOTALS			\$ 178,432	\$ 13,481	\$ 13,481	\$		\$ 78,537	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)	\$ 5,900,962	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,086	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,086	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)	\$ 3,110,730	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	Corporate Allocation				2,414			5
6								6
7	TOTAL				\$ 2,414			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 9,788 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.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 7/1/07 Ending: 6/30/08

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		116		116
3	Classroom Wages (a)	52	12,384		12,436
4	Clinical Wages (b)	155	24,768		24,923
5	In-House Trainer Wages (c)		3,887		3,887
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,720		1,720
9	TOTALS	\$ 207	\$ 42,875	\$	\$ 43,082
10	SUM OF line 9, col. 1 and 2 (e)	\$ 43,082			

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	36
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>37</b>

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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		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	Other (specify):															12
13	Other (specify):															13
14	<b>TOTAL</b>			\$		\$	\$		\$		\$		\$			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: 7/1/07

Ending:

6/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,605	\$	1
2	Cash-Patient Deposits	84,255		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 9,607 )	2,438,707		3
4	Supply Inventory (priced at <u>Cost</u> )	24,635		4
5	Short-Term Investments			5
6	Prepaid Insurance	48,560		6
7	Other Prepaid Expenses	17,667		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due to / from Corporate</u>	(3,061,078)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (444,649)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	4,265,811		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,097,151		16
17	Accumulated Depreciation (book methods)	(3,110,730)		17
18	Deferred Charges	348,504		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):	583,426		22
23	Other(specify): <u>Goodwill</u>	586,862		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,309,024	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,864,375	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 186,008	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	84,255		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,209		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,300		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	40,277		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued HRA</u>	17,650		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 628,699	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,665,799		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 6,665,799	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,294,498	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,430,123)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,864,375	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,131,623)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,131,623)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	701,500	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)	\$ 701,500	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (3,430,123)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Swann Special Care Center# 0035485Report Period Beginning: 7/1/07Ending: 6/30/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,362,149	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,362,149	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	934,085	9
10	Other Government Grants	67,802	10
11	CNA Training Reimbursements	9,116	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	11,295	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,022,298	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	22,929	24
25	Interest and Other Investment Income***	34,064	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 56,993	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DMH Day Training</b>	1,470,212	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,470,212	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,911,652	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,045,461	31
32	Health Care	3,523,373	32
33	General Administration	2,015,119	33
<b>B. Capital Expense</b>			
34	Ownership	717,966	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,507,113	35
36	Provider Participation Fee	401,119	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	1	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,210,152	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	701,500	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 701,500	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: 7/1/07

Ending: 6/30/08

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	1,997	2,097	\$ 66,020	\$ 31.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,123	34,517	873,544	25.31	3
4	Licensed Practical Nurses	8,362	9,060	186,550	20.59	4
5	CNAs & Orderlies	108,537	118,215	1,397,030	11.82	5
6	CNA Trainees					6
7	Licensed Therapist	5,407	6,268	71,673	11.43	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,699	2,092	35,019	16.74	9
10	Activity Assistants	19,815	21,508	183,079	8.51	10
11	Social Service Workers	23	23	1,035	45.00	11
12	Dietician					12
13	Food Service Supervisor	2,027	2,100	42,504	20.24	13
14	Head Cook	13,404	14,637	186,482	12.74	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,056	4,409	59,389	13.47	17
18	Housekeepers					18
19	Laundry	2,138	2,403	36,494	15.19	19
20	Administrator	1,988	2,097	81,028	38.64	20
21	Assistant Administrator					21
22	Other Administrative	4,243	4,617	61,962	13.42	22
23	Office Manager					23
24	Clerical	7,258	9,011	102,439	11.37	24
25	Vocational Instruction					25
26	Academic Instruction	32,342	36,631	530,583	14.48	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) Day Training	51,955	56,671	644,165	11.37	33
34	TOTAL (lines 1 - 33)	297,374	326,356	\$ 4,558,996 *	\$ 13.97	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	376	\$ 15,083	1.3	35
36	Medical Director	N/A	36,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	37	3,170	10.3	38
39	Pharmacist Consultant	N/A	825	10.3	39
40	Physical Therapy Consultant	13	6,383	10A.3	40
41	Occupational Therapy Consultant	990	65,938	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,221	75,702	10A.3	43
44	Activity Consultant	2	114	11.3	44
45	Social Service Consultant	16	884	12.3	45
46	Other(specify) Dental Fees	N/A	431	10.3	46
47	Resident Transport	N/A	24,852	14.3	47
48	See Attached	N/A	353,698		48
49	TOTAL (lines 35 - 48)	2,655	\$ 583,080		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	4,472	\$ 180,991	10.3	50
51	Licensed Practical Nurses	251	8,625	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,723	\$ 189,616		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Swann Special Care Center

Report Period Beginning: 7/1/07 Ending:

**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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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12													
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14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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. \$ 24,000 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. 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. \$ 401,119  
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. \$ 67,802
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes  
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? N/A
- 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. \$ 46,877**
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT